Regular Meeting of the

Santa Clara County Health Authority
Governing Board

Thursday, December 16, 2021, 12:00 PM – 2:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference Only
(669) 900-6833
Meeting ID: 848 6048 4803
Passcode: GovBd2021
https://us06web.zoom.us/j/84860484803

AGENDA

1.	**Roll Call** Welcome new Board Member, Eva Terrazas.	Mr. Brownstein	12:00	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Governing Board reserves the right to limit the duration of the public comment period to 30 minutes.	Mr. Brownstein	12:05	5 min
3.	**Approve Consent Calendar and Changes to the Agenda** Items removed from the Consent Calendar will be considered as regular agenda items. **Possible Action:** Approve Consent Calendar	Mr. Brownstein	12:10	5 min

a. Approve minutes of the September 23, 2020 **Governing Board** Meeting
b. Accept minutes of the October 22, 2021 **Special Executive/Finance Committee** Meeting
- Ratify approval to continue use of teleconferencing without providing public access to each teleconference location pursuant to Government Code Section 54953

c. Accept minutes of the October 28, 2021 **Executive/Finance Committee** Meeting
- Ratify approval of the Fiscal Year 2020-2021 Independent Auditor's Report
- Ratify approval of the August 2021 Financial Statements

d. Accept minutes of the November 18, 2021 **Executive/Finance Committee** Meeting
- Ratify acceptance of the Network Detection and Prevention Update
- Ratify approval to continue the use of teleconferencing without providing public access to each teleconference location pursuant to Government Code Secion 54953
- Ratify approval of the September 2021 Financial Statements

- Ratify approval of three-year contracts with D-SNP Enrollment, Sales & Broker Systems vendors Dynamic Healthcare Systems and Engagem Health
- Ratify approval of Innovation Fund COVID-19 Expenditure for Children's Discovery Museum COVID-19 Vaccination Clinics
- Ratify approval of Innovation Fund Expenditure for Behavioral Health Contractors Association of Santa Clara County for Readiness Support for Delivery System Changes

e. Accept minutes of the November 18, 2021 **Compliance Committee** Meeting
- Ratify approval of the Compliance Program, Standards of Conduct, and Policies
  - CP.07 Corrective Actions
  - CP.10 Compliance Training
  - CP.12 Annual Compliance Program Effectiveness Audit
  - CP.15 Standards of Conduct
  - CP.17 Risk Assessments
  - DE.04 Communication Between SCFHP and FDRs/Delegated Entities
  - DE.05 Joint Operations Committee Meetings Between SCFHP and FDRs/Delegated Entities
  - DE.12 Delegated Entity Reporting

f. Accept minutes of the October 12, 2021 **Quality Improvement Committee** Meeting
- Ratify approval of the Annual Assessment of Physician Directory Accuracy Report 2021
- Ratify approval of the Physician and Hospital Directories Usability Testing Report
- Ratify approval of the Annual Cal MediConnect (CMC) Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis
- Ratify approval of the Assessment of CMC Member Understanding of Policies & Procedures: Call Code Analysis
- Ratify approval of the 2020 Member Experience Analysis
- Ratify approval of the Annual Cal Medi-Connect (CMC) Continuity and Coordination of Medical Care Analysis (2021)
- Ratify approval of the Grievance and Appeals Report Q2 2021
- Ratify acceptance of Committee Reports
  - Pharmacy & Therapeutics Committee – September 16, 2021
  - Credentialing Committee – August 4, 2021

g. Accept minutes of the November 16, 2021 **Special Quality Improvement Committee** Meeting
- Ratify approval of the Appointment Availability Analysis MY 2021
- Ratify approval of the Annual Assessment of Network Adequacy

h. Accept minutes of the December 7, 2021 **Quality Improvement Committee** Meeting
- Ratify approval of the Grievance & Appeals Report Q3 2021
- Ratify acceptance of Committee Reports
  - Utilization Management Committee – October 20, 2021
  - Credentialing Committee – October 6, 2021

i. Accept minutes of the November 10, 2021 **Provider Advisory Council** Meeting
j. Accept minutes of the December 14, 2021 **Consumer Advisory Committee** Meeting
k. Approve **Publicly Available Salary Schedule**
l. Approve September 2021 **Quarterly Investment Compliance Report**
m. Approve revised **2022 Board & Committee Meeting Calendar**
n. Approve **Resolution to Adopt an Amended Conflict of Interest Code**
o. Approve **Annual Report to the Board of Supervisors**
p. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953

4. CEO Update Discuss status of current topics and initiatives.	Ms. Tomcala	12:15	15 min
5. Compliance Report Review and discuss compliance activities and notifications.	Mr. Haskell	12:30	10 min
6. October 2021 Financial Statements Review October 2021 Financial Statements. **Possible Action:** Approve the October 2021 Financial Statements	Mr. Jarecki	12:40	15 min
7. SCFHP Equity Steering Committee Review new structure for organization-wide focus on diversity, equity, and inclusion.	Ms. Bui-Tong	12:55	10 min
8. Medi-Cal Dental Care Review summary of dental coverage for Medi-Cal members.	Ms. Bui-Tong	1:05	15 min
9. Government Relations Update Discuss local, state, and federal legislative and policy issues impacting the Plan and it members.	Mr. Haskell	1:20	15 min
<u>Announcement Prior to Recessing into Closed Session</u> Announcement that the Governing Board will recess into closed session to discuss Item No. 10 below.			
10. Adjourn to Closed Session **a. <u>Contract Rates</u>** (Welfare and Institutions Code Section 14087.38(n)): It is the intention of the Governing Board to meet in Closed Session to discuss Plan partner rates.		1:35	
11. Report from Closed Session		2:25	5 min
12. Adjournment		2:30	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at (408) 874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at (408) 874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Regular Meeting of the

Santa Clara County Health Authority Governing Board

Thursday, September 23, 2021, 12:00 PM – 2:30 PM
Santa Clara Family Health Plan - Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Bob Brownstein, Chair
Alma Burrell
Dave Cameron
Darrell Evora
Kathleen King
Liz Kniss
Sarita Kohli
Michele Lew
Sue Murphy
Ria Paul, M.D.
Debra Porchia-Usher
Sherri Sager

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri, Controller
Chelsea Byom, Director, Marketing, Communications & Outreach
Tyler Haskell, Director, Government Relations
Johanna Liu, Director, Quality & Process Improvement
Khanh Pham, Director, Financial Reporting & Budgeting
Mike Gonzalez, Manager, Community Resource Center
Rahnuma Shaheen, Assistant Controller
Rita Zambrano, Executive Assistant

Others Present
Carlyn Obringer, Government & Community Engagement Manager at Blue Shield of California
Christine Rutherford-Stuart, Board Aide to Susan Ellenberg
Tiffany Washington, Program Manager for Anthem Blue Cross

1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 12:01 pm. Roll call was taken and quorum was established.

2. Public Comment

There were no public comments.

Ms. Burrell joined the meeting.

3. Approve Consent Calendar and Changes to the Agenda

Mr. Brownstein presented the Consent Calendar and indicated all items would be approved in one motion.

a. Approve minutes of the June 24, 2020 **Governing Board** Meeting

b. Accept minutes of the July 22, 2021 **Executive/Finance Committee** Meeting
- Ratify approval of the May 2021 Financial Statements
- Ratify approval of the Special Project Funding Request for Safe Relationships in East San Jose, Next Door Solutions to Domestic Violence (NDS)

c. Accept minutes of the August 26, 2021 **Executive/Finance Committee** Meeting
- Ratify approval of Claims Policy
  - **o** CL.29 Third Party Tort Liability Reporting Requirements
- Ratify retirement of Finance Policy
  - **o** FA.13 Employee Recognition Gift Cards
- Ratify acceptance of the Network Detection and Prevention Update
- Ratify approval of the Preliminary June 2021 Financial Statements
- Ratify approval of the Resolution to Transfer Banking Relationship to City National

d. Accept minutes of the August 26, 2021 **Compliance Committee** Meeting

e. Accept minutes of the August 11, 2021 **Quality Improvement Committee** Meeting
- Ratify approval of the Cal MediConnect (CMC) Availability of Practioners Evaluation
- Ratify approval of the Annual E-Mail Quality and Analysis
- Ratify approval of the Annual Quality and Accuracy of Information to Members via Web and Telephone Analysis
- Ratify acceptance of Committee Reports
  - o Pharmacy & Therapeutics Committee – June 17, 2021
  - o Utilization Management Committee – July 21, 2021
  - o Credentialing Committee – June 2, 2021

f. Accept minutes of the August 10, 2021 **Provider Advisory Council Committee** Meeting

g. Accept minutes of the September 14, 2021 **Consumer Advisory Committee** Meeting

h. Approve **Publicly Available Salary Schedule**

i. Approve **Quarterly Investment Compliance Report**

j. Appoint **Sue Murphy to chair the Compliance Committee**

k. Approve **2022 Board & Committee Meeting Calendar**

It was moved, seconded, and the Consent Calendar was **unanimously approved.**

Motion:	Ms. Murphy
Second:	Ms. Lew
Ayes:	Mr. Brownstein, Ms. Burrell, Mr. Cameron, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager
Absent:	Mr. Evora, Ms. Kohli

4. CEO Update

Christine Tomcala, Chief Executive Officer, presented the updated SCFHP COVID-19 summary and graphs, and noted that 82,600 members have yet to be vaccinated. As of September 14, 88% of county residents age 12+ had received at least one COVAX dose, while 64% of SCFHP members were vaccinated. She also shared that SCFHP has the second highest percentage of vaccinated members compared to other Medi-Cal plans in California.

Ms. Tomcala discussed the member and provider incentive programs, stating we would support providers becoming COVID vaccine administrators, and conduct targeted outreach to vulnerable populations, such as home-bound, communities of color, and members with health conditions. The Plan will continue to be a resource for vaccinations and vaccine information at the Blanca Alvarado Community Resource Center (CRC) and continue hosting clinics in collaboration with the county Public Health Department mobile vaccine unit.

Ms. Tomcala stated that our primary focus has been closing the gap among our members who have not received one vaccination, consistent with the State's expectation for plans. Laura Watkins, VP, Marketing and Enrollment, noted that since the booster has now been approved for those 65 and over, we will use social media and other forms to communicate the availability and eligibility to our members. She also noted that SCFHP would host the

Binational Health Week at the CRC and collaborate with the Public Health Department to administer vaccinations and boosters for eligible individuals.

A discussion ensued regarding who pays for the booster when members go to the pharmacy, and Ngoc Bui-Tong, VP, Strategies and Analytics, stated that COVID vaccines are paid directly by Medi-Cal fee-for-service, and there is no cost to the Plan.

Mr. Evora joined the meeting.

Ms. Tomcala shared that Ngoc Bui-Tong, VP, Strategies & Analytics, and Johanna Liu, Director, Quality & Process Improvement, would be representing SCFHP in the Health Disparities Leadership Program at the Massachussetts General Hospital Disparities Solution Center. They will focus on decreasing health disparities for Hispanics in controlling diabetes.

Ms. Kohli joined the meeting.

Ms. Tomcala noted that 82% of our employees are fully vaccinated, and return to the office has been delayed due to the Delta variant. It was noted that the majority of staff are interested in a hybrid work schedule once the office reopens.

Ms. Tomcala shared highlights of the 2021 Diversity Surveys, which show how the diversity of Staff, Board members, and Committee members align with our membership. She noted that while SCFHP's Hispanic/Latino staff make up the largest race/ethnic group in the organization, there is still underrepresentation relative to the percentage of SCFHP members who are Hispanic/Latino. Ms. Tomcala cited a similar opportunity with respect to Hispanic/Latino representation on the Board and Committees.

Ms. Tomcala gave a brief update on the Blanca Alvarado Community Resource Center (CRC), noting that all exterior signage has been installed. She also shared pictures of the murals painted by a local East San Jose artist. Ms. Tomcala referred to the CRC planning process, noting that Mike Gonzalez, Director, Community Engagement, is leading work with residents in the community and community-based organizations to identify the needs of residents and our members living on the east side. She noted that the CRC grand opening would be on Saturday, October 2, and she extended the invitation to the Board members. She also stated that Blanca Alvarado would participate in the event in person, along with many individuals who sit on our resident advisory committees.

Ms. Tomcala welcomed Sarita Kohli as a new Board member.

Lastly, Ms. Tomcala presented the Board Dashboard, and Ms. King noted that it is helpful when talking about SCFHP and suggested it be sent separately to members.

5. Compliance Report

Tyler Haskell, Director of Government Relations, provided an update on recent and upcoming federal and state government actions. He gave an overview of the health care provisions in the draft infrastructure legislation being considered in the House of Representatives. Mr. Haskell discussed the new Medi-Cal benefits and CalAIM programs going into effect in 2022, and gave an update on state legislation pending action by the Governor.

6. Government Relations Update

Tyler Haskell, Interim Compliance Officer, discussed the final report of the annual Department of Health Care Services (DHCS) audit, which included three findings related to delegate oversight, utilization management, and transportation vendor enrollment. Mr. Haskell also discussed the final report from the Department of Managed Health Care (DMHC) 2019 follow-up audit, which included one uncorrected deficiency related to delegation oversight of authorization denial letters. He reported that the Plan had achieved 100% compliance in all four areas of the Medicare Data Validation audit and submitted the final results to CMS in late June. Mr. Haskell noted that the Plan is participating in the 2021 performance measure validation audit, focusing on compliance with Cal MediConnect requirements for initial health risk assessments and initial care plans.

7. July 2021 Financial Statements

Mr. Jarecki presented the July 2021 unaudited financial statements, which reflected a current month net surplus of $5.6 million ($4.3 million favorable to budget).

Enrollment increased by 1,508 members from the prior month to 284,178 members (747 members lower than budget). Membership growth continues due to the extended duration of the COVID pandemic during which member disenrollments have been suspended.

Revenue reflected a favorable current month variance of $657 thousand (0.6%) largely due to higher supplemental kick revenue partially offset by lower enrollment than budgeted.

Medical Expense reflected an unfavorable current month variance of $2.9 million (2.8%) largely due to (1) pharmacy expense favorable to budget by $1.9M due to lower trends, (2) lower capitated enrollment and (3) timing of certain other expenses.

Administrative Expense reflected a favorable current month variance of $973 thousand (15.0%) due to lower headcount than budgeted and the deferred timing of certain non-personnel expenses.

The balance sheet reflected a Current Ratio, a key measure of liquidity, of 1.31:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $255.9 million, which represented approximately two months of the Plan's total expenses, included unrestricted net assets of $211 million.

Year-to-date capital investments of $320 thousand were made, predominately computer software licenses.

It was moved, seconded, and the July 2021 Financial Statements were **unanimously approved.**

Motion:	Mr. Cameron
Second:	Mr. Evora
Ayes:	Mr. Brownstein, Ms. Burrell, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager

8. Fiscal Year 2021-2022 Plan Objectives

Ms. Tomcala presented the Fiscal Year 2021-2022 Plan Objectives, which have an overarching focus on driving quality improvement and reducing health disparities. Seven objectives were proposed: Lead improvement in the health of communities impacted by disparities, Pursue benchmark quality & health equity, and Implement initial CalAIM deliverables, are critical priorities, with additional objectives to Enhance compliance program & delegation oversight, Foster membership growth & retention, Achieve budgeted financial performance, and Seek to be an Employer of Choice.

Ms. Burrell left the meeting.

Kathleen King mentioned the work Health Plan of San Mateo is doing toward integration of dental services, and suggested that SCFHP consider evaluating the need for member dental services, leading to a potential strategy for Fiscal Year 2022-2023.

It was moved, seconded, and the FY '21-'22 Plan Objectives were **unanimously approved**, with the request that staff explore a possible dental objective for FY '22-'23.

Motion:	Ms. Lew
Second:	Mr. Evora
Ayes:	Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager
Absent:	Ms. Burrell

9. Fiscal Year 2020-2021 Team Incentive Compensation

Ms. Tomcala presented the Fiscal Year 2020-2021 Team Incentive Compensation Year-End Review, noting that performance merited a 0.3% payout. She further indicated that in August, the Executive/Finance Committee members expressed appreciation for the team rising to the challenge presented by the pandemic, and in light of the team's performance in times of adversity, recommended consideration of a team incentive payout beyond the metrics chosen at the beginning of the year. Ms. Tomcala presented a recommendation that staff members each receive a payout of $1,000 in recognition of the flexibility and dedication demonstrated during the year.

It was moved, seconded, and a FY'20-'21 Team Incentive payout of $1,000 for each employee ($250 for each quarter employed) was **unanimously approved** in recognition of staff's dedication and commendable performance during an extraordinarily difficult year.

Motion:	Ms. Lew
Second:	Ms. Kniss
Ayes:	Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager
Absent:	Ms. Burrell

10. Fiscal Year 2021-2022 Team Incentive Compensation

Ms. Tomcala presented the Fiscal Year 2021-2022 Team Incentive Compensation Program, designed to recognize employees for achieving critical Plan Objectives, and noted the addition of two new metrics that are key initiatives on our plan objectives: Reduce COVID Vaccination Disparities and D-SNP Network Contracting. She discussed the increase in potential payout percentages, noting the five, seven, and ten percent performance tiers.

It was moved, seconded, and the FY '21'22 Team Incentive Compensation Program was **unanimously approved**.

Motion:	Ms. Murphy
Second:	Mr. Cameron
Ayes:	Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager
Absent:	Ms. Burrell

13. Adjourn to Closed Session

a. Public Employee Performance Evaluation

The Governing Board met in Closed Session to consider the performance evaluation of the Chief Executive Officer.

14. Report from Closed Session

Mr. Brownstein reported the Governing Board met in Closed Session to discuss the public employee performance evaluation.

15. Annual CEO Evaluation Process

Ms. Murphy presented the 2020-2021 annual CEO evaluation and reported that the ad hoc CEO Evaluation Subcommittee recommended a compensation increase of 4% in base pay, and a 9% incentive bonus, based on the favorable evaluation of the CEO, effective July 1, 2021.

It was moved, seconded, and the recommended 4% annual salary increase effective July 1, 2021, and 9% incentive bonus, for the CEO was **unanimously approved.**

Motion:	Ms. Murphy
Second:	Mr. Evora

Ayes: Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Ms. Paul, Ms. Porchia-Usher, Ms. Sager
Absent: Ms. Burrell

14. Adjournment

The meeting was adjourned at 2:15 pm.

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Michele Lew, Secretary

Special Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Friday, October 22, 2021, 10:30 AM – 11:00 AM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Bob Brownstein, Chair
Dave Cameron
Michele Lew

Members Absent
Alma Burrell
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Jonathan Tamayo, Chief Information Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Teresa Chapman, VP, Human Resources
Tyler Haskell, Interim Compliance Officer
Rita Zambrano, Executive Assistant

1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 10:30 am. Roll call was taken and a quorum was established.

2. Public Comments

There were no public comments.

3. AB 361 Compliance

Tyler Haskell, Interim Compliance Officer, explained the need for the Committee to meet in order to comply with AB 361. Under this new law, public agencies that intend to continue meeting by teleconference without providing public access to each teleconference location need to make certain findings and certify the ongoing need for teleconferencing within 30 days of the first teleconference meeting following enactment of AB 361, and every 30 days thereafter.

It was moved, seconded and unanimously approved to continue use of teleconferencing without providing public access to each teleconference location pursuant to Government Code Section 54953.

Motion: Ms. Lew
Second: Mr. Cameron
Ayes: Mr. Brownstein, Mr. Cameron, Ms. Lew

4. Adjournment

The meeting was adjourned at 10:34 am.

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Michele Lew, Secretary

MEMORANDUM

Date: October 20, 2021

From: Tyler Haskell, Interim Compliance Officer

To: SCFHP Executive/Finance Committee

Re. AB 361 compliance

Background

Because the Governor's executive order suspending certain Brown Act requirements expired at the end of September, the Legislature passed AB 361, which was signed into law in September. AB 361 amends Government Code §54953 to permit teleconferencing by local agencies during a declared state of emergency without providing public access to each individual teleconference location. In order to do so, a local agency must, within 30 days of its first teleconference meeting following enactment of AB 361 and every 30 days thereafter, make the following findings by majority vote:

- The local agency has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

The reason for today's meeting is that there was not a Governing Board or Executive/Finance Committee meeting scheduled within 30 days of the September Governing Board meeting. In order to comply with AB 361, this action needs to be taken by Saturday, October 23.

Recommended Action

Make the following findings and approve continued use of teleconferencing without providing public access to each teleconference location:

- Santa Clara Family Health Plan has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, October 28, 2021, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan - Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Bob Brownstein, Chair
Alma Burrell
Dave Cameron
Michele Lew

Members Absent
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Chris Turner, Chief Operations Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Teresa Chapman, VP, Human Resources
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri, Controller
Tyler Haskell, Director Government Relations
Johanna Liu, Director, Quality & Process Improvement
Khanh Pham, Director, Financial Reporting & Budgeting
Robyn Esparza, Administrative Assistant
Rita Zambrano, Executive Assistant

Other Present
Michael Daponde, DSR Health Law
John Domingue, Rossi Dominque LLP
Chris Pritchard, Moss Adams LLP
Rianne Suico, Moss Adams LLP

1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 10:31 am. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Fiscal Year 2020-2021 Independent Auditor's Report

Neal Jarecki, Chief Financial Officer, introduced Chris Pritchard & Rianne Suicco, partners from the Plan's independent accounting firm, Moss-Adams, LLP. Mr. Pritchard presented the Plan's audited financial statements and Board communication letter for the fiscal year ended June 30, 2021. He indicated that the financial statements received an unmodified audit opinion (meaning that the Plan has presented fairly its financial position, results of operations, and changes in cash flow and that the financial statements are in conformity with general-accepted accounting principles). Ms. Suicco reviewed a summary of the Plan's financial statement detail and advised that (1) management's accounting estimates, were reasonable, (2) there were no disagreements with management, and (3) no audit adjustment to the financial statements were necessary.

It was moved, seconded, and the Fiscal Year 2020-2021 Independent Auditor's Report was **unanimously approved.**

Motion:	Mr. Cameron
Second:	Ms. Burrell
Ayes:	Mr. Brownstein, Ms. Burrell, Mr. Cameron, Ms. Lew
Absent:	Ms. Murphy

4. Approve Consent Calendar and Changes to the Agenda

Mr. Brownstein presented the Consent Calendar and indicated all agenda items would be approved in one motion.

a. Approve minutes of the August 26, 2021 Executive/Finance Committee meeting
b. Approve minutes of the October 22, 2021 Special Executive/Finance Committee meeting

It was moved, seconded, and the consent calendar was **unanimously approved.**

Motion:	Ms. Lew
Second:	Ms. Burrell
Ayes:	Mr. Brownstein, Ms. Burrell, Mr. Cameron, Ms. Lew
Absent:	Ms. Murphy

5. August 2021 Financial Statements

Mr. Jarecki presented the August 2021 unaudited financial statements, which reflected a current month net surplus of $4.6 million ($3.2 million favorable to budget). Enrollment increased by 1,294 members from the prior month to 285,472 members (1,471 members or 0.5% lower than monthly budget). Membership growth continues due to the extended duration of the COVID pandemic during which member disenrollments have been suspended. YTD member months trailed budget by 2,218 member months or 0.4%). Revenue reflected a favorable current month variance of $1.7 million (1.6%) largely due to higher CY21 rates versus budget coupled with higher supplemental kick revenue due to higher utilization, partially offset by lower enrollment than budgeted. YTD revenue was $2.4M (1.1%) favorable to budget due to the same factors. Medical Expense reflected a favorable current month variance of $854 thousand (0.8%) largely due to (1) pharmacy expense favorable to budget due to lower cost trends, (2) lower capitated enrollment and (3) timing of certain other expenses, partially offset by (4) higher fee-for-service costs and supplemental kick utilization. YTD Medical Expense was $3.7 million (1.8%) favorable to budget due to the same factors. Administrative Expense reflected a favorable current month variance of $841 thousand (13.0%) due to lower headcount than budgeted and the deferred timing of certain non-personnel expenses. YTD Administrative Expense was $1.8 million (14%) favorable to budget due to the same factors. The balance sheet reflected a Current Ratio, a key measure of liquidity, of 1.31:1 versus the DMHC minimum current ratio requirement of 1.00:1. Tangible Net Equity of $260.5 million, which represented approximately two months of the Plan's total expenses, included unrestricted net assets of $216 million.

Year-to-date capital investments of $492 thousand were made, predominately computer software licenses.

It was moved, seconded, and the August 2021 unaudited Financial Statements were **unanimously approved.**

Motion:	Mr. Cameron
Second:	Ms. Lew
Ayes:	Mr. Brownstein, Ms. Burrell, Mr. Cameron, Ms. Lew
Absent:	Ms. Murphy

6. CEO Update

Christine Tomcala, Chief Executive Officer, presented the updated SCFHP COVID-19 summary, noting additional incentives, outreach, and collaboration efforts underway to assist our members in getting vaccinated. She shared data on the percentage of SCFHP members with at least one COVID vaccination dose (68%) by age band and ethnicity, compared to the county as a whole (89%). She reported that SCFHP had the second highest vaccination

rate among Medi-Cal managed care plans statewide, and noted that Anthem in Santa Clara County had a 64.7% vaccination rate.

7. Government Relations Update

Tyler Haskell, Director of Government Relations, provided an update on federal and state government actions. He discussed the details of a newly-released compromise agreement on infrastructure legislation developing in Congress. Mr. Haskell provided an update on new Medi-Cal benefits going into effect in 2022, the final status of relevant State legislation, and the upcoming reprocurement process for commercial Medi-Cal health plan contracts.

8. Adjourn to Closed Session

a. Litigation

The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding arbitration initiated by a provider: one case.

b. Existing Litigation

The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding litigation initiated by a vendor. Case name unspecified: disclosure of case name may jeopardize existing settlement negotiations.

c. Report Involving Trade Secrets

The Executive/Finance Committee met in Closed Session to discuss Plan Contract Rates.

d. Contract Rates

The Executive/Finance Committee met in Closed Session to discuss Plan partner rates.

9. Report from Closed Session

Mr. Brownstein reported the Executive/Finance Committee met in Closed Session to discuss litigation, existing litigation, trade secrets, and contract rates.

10. Adjournment

The meeting was adjourned at 12:36 pm.

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Michele Lew, Secretary

MOSSADAMS

2021 Audit Results:

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

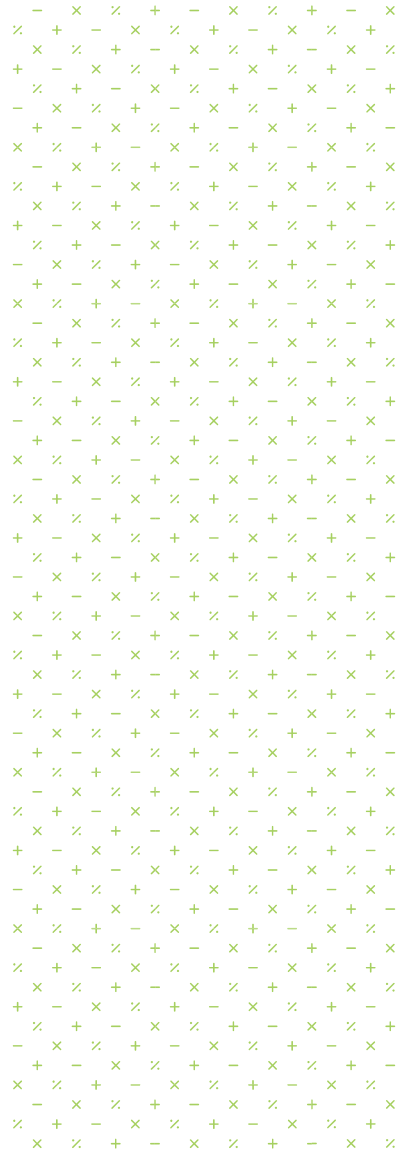
Report of Independent Auditors

Unmodified Opinion

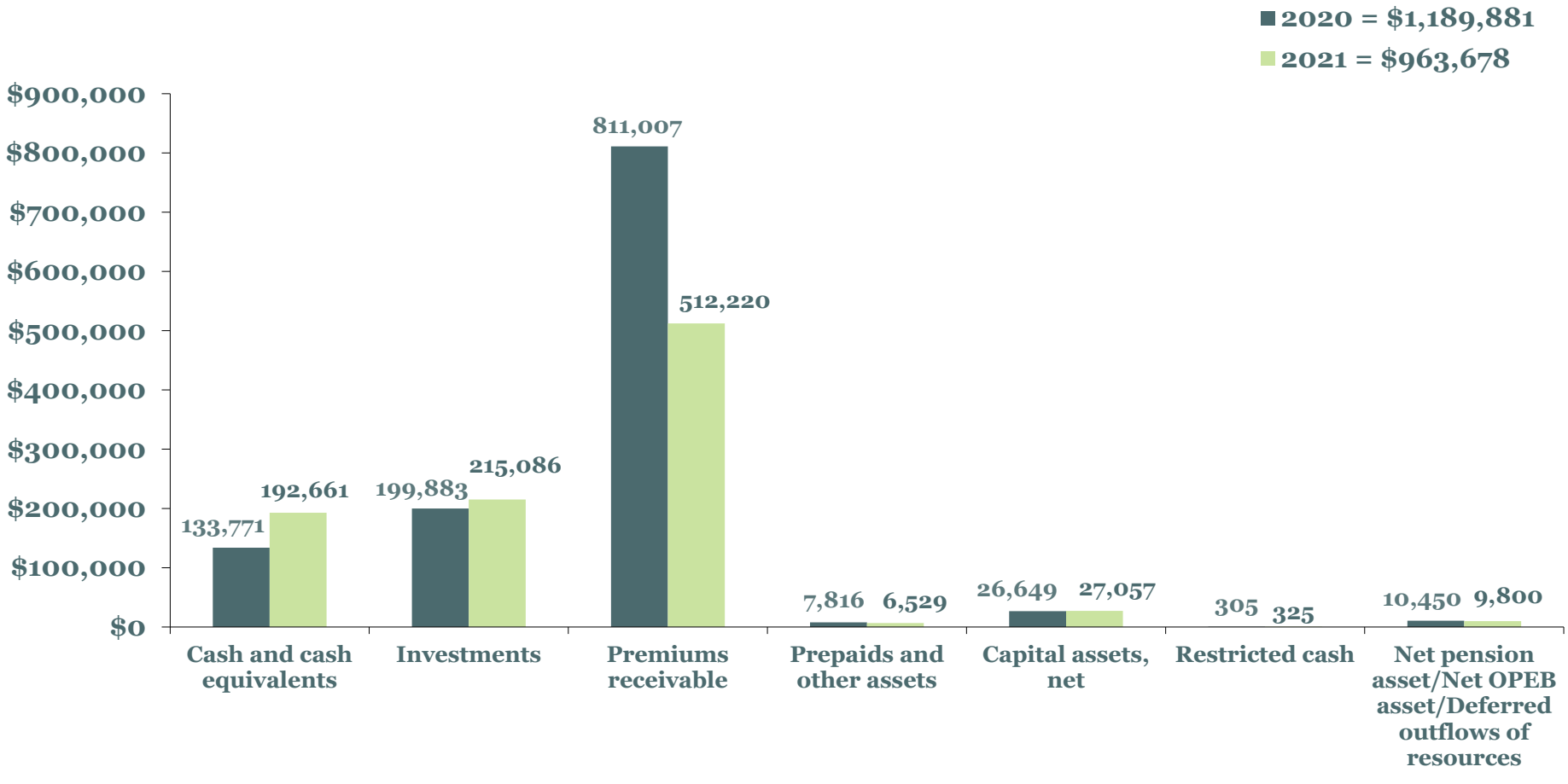
Financial statements are fairly presented in accordance with generally accepted accounting principles.

MOSSADAMS

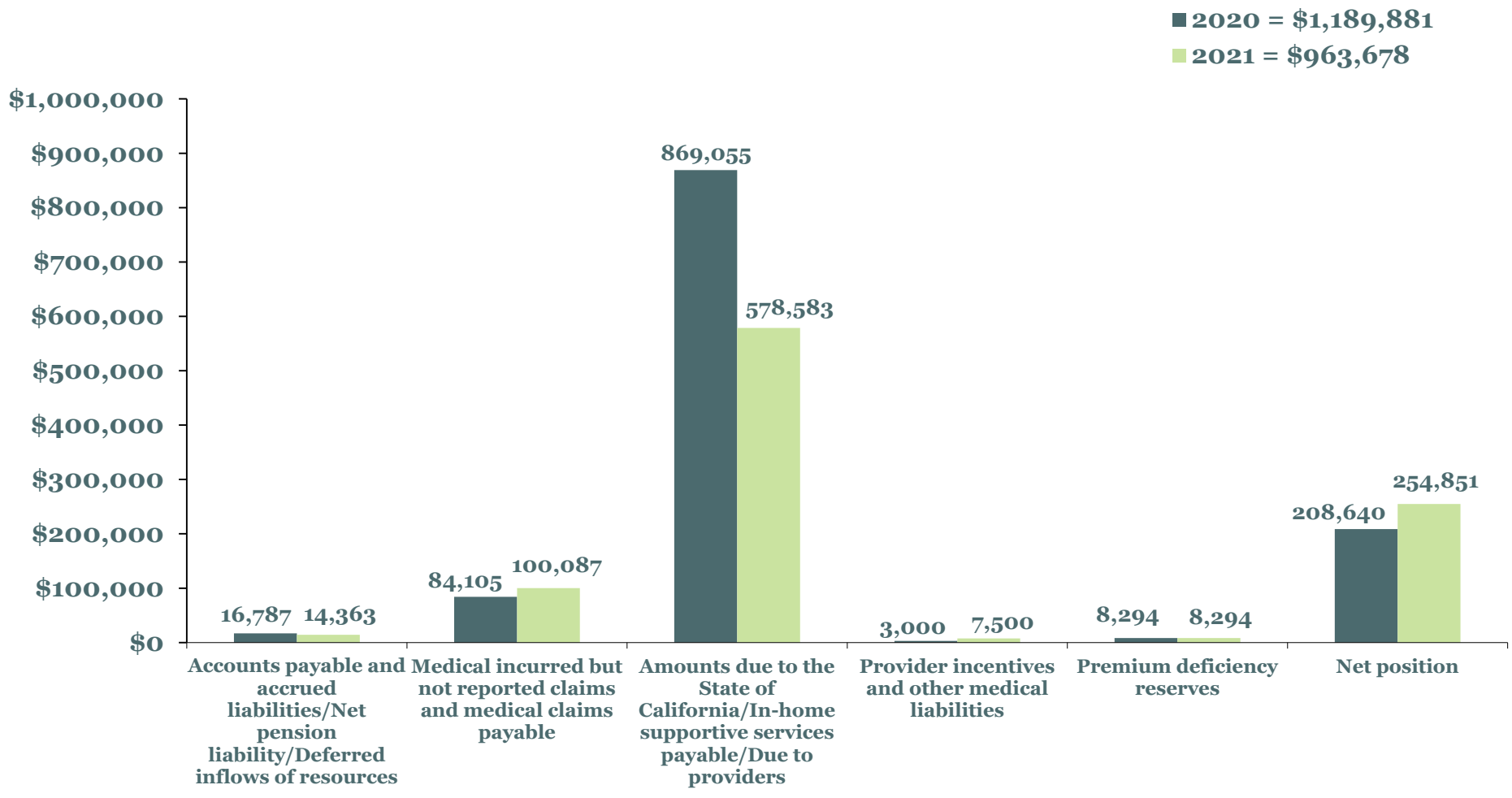
Statements of Net Position



Asset Composition (in Thousands)

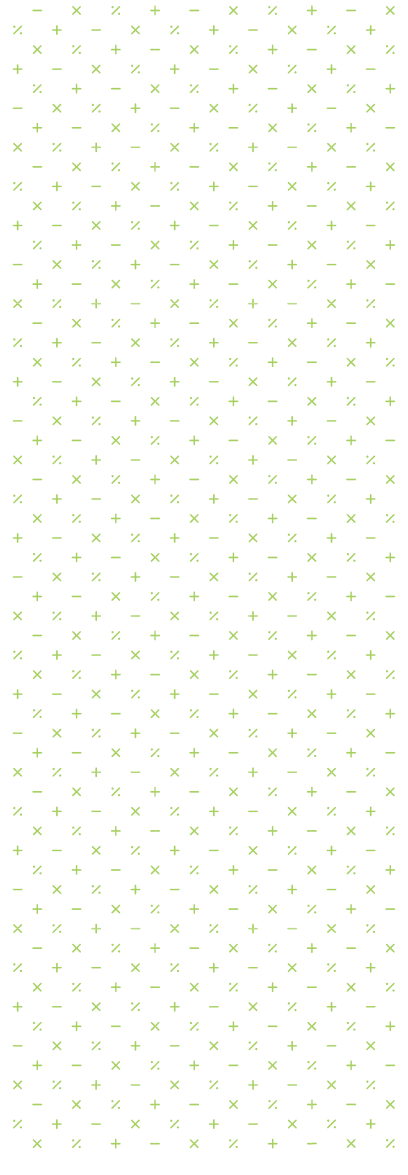


Liabilities and Net Position Balance (in Thousands)



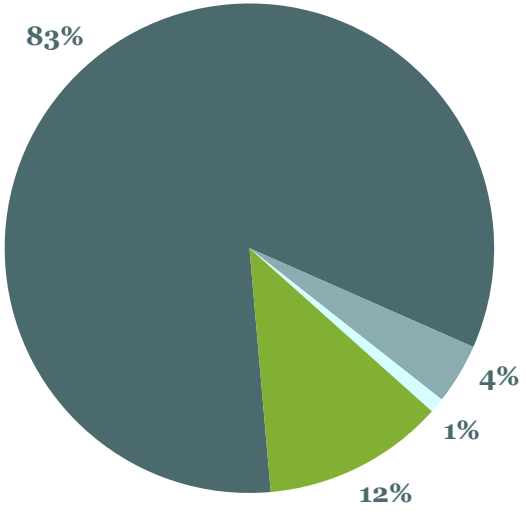
MOSSADAMS

Operations

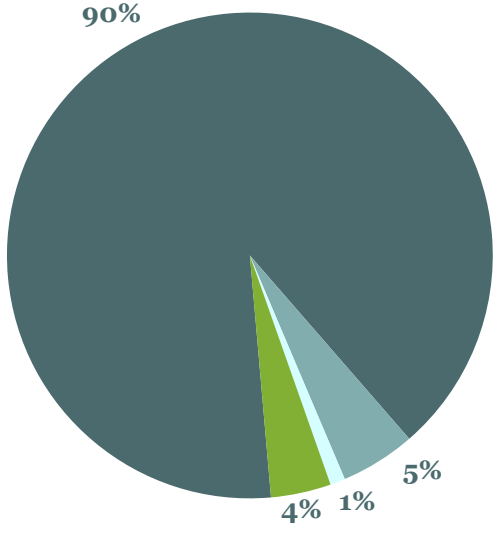


Operating Expenses (in Thousands)

June 30, 2021
$1,396,976

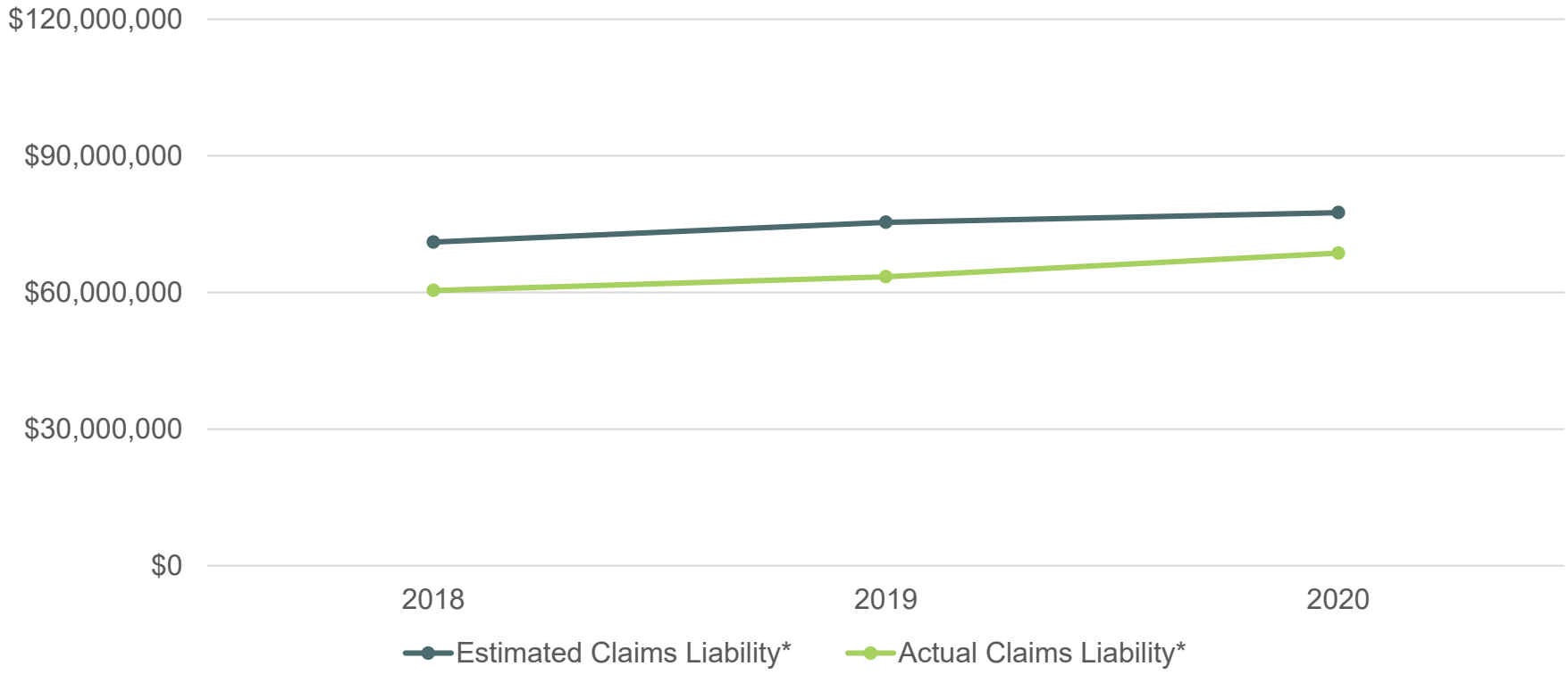


June 30, 2020
$1,147,788



- Medical expenses
- Marketing, general, and administrative expenses
- Depreciation
- Premium tax

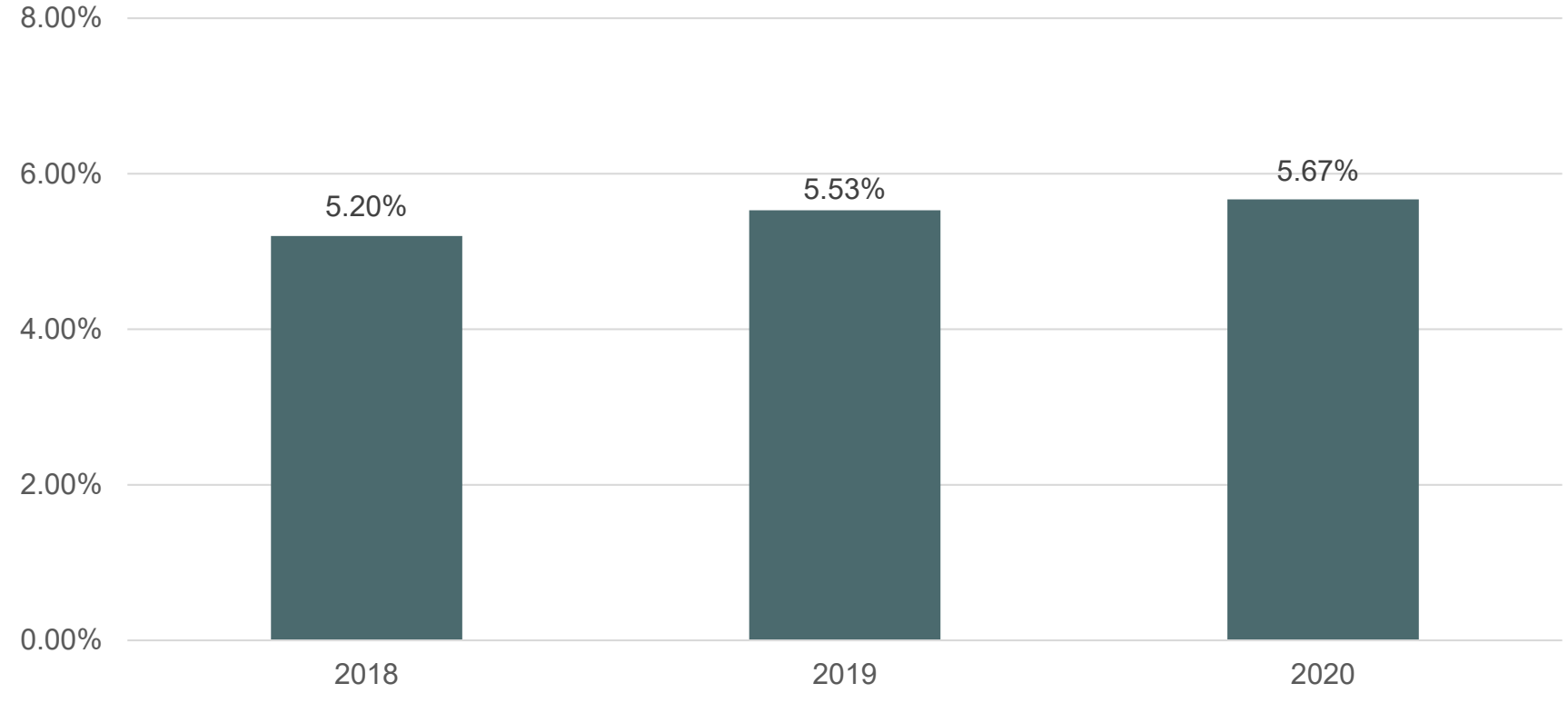
Historic Estimated Claims Liability and Historic Actual Claims Liability



* Estimated claims liability and actual claims liability excludes pharmacy claims.

Source: SCFHP's internal reports

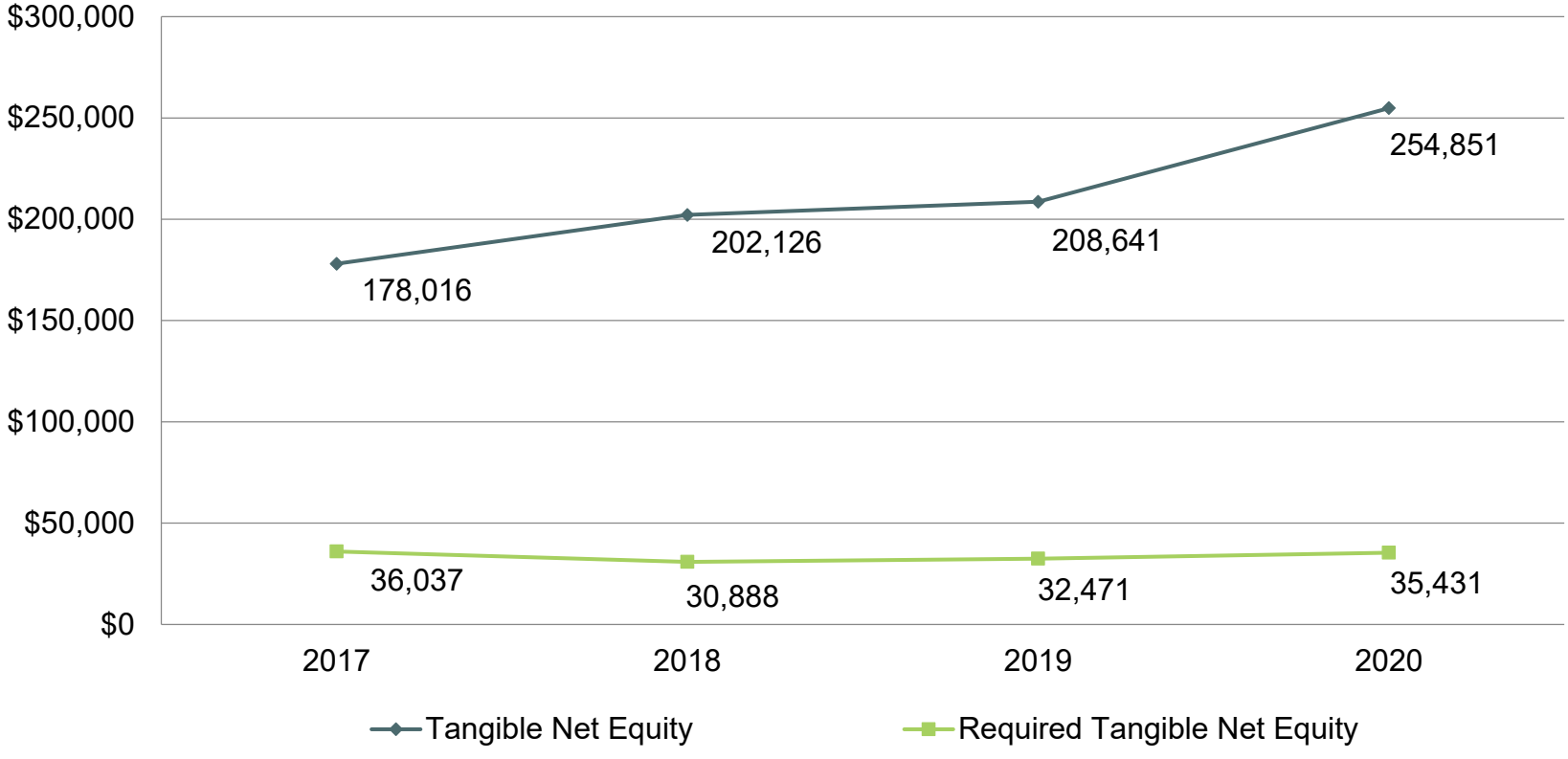
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* Actual claims liability excludes pharmacy claims

Source: SCFHP's internal reports

Tangible Net Equity (in Thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of material instances of fraud or noncompliance with laws and regulations

Questions?

10/22/21

Communication with
the Governing Board

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

June 30, 2021

Communication with the Governing Board

To the Governing Board
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

We have audited the financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority"), as of and for the year ended June 30, 2021, and have issued our report thereon dated October XX, 2021. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated May 27, 2021, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America, and to design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Authority's internal control over financial reporting. Accordingly, we considered the Health Authority's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to management, who has been charged by the Governing Board to oversee the audit, during our pre-audit planning meeting on May 20, 2021.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Health Authority are described in Note 1 to the financial statements. During the year, management adopted Governmental Accounting Standards Board ("GASB") Statement No. 84, *Fiduciary Activities*, and GASB Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32*. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2021. We noted no transactions entered into by the Health Authority during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- Management recorded an estimated liability for incurred but unpaid claims expense. The estimated liability for unpaid claims is based on management's estimate of historical claims experience and known activity subsequent to year-end. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- Management's estimate of net other post-employment benefit ("OPEB") liability is actuarially determined using assumptions on the long-term rate of return on OPEB plan assets, the discount rate used to determine the present value of benefit obligations, and changes in healthcare costs. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- Management recorded an estimated liability for premium deficiency reserve. The estimated liability is based on management's analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the Health Authority's financial statements relate to medical claims payable, net pension, other-post employment benefit liability, and capitation and premium revenues.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October XX, 2021.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Health Authority's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Health Authority that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Health Authority within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Health Authority's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Governing Board of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and its management, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October XX, 2021

10/22/21

Report of Independent Auditors and Financial Statements

Santa Clara County Health Authority (dba Santa Clara Family Health Plan)

June 30, 2021 and 2020

Table of Contents

Management's Discussion and Analysis

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Management's Discussion and Analysis
June 30, 2021, 2020, and 2019

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board Codification Section 2200, Annual Comprehensive Financial Report, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority") has prepared this discussion and analysis to provide readers and interested parties with an overview of the organizations' financial activities for the fiscal years ended June 30, 2021, 2020, and 2019. This discussion should be reviewed in conjunction with the Health Authority's financial statements and accompanying notes to enhance the reader's understanding of the Health Authority's financial performance.

ORGANIZATION:

Santa Clara County Health Authority is a licensed health maintenance organization that operates in Santa Clara County (the "County"). The County's Board of Supervisors established Santa Clara County Health Authority in August 1995, in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.38. During 1996, the Health Authority obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations.

The Santa Clara Community Health Authority Joint Powers Authority ("JPA") is a licensed health maintenance organization that operated in the County. The County's Board of Supervisors established the JPA in October 2005, in accordance with the Code Section 14087.54. During 2006, the JPA obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975 and commenced operations. The Health Authority has advised the California Department of Managed HealthCare ("DMHC") of its intent to surrender the JPA's license as of December 31, 2019, and the JPA ceased to exist on December 31, 2019.

OVERVIEW OF FINANCIAL STATEMENTS:

The Health Authority's annual financial report consists of three statements – Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows and accompanying notes. The statements report the following financial information:

- The Statements of Net Position present the Health Authority's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position.
- The Statements of Revenues, Expenses, and Changes in Net Position present the results of operations during the fiscal years and the resulting changes in net position.
- The Statements of Cash Flows identify sources and uses of cash from operating activities, capital and financing activities, and investing activities.

The following discussion and analysis addresses the Health Authority's overall program activities.

FINANCIAL HIGHLIGHTS:

- Total enrollment increased 11.3% to 282,670 members at June 30, 2021, from 253,875 members at June 30, 2020. Total enrollment increased 1.9% to 253,875 members at June 30, 2020, from 249,206 members at June 30, 2019.

- Net position increased by $46,209,816 to $254,850,602 for the fiscal year ended June 30, 2021, from $208,640,786 for the fiscal year ended June 30, 2020, due to operating income of $43,357,542 and nonoperating income of $2,852,274. Net position increased by $6,515,031 to $208,640,786 for the fiscal year ended June 30, 2020, from $202,125,755 for the fiscal year ended June 30, 2019, due to operating income of $38,958 and nonoperating income of $6,476,073.

- Total assets and deferred outflows of resources decreased to $963,677,770 as of June 30, 2021, from $1,189,881,233 as of June 30, 2020. Total assets and deferred outflows of resources increased to $1,189,881,233 as of June 30, 2020, from $1,009,258,566 as of June 30, 2019.

- Total liabilities and deferred inflows of resources increased to $708,827,168 at June 30, 2021, from $981,240,447 at June 30, 2020. Total liabilities and deferred inflows of resources increased to $981,240,447 at June 30, 2020, from $897,132,811 at June 30, 2019.

- The current ratio (current assets divided by current liabilities) of 1.31 as of June 30, 2021, reflected an increase from 1.18 as of June 30, 2020. The current ratio (current assets divided by current liabilities) of 1.18 as of June 30, 2020, reflected a decrease from 1.19 at June 30, 2019.

CONDENSED STATEMENTS OF NET POSITION:

	June 30			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Assets:							
Current assets	$ 926,495,698	$ 1,152,476,888	$ 1,060,344,723	$ (225,981,190)	-19.6%	$ 92,132,165	8.7%
Capital assets	27,056,663	26,649,088	27,392,240	407,575	1.5%	(743,152)	-2.7%
Other assets	2,712,052	2,352,997	2,283,994	359,055	15.3%	69,003	3.0%
Total assets	956,264,413	1,181,478,973	1,090,020,957	(225,214,560)	-19.1%	91,458,016	8.4%
Deferred outflows of resources	7,413,357	8,402,260	9,237,609	(988,903)	-11.8%	(835,349)	-9.0%
Total assets and deferred outflows of resources	$ 963,677,770	$ 1,189,881,233	$ 1,099,258,566	$ (226,203,463)	-19.0%	$ 90,622,667	8.2%
Liabilities:							
Current liabilities	$ 706,350,909	$ 977,464,723	$ 891,447,827	$ (271,113,814)	-27.7%	$ 86,016,896	9.6%
Noncurrent liabilities	199,654	-	2,539,090	199,654	100.0%	(2,539,090)	-100.0%
Total liabilities	706,550,563	977,464,723	893,986,917	(270,914,160)	-27.7%	83,477,806	9.3%
Deferred inflow of resources	2,276,605	3,775,724	3,145,894	(1,499,119)	-39.7%	629,830	20.0%
Net position:							
Net investment in capital assets	27,056,663	26,649,088	27,392,240	407,575	1.5%	(743,152)	-2.7%
Restricted	325,000	305,350	305,350	19,650.0	6.4%	-	0.0%
Unrestricted:							
Designated by Governing Board	17,067,275	17,339,275	2,200,000	(272,000)	-1.6%	15,139,275	100.0%
Unrestricted	210,401,664	164,347,073	172,228,165	46,054,591	28.0%	(7,881,092)	-4.6%
Total net position	254,850,602	208,640,786	202,125,755	46,209,816	22.1%	6,515,031	3.2%
Total liabilities, deferred inflows of resources, and net position	$ 963,677,770	$ 1,189,881,233	$ 1,099,258,566	$ (226,203,463)	-19.0%	$ 90,622,667	8.2%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2021, assets decreased $225,214,560 or -19.1% due primarily to decreases in hospital pass-through receivables. During the same period, deferred outflows of resources decreased $988,903 or -11.8% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2020, assets increased $91,458,016 or 8.4% due primarily to increases in receivables from the California Department of Health Care Services (“DHCS”). During the same period, deferred outflows of resources decreased $835,349 or -9.0% due to the timing of amounts attributable to employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2021, liabilities decreased $270,914,160 or -27.7% due primarily to decreases in hospital pass-through payables. During the same period, deferred inflows of resources decreased $1,499,119 or -39.7% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2020, liabilities increased $83,477,806 or 9.3% due primarily to increases in timing of payables to DHCS and certain providers. During the same period, deferred inflows of resources increased $629,830 or 20.0% due to the timing of amounts attributable to employee retirement plans.

Tangible Net Equity

The Health Authority is required to maintain a minimum level of tangible net equity ("TNE") per its contract with DHCS. TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets, if any. The Health Authority's TNE was $254,850,602, $208,640,786, and $202,125,755 at June 30, 2021, 2020, and 2019, respectively. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

CONDENSED RESULTS OF OPERATIONS:

	Fiscal Year			2020 to 2019 Change		2019 to 2018 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	272,590	244,888	237,698	27,702	11.3%	7,190	3.0%
Cal Medi-Connect	10,080	8,987	8,022	1,093	12.2%	965	12.0%
Healthy Kids	-	-	3,486	-	0.0%	(3,486)	-100.0%
Total year end membership	282,670	253,875	249,206	28,795	11.3%	4,669	1.9%
Annual member months:							
Medi-Cal	3,137,271	2,829,690	2,904,840	307,581	10.9%	(75,150)	-2.6%
Cal Medi-Connect	116,365	101,391	92,838	14,974	14.8%	8,553	9.2%
Healthy Kids	-	10,528	40,083	(10,528)	-100.0%	(29,555)	-73.7%
Total annual member months	3,253,636	2,941,609	3,037,761	312,027	10.6%	(96,152)	-3.2%
Operating revenues:							
Capitation and premium revenue	$ 1,440,333,331	$ 1,147,826,608	$ 1,161,897,093	$ 292,506,723	25.5%	$ (14,070,485)	-1.2%
Total operating revenues	1,440,333,331	1,147,826,608	1,161,897,093	292,506,723	25.5%	(14,070,485)	-1.2%
Operating expenses:							
Medical expenses	1,162,912,637	1,036,714,518	979,947,150	126,198,119	12.2%	56,767,368	5.8%
General and administrative expenses	60,991,517	57,442,133	54,419,879	3,549,384	6.2%	3,022,254	5.6%
Depreciation and amortization	3,729,409	3,370,268	3,816,251	359,141	10.7%	(445,983)	-11.7%
Premium tax	169,342,226	50,260,731	105,415,550	119,081,495	236.9%	(55,154,819)	-52.3%
Total operating expenses	1,396,975,789	1,147,787,650	1,143,598,830	249,188,139	21.7%	4,188,820	0.4%
Operating income	43,357,542	38,958	18,298,263	43,318,584	111193.0%	(18,259,305)	-99.8%
Nonoperating revenues:							
Interest and other income	2,852,274	6,476,073	5,811,627	(3,623,799)	-56.0%	664,446	11.4%
Changes in net position	46,209,816	6,515,031	24,109,890	39,694,785	609.3%	(17,594,859)	-73.0%
Net position, beginning of year	208,640,786	202,125,755	178,015,865	6,515,031	3.2%	24,109,890	13.5%
Net position, end of year	$ 254,850,602	$ 208,640,786	$ 202,125,755	$ 46,209,816	22.1%	$ 6,515,031	3.2%

Membership and Enrollment

During the fiscal year ended June 30, 2021, the Health Authority experienced an increase in enrollment of 11.3% predominately due to the County's suspension of Medi-Cal disenrollment during the COVID-19 public health emergency.

During the fiscal year ended June 30, 2020, the Health Authority experienced an increase in enrollment of 1.9% predominately due to the County's suspension of Medi-Cal disenrollment during the COVID-19 public health emergency.

Operating Revenue

During the fiscal year ended June 30, 2021, operating revenues increased by $292,506,723 or 25.5% to $1,440,333,331 versus the prior year operating revenue of $1,147,826,608. Much of the increase was attributable to changes in enrollment and capitation rates.

During the fiscal year ended June 30, 2020, operating revenues decreased by $14,070,485 or -1.2% to $1,147,826,608 versus the prior year operating revenue of $1,161,897,093. Much of the decrease was attributable to changes in enrollment and capitation rates.

Medical Expenses

During the fiscal year ended June 30, 2021, medical expenses increased by $126,198,119 or 12.2% to $1,162,912,637 versus the prior year of $1,036,714,518. Much of the increase was attributable to increases in certain capitation and fee-for-service expenses.

During the fiscal year ended June 30, 2020, medical expenses increased by $56,767,368 or 5.8% to $1,036,714,518 versus the prior year of $979,947,150. Much of the increase was attributable to certain increases in capitation and fee-for-service expenses.

The Health Authority's medical loss ratio ("MLR"), or medical expenses as a percentage of capitation and premium revenue (less contra-revenue premium tax), was 91.4%, 94.5%, and 92.8% for the fiscal years ended June 30, 2021, 2020, and 2019, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2021, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2022 due to continued uncertainties and past reconciliations.

During the fiscal year ended June 30, 2020, management maintained its estimated premium deficiency reserve ("PDR") on the CMC contract at $8,294,025 for fiscal year 2021 due to continuing uncertainties about final rate recasts for multiple fiscal years, shared risk corridor payments and hierarchical condition category ("HCC") risk adjustments, for which management cannot fully quantify the likelihood of these impacts.

General and Administrative Expenses

During the fiscal year ended June 30, 2021, general and administrative expenses increased by $3,549,384 or 6.2% to $60,991,517 versus the prior year expense of $57,442,133 due to increased employee headcount and associated benefit costs.

During the fiscal year ended June 30, 2020, general and administrative expenses increased by $3,022,254 or 5.6% to $57,442,133 versus the prior year expense of $54,419,879 due to increased staffing and increases in other expenses.

The Health Authority's administrative loss ratio ("ALR"), or general and administrative (including depreciation and amortization expense) as a percentage of capitation and premium revenue (including contra-revenue premium tax), was 5.1%, 5.5%, and 5.5% for the fiscal years ended June 30, 2021, 2020, and 2019, respectively.

CONDENSED CASH-FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2021, 2020, and 2019:

	Fiscal Year			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Cash flows from operating activities	$ 75,810,997	$ 30,675,986	$ 75,870,490	$ 45,135,011	147.1%	$ (45,194,504)	-59.6%
Cash flows from capital and financing activities	(4,350,663)	(2,826,838)	(6,415,822)	(1,523,825)	53.9%	3,588,984	-55.9%
Cash flows from investing activities	(12,569,800)	(193,195,538)	5,811,627	180,625,738	-93.5%	(199,007,165)	-3424.3%
Net change in cash and cash equivalents	58,890,534	(165,346,390)	75,266,295	224,236,924	-135.6%	(240,612,685)	-319.7%
Cash and cash equivalents, beginning of year	133,770,764	299,117,154	223,850,859	(165,346,390)	-55.3%	75,266,295	33.6%
Cash and cash equivalents, end of year	$ 192,661,298	$ 133,770,764	$ 299,117,154	$ 58,890,534	44.0%	$ (165,346,390)	-55.3%

The Health Authority considers all highly liquid instruments with a maturity of three months or less to be cash and cash equivalents. The Health Authority invests excess cash in the Santa Clara County Investment Pool, which can be withdrawn on demand.

CONDENSED CAPITAL ASSET INFORMATION:

The table below summarizes the major changes in capital assets for the fiscal years ended June 30, 2021, 2020, and 2019. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2021 to 2020 Change		2020 to 2019 Change	
	2021	2020	2019	Amount	% Change	Amount	% Change
Beginning balance, net	$ 26,649,088	$ 27,392,240	$ 24,269,369	$ (743,152)	-2.7%	$ 3,122,871	12.9%
Additions	4,583,540	2,826,838	6,941,405	1,756,702	62.1%	(4,114,567)	-59.3%
Reductions/adjustments	(446,556)	(199,722)	(2,283)	(246,834)	123.6%	(197,439)	8648.2%
Depreciation and amortization expense	(3,729,409)	(3,370,268)	(3,816,251)	(359,141)	10.7%	445,983	-11.7%
Ending balance, net	$ 27,056,663	$ 26,649,088	$ 27,392,240	$ 407,575	1.5%	$ (743,152)	-2.7%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2021-2022 BUDGET:

- COVID-19 Impact – The declaration of a Public Health Emergency by the State of California paused the normal Medi-Cal disenrollment process. The Plan saw a significant increase in enrollment for the fiscal years ended June 30, 2021 and June 30, 2020. Following the conclusion of the public health emergency, the Plan anticipates that Medi-Cal disenrollment process resumes.

- CalAIM – The State of California launched a multi-year initiative entitled California Advancing and Innovative Medi-Cal ("CalAIM") to improve health outcomes for the Medi-Cal population by implementing a multi-year program of broad reforms to the delivery systems, programs, and payment reforms. The initial components of CalAIM are scheduled to launch January 1, 2022. CalAIM is expected to provide new funding to the Plan and increased expenses, the magnitude of which are unknown at this time.

In June 2021, the Health Authority's Governing Board formally approved operating and capital budgets for the fiscal year ending June 30, 2022. The fiscal year 2022 operating budget anticipates enrollment growth of 11.3%, carve-out of pharmacy from Medi-Cal for the second half of the fiscal year, introduction of Enhanced Care Management ("ECM") in January 2022, modest changes in capitation rates, and modest growth in operating expenses.

REQUESTS FOR INFORMATION

This financial report is designed to provide a general overview of the Health Authority's finances for interested parties. Questions concerning any of the information provided in this report or requests for additional information should be addressed to Santa Clara Family Health Plan, Attn: Controller, 6201 San Ignacio Avenue, San Jose, California 95119 or call (408) 376-2000.

Report of Independent Auditors

To the Governing Board
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)

Report on the Financial Statements

We have audited the accompanying financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) ("Health Authority"), which comprise the statements of net position as of June 30, 2021 and 2020, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) as of June 30, 2021 and 2020, and the results in its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 6, supplementary schedule of proportionate share of the net pension asset/liability, supplementary schedule of pension contributions, supplementary schedules of changes in net other post-employment benefit liability, and supplementary schedule of other post-employment benefit contributions on pages 39 through 42 are not a required part of the financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Health Authority's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the financial statements, and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
October XX, 2021

Financial Statements

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Net Position
June 30, 2021 and 2020

	2021	2020
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	$ 192,661,298	$ 133,770,764
Investments	215,085,767	199,883,355
Premiums receivable	512,219,526	811,006,716
Prepaids and other assets	6,529,107	7,816,053
Total current assets	926,495,698	1,152,476,888
Capital assets, net		
Nondepreciable	3,509,128	4,074,349
Depreciable, net of accumulated depreciation and amortization	23,547,535	22,574,739
Total capital assets, net	27,056,663	26,649,088
Assets restricted as to use	325,000	305,350
Net pension asset	-	1,017,002
Other post-employment benefits asset	2,387,052	1,030,645
Total assets	956,264,413	1,181,478,973
Deferred outflows of resources	7,413,357	8,402,260
Total deferred outflows of resources	7,413,357	8,402,260
Total assets and deferred outflows of resources	$ 963,677,770	$ 1,189,881,233
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	$ 11,886,885	$ 13,010,770
Amounts due to the State of California	90,485,269	104,429,798
In-home supportive services payable	419,990,933	419,268,582
Due to providers	68,106,473	345,356,397
Medical incurred but not reported claims and medical claims payable	100,087,324	84,105,151
Provider incentives and other medical liabilities	7,500,000	3,000,000
Premium deficiency reserves	8,294,025	8,294,025
Total current liabilities	706,350,909	977,464,723
Noncurrent liabilities		
Net pension liability	199,654	-
Total liabilities	706,550,563	977,464,723
Deferred inflows of resources	2,276,605	3,775,724
Total deferred inflows of resources	2,276,605	3,775,724
Net position		
Net investment in capital assets	27,056,663	26,649,088
Restricted	325,000	305,350
Unrestricted:		
Designated by Governing Board	17,067,275	17,339,275
Unrestricted	210,401,664	164,347,073
Total net position	254,850,602	208,640,786
Total liabilities, deferred inflows of resources, and net position	$ 963,677,770	$ 1,189,881,233

See accompanying notes to financial statements.

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Revenues, Expenses, and Changes in Net Position
For the Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenues		
Capitation and premium revenue	$ 1,440,333,331	$ 1,147,826,608
Total operating revenues	1,440,333,331	1,147,826,608
Operating expenses		
Medical expenses	1,162,912,637	1,036,714,518
Premium tax	169,342,226	50,260,731
General and administrative expenses	60,991,517	57,442,133
Depreciation and amortization	3,729,409	3,370,268
Total operating expenses	1,396,975,789	1,147,787,650
Operating income	43,357,542	38,958
Nonoperating revenues		
Interest and other income	2,852,274	6,476,073
Change in net position	46,209,816	6,515,031
Net position, beginning of year	208,640,786	202,125,755
Net position, end of year	$ 254,850,602	$ 208,640,786

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Statements of Cash Flows
For the Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Capitation and premiums received	$ 1,739,120,521	$ 1,087,886,018
Medical expenses paid	(1,602,264,442)	(1,004,597,624)
Marketing, general, and administrative expenses paid	(61,045,082)	(52,612,408)
Net cash provided by operating activities	75,810,997	30,675,986
Cash flows from capital and financing activities		
Purchases of capital assets	(4,350,663)	(2,826,838)
Net cash used in capital and financing activities	(4,350,663)	(2,826,838)
Cash flows from investing activities		
Purchase of investments	(693,316,965)	(311,427,165)
Sale of investments	677,894,891	111,755,554
Interest collection on investments	2,852,274	6,476,073
Net cash used in investing activities	(12,569,800)	(193,195,538)
Net change in cash and cash equivalents	58,890,534	(165,346,390)
Cash and cash equivalents, beginning of year	133,770,764	299,117,154
Cash and cash equivalents, end of year	$ 192,661,298	$ 133,770,764
Reconciliation of operating income to net cash provided by operating activities		
Operating income	$ 43,357,542	$ 38,958
Adjustments to reconcile operating income to net cash provided by operating activities		
Depreciation and amortization	3,729,409	3,370,268
Net unrealized loss (gain) on investments	219,662	(211,744)
Changes in operating assets and liabilities:		
Premiums receivable	298,787,190	(59,940,590)
Prepaids and other assets	1,267,296	2,345,390
Net pension asset/liability	1,216,656	961,642
Other post-employment benefits asset	(1,356,407)	(3,569,735)
Deferred outflows of resources	988,903	835,349
Accounts payable and accrued liabilities	(910,206)	3,838,993
Amounts due to the State of California	(13,944,529)	51,286,710
In-home supportive services payable	722,351	3,176,056
Due to providers	(277,249,924)	28,664,725
Medical incurred but not reported claims and medical claims payable	15,982,173	1,750,134
Provider incentives and other medical liabilities	4,500,000	(2,500,000)
Deferred inflows of resources	(1,499,119)	629,830
Net cash provided by operating activities	$ 75,810,997	$ 30,675,986
Supplemental cash-flow disclosure		
Cash paid during the year for premium tax	$ 82,038,521	$ 26,353,887
Supplemental disclosure of noncash item		
Payables for capital asset purchases	$ 232,877	$ 257,855

See accompanying notes to financial statements.

NOTE 1 – ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization – The Santa Clara County Health Authority (dba Santa Clara Family Health Plan ("Health Authority") was established on August 1, 1995, by the Santa Clara County Board of Supervisors pursuant to Section 14087.38 of the State of California Welfare and Institutions Code (the "Code"). SCFHP was created for the purpose of developing the Local Initiative Plan (the "Plan") for the expansion of Medi-Cal Managed Care, as presently regulated by the California Department of Managed Health Care ("DMHC"). The Medi-Cal Managed Care Program offers no-cost health coverage to children, birth through age 18, pregnant women, and other low-income adults in Santa Clara County (the "County"). During 1996, SCFHP obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975 and commenced operations. The financial statements are included in the County of Santa Clara's basic financial statements as a discretely presented component unit.

The Santa Clara Community Health Authority Joint Powers Authority ("JPA") is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005, in accordance with the Code Section 14087.54. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006. The Health Authority advised the DMHC of its intent to surrender the JPA's license as of December 31, 2019, and the JPA ceased to exist on December 31, 2019.

The following table presents certain combined financial statement captions as previously reported which combines the JPA with the Health Authority, and compares them to the current presentation which does not combine the JPA with the Health Authority as of and for the year ended June 30, 2020:

	Health Authority with JPA	Health Authority without JPA	Difference
Total operating revenues	$ 1,147,826,608	$ 1,147,826,608	$ -
Total operating expenses	$ 1,147,787,650	$ 1,147,787,650	$ -
Change in net position	$ 6,515,031	$ 6,515,031	$ -

The Health Authority has contracted with the California Department of Health Care Services ("DHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Health Authority ("DHCS contract"). The DHCS contract specifies capitation rates, which may be adjusted annually. DHCS revenue is paid monthly and is based upon contracted rates, and actual Medi-Cal enrollment. The Health Authority, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The Health Authority contracts with the Centers for Medicare & Medicaid Services ("CMS") and the DHCS, effective January 1, 2015, to participate in Cal MediConnect ("CMC"), a demonstration project to integrate care for dual-eligible beneficiaries. Cal MediConnect is part of California's larger demonstration plan known as the Coordinated Care Initiative ("CCI"), which transforms the delivery of health care for seniors and people with disabilities. It integrates dual eligibles' care across all their entitlement benefits from Medicare, Medi-Cal, and other supportive services.

The Health Authority operates a Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for the Medi-Cal program. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

On March 1, 2016, SB X2-2 established a Managed Care Organization ("MCO") provider tax for July 1, 2016, through June 30, 2019, and administered by DHCS. The tax is assessed on by DHCS on licensed health plans contracted to provide Medi-Cal services. The legislation established taxing tiers and per-enrollee amounts for the fiscal years ended June 30, 2017, 2018, and 2019. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the federal Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022. The Health Authority paid $82,038,521 and $0 in MCO premium taxes during fiscal years 2021 and 2020, respectively. At June 30, 2021 and 2020, the Health Authority had payables due in the amount of $31,975,622 and $48,615,420, respectively, included in amounts due to the State of California.

Basis of accounting – The Health Authority is a governmental health insuring organization and, accordingly, follows principles, as prescribed by the Governmental Accounting Standards Board ("GASB"), the provisions of the American Institute of Certified Public Accountants Audit and Accounting Guide ("AICPA"), *Health Care Organizations*, and the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines. The Health Authority utilizes the proprietary fund method of accounting under which the financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred.

Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Health Authority's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Use of estimates – The preparation of the financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported ("IBNR") claims and medical claims payable, premiums receivable, fair market value of investments, net pension asset/liability, other post-employment benefits asset, premium deficiency reserves, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost, which approximates fair value. At June 30, 2021 and 2020, the Health Authority's cash deposits and investment pool had carrying amounts of $192,661,298 and $133,770,764, respectively. The Health Authority's bank and investment pool balances at June 30, 2021 and 2020, including interests in an investment pool, were $223,433,288 and $344,500,631, respectively. Of the bank and investment pool balances at June 30, 2021 and 2020, $222,563,094 and $343,653,375, respectively, were not covered by federal depository insurance.

Amounts invested in the County Treasurer's investment pool (the "Investment Pool") are considered cash and cash equivalents, as funds can be withdrawn by the Health Authority on demand. The County's Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not U.S. Securities and Exchange Commission registered, and based on the California statutes and the County's investment policy, primarily invests in obligations of U.S. Treasury, certain federal agencies, bankers' acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer's Local Agency Investment Fund. The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. As the Health Authority does not own identifiable investment securities of the pool but participates as a shareholder of the pool, these cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions*, Section 150, *Investments* and Section 155, *Investments – Reverse Repurchase Agreements*. The fair value of the Health Authority's share in the pool approximated the fair value of the position in the pool at June 30, 2021 and 2020.

Investments – The Health Authority adopted GASB Statement No. 72, *Fair Value Measurement and Application* ("GASB 72"), effective July 1, 2019. GASB 72 requires the Health Authority to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

Capital assets – Purchased capital assets are stated at cost. Depreciation and amortization is provided using the straight-line method over the estimated useful lives of the respective assets, generally three to five years. Leasehold improvements are amortized over the shorter of the remaining term of the lease or the useful life. The Health Authority capitalizes capital expenditures over $1,000, which will have a useful life of three or more years.

The Health Authority evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Assets restricted as to use – The Health Authority is required by DMHC to restrict cash having a fair value of at least $300,000 for payment of member claims in the event of insolvency. The amount recorded was $325,000 and $305,350 at June 30, 2021 and 2020, respectively.

Amounts due to the State of California – When the Health Authority is made aware of changes to DHCS rate structure, such as rate changes, risk corridors or program reconciliations, that significantly impact the financial outlook, an accrual for the estimated change is recorded.

In-Home Supportive Services ("IHSS") payable – DHCS paid IHSS payments directly to the Santa Clara County's Department of Social Services. As part of CCI, the Health Authority assumed full risk for IHSS provider payments. These amounts are included in both premium revenue and medical expenses and equivalent amounts are recorded as premiums receivable and IHSS payable, respectively, in the Health Authority's financials statements. Additionally, the Health Authority paid the MCO tax on the IHSS revenue and recorded it as premium tax. Effective January 1, 2018, IHSS was phased-out of CCI.

Due to providers – Due to providers consists predominately of payables related to managed care hospital directed payments, Proposition 56 funds, and Ground Emergency Medical Transportation ("GEMT") funds.

Effective July 1, 2017, DHCS implemented three Medi-Cal managed care hospital directed payments: (1) Private Hospital Directed Payment ("PHDP"), (2) Designated Public Hospital Enhanced Payment Program ("EPP"), and (3) Designated Public Hospital Quality Incentive Pool ("QIP").

- For PHDP, the Department has directed Managed Care Plans ("MCP") to reimburse private hospitals as defined in WIC 14169.51, based on actual utilization of contracted services. The enhanced payment is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient care.

- For EPP, which consists of fee-for-service and capitated pools, the Department has directed MCPs to reimburse California's designated public hospitals ("DPH") for contracted services based on actual utilization of contracted services.

- For QIP, the Department has directed MCPs to make additional payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

Proposition 56 is a supplemental payment for certain professional medical services to Medi-Cal beneficiaries funded by the Tobacco Tax (California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56) as defined by DHCS in APL 19-006.

GEMT is a supplemental payment that provides additional funding to eligible providers of GEMT services to Medi-Cal beneficiaries as defined by DHCS in APL 19-007.

Medical incurred but not reported claims and medical claims payable – The Health Authority contracts with various providers, including physicians and hospitals, to provide certain health care products and services to enrolled beneficiaries. The cost of the health care products and services provided or contracted for is accrued in the period in which it is provided to a member, based in part on actuarial estimates, including an accrual for medical services incurred but not yet reported to the Health Authority. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Provider incentives and other medical liabilities – The Health Authority has various incentive agreements with certain providers whereby the providers are reimbursed for efficient and quality services provided to certain enrolled beneficiaries. Under the incentive agreements, health care costs (which include all fee-for-service claims and estimated medical incurred but not reported claims and medical claims payable) are allocated on a per member per month basis. Based on the terms of certain incentive agreements, a final reconciliation of surpluses is completed annually and paid within six months of the end of the Health Authority's fiscal year. Incentive payments are recorded as medical expenses in the accompanying financial statements.

Net pension liability/asset – The Health Authority recognizes a net pension liability/asset, which represents the proportionate share of the difference of the total pension asset/liability over the fiduciary net position of the pension reflected in the actuarial report provided by the California Public Employees' Retirement System ("CalPERS"). The net pension liability/asset is measured as of the Health Authority's prior fiscal year-end. Changes in the net pension liability/asset are recorded in the period incurred as pension expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net pension liability/asset that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in pension expense systematically over time.

For purposes of measuring the net pension liability/asset, deferred outflows and inflows of resources related to pensions, pension expense, information about the fiduciary net position, and additions to and deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

Other post-employment benefits asset – The Health Authority recognizes a net other post-employment benefits ("OPEB") asset, which represents the difference of the total OPEB liability over the fiduciary net position of the Health Authority's OPEB plan, which is administered by CalPERS. The net OPEB asset is measured as of the Health Authority's prior fiscal year-end. Changes in the net OPEB asset are recorded in the period incurred as OPEB expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net OPEB asset that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in OPEB expense systematically over time.

For purposes of measuring the net OPEB asset, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position, and additions to and deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value, except for money market investments and participating interest-earning investment contracts that have a maturity at the time of purchase of one year or less, which are reported at cost.

Net position – Net position is classified as net investment in capital assets, restricted net position, and unrestricted net position, which includes board designated funds. Net investment in capital assets represents capital assets, net of accumulated depreciation and amortization. Restricted net position is noncapital net position that must be used for a particular purpose, as specified by the state regulatory agency, grantors, or contributors external to the Health Authority. Unrestricted net position consists of net position that does not meet the definition of restricted or net investment in capital assets and board designated funds. In December 2019, the Health Authority's Governing Board designated $16,000,000 for an Innovation fund and increased its previous designation for a Community-Based Organization fund to $4,000,000. As of June 30, 2021 and 2020, $17,067,275 and $17,339,275 was unexpended, respectively.

Capitation and premium revenue – The Health Authority has agreements with the Medi-Cal Program in the State of California to provide certain health care products and services to enrolled Medi-Cal beneficiaries. Eligibility of beneficiaries is determined by Santa Clara County Social Services Agency and validated by the State of California. The State of California provides the Health Authority the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month. The Health Authority receives monthly premium payments from DHCS based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from DHCS monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments. For the years ended June 30, 2021 and 2020, premium revenues recorded from DHCS under the Medi-Cal Program totaled $1,229,229,175 and $970,210,089, respectively.

The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in the CMC program. For the years ended June 30, 2021 and 2020, premium revenues totaled $45,682,524 and $34,839,647, and $165,421,632 and $141,653,083 for the Medi-Cal and Medicare components of the CMC program, respectively. According to Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), premium tax is imposed on only the revenues received by MCOs through their Medi-Cal and Healthy Kids managed care plans; consequently, Medicare revenues are not subject to premium tax.

The Health Authority has an agreement with the County of Santa Clara to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the funding organization for its respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month. Annual premium revenue for the Healthy Kids Program totaled $1,123,789 for the year ended June 30, 2020, and was funded by County of Santa Clara. All Health Kids members transitioned to Medi-Cal by December 31, 2019.

Premium deficiency reserves – The Health Authority performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015, to participate in a demonstration project to integrate care for dual-eligible beneficiaries. The Contract shall be renewed in one-year terms through December 31, 2022. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it may incur losses on the contract. Accordingly, a premium deficiency reserve in the amount of $8,294,025 has been recorded at June 30, 2021 and 2020. The Health Authority may receive future revenue adjustments in the form of shared risk corridor payments and CMS hierarchical condition category risk adjustment true-ups; however, these adjustments cannot currently be estimated. Management has determined that no other premium deficiency reserves are needed at June 30, 2021 and 2020.

Concentration of credit risk – A majority of the Health Authority's revenues are derived from contracts with DHCS and CMS. Loss of the contracts due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Authority. As of June 30, 2021, the Health Authority had premiums receivable of $490,415,912, $9,002,439, and $12,801,175 due from Medi-Cal Program, CMC program, and Medicare, respectively. As of June 30, 2020, the Health Authority had premiums receivable of $785,628,061, $7,405,424, $17,972,777, and $454 due from Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, respectively.

Medical expenses – Hospital, physician, and other service costs are based on actual paid claims plus an estimate for accrued incurred but not reported claims. Claims are paid primarily on a fee-for-service basis. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

Operating revenues and expenses – The Health Authority's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting,* all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating expense is medical care cost. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Income taxes – The Health Authority is a public entity and falls under the purview of Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

New accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities* (“GASB 84”). GASB 84 provides improved guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 84 to reporting periods beginning after December 15, 2019. The Health Authority adopted GASB 84 in the current fiscal year. The Health Authority adopted GASB 84 in the current fiscal year. The adoption of this standard did not have significant impact to the financial statements.

In June 2017, the GASB issued GASB Statement No. 87, *Leases ("GASB 87")*. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB 87 to fiscal years beginning after June 15, 2021. The Health Authority is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* ("GASB 97"). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The Health Authority adopted GASB 97 in the current fiscal year. The adoption of this standard did not have significant impact to the financial statements.

Reclassifications – Certain amounts in the 2020 financial statements have been reclassified to conform to the 2021 presentation. These reclassifications have no effect on the 2020 operating income or net position.

NOTE 2 – INVESTMENTS

At June 30, 2021 and 2020, the Health Authority's investments consisted of money market funds, commercial paper, U.S. government agency bonds, corporate bonds, municipal bonds, asset back securities, commercial paper, and U.S. treasury securities.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. The Health Authority manages risk of market value fluctuations due to overall changes in the general level of interest rates by complying with California Government Code Section 53600.5. As of June 30, 2021 and 2020, the Health Authority's investments all have maturities of less than one year.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of rating by a nationally recognized statistical rating organization. The following are the credit ratings for each investment type at June 30, 2021:

Description	Fair value	AAA	AA+	AA	AA-	A+	A	A-	A-1+	A-1
Investments in:										
U.S. government agency bonds	$ 91,032,849	$ 25,549,604	$ -	$ 5,074,397	$ -	$ -	$ -	$ -	$ 60,408,848	$ -
Corporate bonds	62,445,780	-	3,019,216	-	9,520,715	16,644,503	20,140,173	13,121,173	-	-
Municipal bonds	13,108,692	1,925,611	499,868	6,596,581	4,086,632	-	-	-	-	-
Commercial paper	40,257,340	-	-	-	-	-	-	-	24,658,032	15,599,308
U.S. treasury securities	8,241,106	2,541,134	-	-	-	-	-	-	5,699,972	-
Total investments	$ 215,085,767	$ 30,016,349	$ 3,519,084	$ 11,670,978	$ 13,607,347	$ 16,644,503	$ 20,140,173	$ 13,121,173	$ 90,766,852	$ 15,599,308

The following are the credit ratings for each investment type at June 30, 2020:

Description	Fair value	AAA	AA+	AA	AA-	A+	A	A-	A-1+
Investments in:									
U.S. government agency bonds	$ 101,825,363	$ 2,026,549	$ -	$ -	$ -	$ -	$ -	$ -	$ 99,798,814
Corporate bonds	34,790,027	2,047,076	-	-	2,015,254	22,744,968	7,982,729	-	-
Municipal bonds	9,018,771	-	1,681,741	2,560,532	-	761,476	-	-	4,015,022
Asset-backed securities	1,203,170	1,203,170	-	-	-	-	-	-	-
Commercial paper	10,995,235	-	-	-	-	-	-	-	10,995,235
U.S. treasury securities	42,050,789	18,358,657	-	-	-	-	-	-	23,692,132
Total investments	$ 199,883,355	$ 23,635,452	$ 1,681,741	$ 2,560,532	$ 2,015,254	$ 23,506,444	$ 7,982,729	$ -	$ 138,501,203

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Health Authority's investments as a percentage of its portfolio at June 30, 2021 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	42.0 %
Corporate bonds	Various	29.0
Municipal bonds	Various	6.0
Commercial paper	Various	19.0
U.S. treasury securities	Various	4.0
		100.00 %

The Health Authority's investments as a percentage of its portfolio at June 30, 2020 were as follows:

Investment	Issuer	Percentage of portfolio
U.S. government agency bonds	Various	50.0 %
Corporate bonds	Various	17.0
Municipal bonds	Various	5.0
Asset-backed securities	Various	1.0
Commercial paper	Various	6.0
U.S. treasury securities	Various	21.0
		100.00 %

NOTE 3 – FAIR VALUE

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following table present fair value measurements of assets recognized in the accompanying financial statements measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30:

Description	Level 1	Level 2	Level 3	2021
Investments in:				
U.S. government agency bonds	$ -	$ 91,032,849	$ -	$ 91,032,849
Corporate bonds	-	62,445,780	-	62,445,780
Municipal bonds	-	13,108,692	-	13,108,692
Total investments subject to fair value hierarchy	$ -	$ 166,587,321	$ -	166,587,321
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				40,257,340
U.S. treasury securities				8,241,106
Certificate of deposits				325,000
Total investments and restricted cash				$ 215,410,767

Description	Level 1	Level 2	Level 3	2020
Investments in:				
U.S. government agency bonds	$ -	$ 101,825,363	$ -	$ 101,825,363
Corporate bonds	-	34,790,027	-	34,790,027
Municipal bonds	-	9,018,771	-	9,018,771
Asset-backed securities	-	1,203,170	-	1,203,170
Total investments subject to fair value hierarchy	$ -	$ 146,837,331	$ -	146,837,331
Investments and restricted cash not subject to fair value hierarchy				
Commercial paper				10,995,235
U.S. treasury securities				42,050,789
Certificate of deposits				305,350
Total investments and restricted cash				$ 200,188,705

NOTE 4 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2021 and 2020, are as follows:

	2021				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ 1,550	$ -	$ -	$ 3,509,128
Furniture and equipment	12,642,255	594,237	-	-	13,236,492
Building and building improvements	19,008,213	3,767,238	(214,889)	353,401	22,913,963
Software	11,631,752	220,515	(18,297)	-	11,833,970
Vehicles	29,248	-	-	-	29,248
Building improvements work in progress	566,771	-	(213,370)	(353,401)	-
Total capital assets	47,385,817	4,583,540	(446,556)	-	51,522,801
Less accumulated depreciation and amortization for:					
Furniture and equipment	10,860,863	613,456	-	-	11,474,319
Building and building improvements	1,557,918	1,327,117	-	-	2,885,035
Software	8,306,167	1,783,962	-	-	10,090,129
Vehicles	11,781	4,874	-	-	16,655
Total accumulated depreciation and amortization	20,736,729	3,729,409	-	-	24,466,138
Capital assets, net	$ 26,649,088	$ 854,131	$ (446,556)	$ -	$ 27,056,663

	2020				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Land	$ 3,507,578	$ -	$ -	$ -	$ 3,507,578
Furniture and equipment	11,983,493	849,663	(6,290)	(184,611)	12,642,255
Leasehold improvements	-	-	-	-	-
Building and building improvements	17,267,569	1,568,598	(12,565)	184,611	19,008,213
Software	11,342,155	408,577	(150,207)	31,227	11,631,752
Vehicles	29,248	-	-	-	29,248
Software work in progress	61,887	-	(30,660)	(31,227)	-
Building improvements work in progress	566,771	-	-	-	566,771
Total capital assets	44,758,701	2,826,838	(199,722)	-	47,385,817
Less accumulated depreciation and amortization for:					
Furniture and equipment	9,647,338	621,469	592,056	-	10,860,863
Leasehold improvements	592,056	-	(592,056)	-	-
Building and building improvements	755,003	802,915	-	-	1,557,918
Software	6,365,158	1,941,009	-	-	8,306,167
Vehicles	6,906	4,875	-	-	11,781
Total accumulated depreciation and amortization	17,366,461	3,370,268	-	-	20,736,729
Capital assets, net	$ 27,392,240	$ (543,430)	$ (199,722)	$ -	$ 26,649,088

Depreciation and amortization expense totaled $3,729,409 and $3,370,268 at June 30, 2021 and 2020, respectively.

NOTE 5 – MEDICAL INCURRED BUT NOT REPORTED CLAIMS AND MEDICAL CLAIMS PAYABLE

The Health Authority estimates IBNR claims and medical claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed and, as settlements are made or estimates are adjusted, differences are reflected in current operations. Such estimates are subject to impact of changes in the regulatory environment. Activity for medical IBNR and medical claims payable for the years ended June 30, 2021 and 2020, is summarized as follows:

	2021	2020
Beginning balance	$ 84,105,151	$ 82,355,017
Incurred related to:		
Current year	677,315,048	609,184,841
Prior year	(13,082,432)	(12,867,896)
Total incurred	664,232,616	596,316,945
Paid related to:		
Current year	578,912,062	529,237,516
Prior year	69,338,381	65,329,295
Total paid	648,250,443	594,566,811
Ending balance	$ 100,087,324	$ 84,105,151

As presented in the table above, $664,232,616 and $596,316,945 in medical claims were incurred for the years ended June 30, 2021 and 2020, respectively, which are reflected in medical services in the statements of revenues, expenses, and changes in net position.

IBNR liability increased by $15,982,173 in comparison to the previous year as a result of changes between actual payments for medical services and estimated amounts in previous years. Management believes the increase in estimated prior year's claims experience is largely a result of higher-than-anticipated adverse health care claims experience.

NOTE 6 – DESIGNATED NET POSITION

Designated funds remain under the control of the Governing Board, which may, at its discretion, later use the funds for other purposes. For the fiscal years ended June 30, 2021 and 2020, board-designated funds of $17,067,275 and $17,339,275, respectively, were made.

NOTE 7 – OPERATING LEASE OBLIGATIONS

The Health Authority leases the Blanca Alvarado Community Resource Center and various equipment leases expiring in various years.

Future minimum lease payments as of June 30, 2021, consist of the following:

Years Ending June 30,	
2022	$ 314,857
2023	326,711
2024	316,187
2025	212,484
2026	18,157
Total minimum lease payments	$ 1,188,396

Rent expense, included in general and administrative expenses in the statements of revenues, expenses, and changes in net position, for the years ended June 30, 2021 and 2020, was $189,949 and $23,923, respectively.

NOTE 8 – EMPLOYEE BENEFIT PLANS

Internal Revenue Code 401(a) Plan – The Health Authority has a defined contribution plan under Section 401(a) of the Internal Revenue Code. For employees hired prior to January 1, 2013, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participant's gross compensation. For employees hired on or after January 1, 2013, participants must contribute 6.25% of their gross compensation within a specific range and the Health Authority must contribute 6.533% of the participant's gross compensation with the same specific range. For senior staff employees, the Health Authority contributes greater than 3% of gross compensation and senior staff employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled $854,462 and $775,731 for the years ended June 30, 2021 and 2020, respectively.

The 401(a) plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's financial statements.

Internal Revenue Code 457 Plan – The Health Authority has a deferred compensation plan under Section 457 of the Internal Revenue Code. Participants may contribute up to the maximum allowed under Section 457. The Health Authority makes matching contributions only to 457 plan participants who are not participating in the 401(a) plan. For those employees, the Health Authority matches 50% of employee contributions, up to a maximum of 3% of compensation. Matching contributions are made to the 401(a) plan.

The 457 plan is administered through a third-party administrator and is available to all employee groups. The Heath Authority does not perform the investment function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's financial statements.

California Public Employees' Retirement System

Plan description – The Health Authority participates in CalPERS, a cost sharing multiple-employer defined benefit pension plan. CalPERS acts as a common investment and administrative agent for various local and state governmental agencies within the State of California. CalPERS provides retirement, disability, and death benefits based on the employees' years of service, age, and final compensation. CalPERS provides retirement benefits payable beginning at age 55 that are equal to 2% of the employee's final 3-year average compensation multiplied by the employee's years of service.

The State passed the California Employees' Pension Reform Act of 2013 ("PEPRA") which became effective on January 1, 2013. PEPRA changes include the classification of active employees into two distinct classifications: classic members and new members. Classic members represent active members hired before January 1, 2013, and retain the pension plan benefits in effect. This plan was closed to entrants on January 1, 2013, or after. New members are active members hired on or after January 1, 2013, and are subject to PEPRA. PEPRA offers a reduced benefit formula and increased retirement ages to new public employees, who first became PERS members on or after January 1, 2013. CalPERS provides retirement benefits payable beginning at age 62 that are equal to 2% of the employee's final 3-year average compensation times the employee's years of service. The provisions and all other requirements are established by State statute. CalPERS issues a stand-alone report that is available upon request at the following address: CalPERS Actuarial & Employer Service Division; P.O. Box 942709; Sacramento, California 94229-2709.

Funding policy – The contribution requirements of the plan members and the Health Authority are established and may be amended by CalPERS. With the election to participate in CalPERS, participation in Social Security is discontinued, and contributions to CalPERS are in lieu of contributions to Social Security. The Health Authority is required to contribute an actuarially determined rate. The employer contribution rate was 8.00% of annual covered payroll for both the years ended June 30, 2021 and 2020. All eligible participating employees are required to contribute 7.00% of their monthly salaries to CalPERS. The Health Authority deducts the contributions from employees' wages and remits to CalPERS on their behalf and for their account. Contributions to the pension plans from the Health Authority were $2,361,122 and $2,058,408 for the years ended June 30, 2021 and 2020, respectively.

Pension liability/asset, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2021, is measured as of June 30, 2020, using an annual actuarial valuation as of June 30, 2019, rolled forward to June 30, 2020, using standard update procedures. The total pension liability in the June 30, 2019, actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.50% until Purchasing Power Protection Allowance Floor on Purchasing Power applies

The net pension asset at June 30, 2020, is measured as of June 30, 2019, using an annual actuarial valuation as of June 30, 2018, rolled forward to June 30, 2019, using standard update procedures. The total pension asset in the June 30, 2018, actuarial valuation was based on the following actuarial methods and assumptions:

Actuarial cost method:	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.15%
Inflation	2.50%
Salary increases	Varies by Entry Age and Service
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Postretirement benefit increase:	Contract COLA up to 2.00% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

All other actuarial assumptions used in the June 30, 2019 and 2018 valuations were based on the results of an actuarial experience study for the fiscal years 1997 to 2015, including updates to salary increase, mortality, and retirement rates. The experience study report can be obtained at the CalPERS' website under Forms and Publications.

Change of assumptions – The inflation rate remained unchanged at 2.50% for the June 30, 2020 and 2019, measurement dates.

Discount rate – The discount rate used to measure the total pension asset at June 30, 2021 and 2020, measurement date was 7.15%. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. The test revealed the assets would not run out. Therefore, the current 7.15% discount rate is appropriate and the use of the municipal bond rate calculation is not deemed necessary. The long-term expected discount rate of 7.15% is applied to all plans in the Public Employees Retirement Fund. The cash flows used in the testing were developed assuming that both members and employers will make their required contributions on time and as scheduled in all future years. The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation.

Asset Class	Current Target Allocation	Real Return Years 1-10 [(a)]	Real Return Years 11+ [(b)]
Global equity	50.0%	4.80%	5.98%
Fixed income	28.0%	1.00%	2.62%
Inflation assets	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

[(a)] An expected inflation rate of 2.00% was used for this period.
[(b)] An expected inflation rate of 2.92% was used for this period.

Sensitivity of the employer's proportionate share of the net pension liability/asset to changes in the discount rate – The following presents the Health Authority's net pension liability/asset as of June 30, 2021 and 2020, as well as what the net pension liability/asset would be if it were calculated using a discount rate that is 1% point lower or 1% point higher than the current rate:

	June 30, 2021		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension liability (asset)	$ 7,419,584	$ 199,654	$ (5,765,948)

	June 30, 2020		
	1% Decrease (6.15%)	Current Discount Rate (7.15%)	1% Increase (8.15%)
Health Authority's net pension (asset) liability	$ 5,574,335	$ (1,017,002)	$ (6,457,686)

The Health Authority's proportion for the miscellaneous plan was 0.00183% and -0.00992% at June 30, 2021 and 2020, respectively.

For the years ended June 30, 2021 and 2020, the Health Authority recognized pension expense of $3,551,927 and $2,924,828, respectively. Pension expense represents the change in the net pension liability/asset during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

As of June 30, 2021, the Health Authority had $4,204,264 of deferred outflows of resources and $539,318 of deferred inflows of resources related to pensions from the following sources:

	2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 1,248,667	$ (84,236)
Difference in experience	10,290	-
Differences between employer's actual contributions and its proportionate share of total employer contributions	573,703	(453,658)
Net differences between projected and actual earnings on pension plan investments	5,931	-
Changes in assumptions	-	(1,424)
Pension contributions made subsequent to measurement date	2,365,673	-
	$ 4,204,264	$ (539,318)

As of June 30, 2020, the Health Authority had $5,296,371 of deferred outflows of resources and $1,661,827 of deferred inflows of resources related to pensions from the following sources:

	2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Change in employers' proportionate share	$ 686,603	$ (1,245,899)
Difference in experience	5,473	(70,635)
Differences between employer's actual contributions and its proportionate share of total employer contributions	2,510,916	(296,798)
Net differences between projected and actual earnings on pension plan investments	17,780	-
Changes in assumptions	17,191	(48,495)
Pension contributions made subsequent to measurement date	2,058,408	-
	$ 5,296,371	$ (1,661,827)

Deferred outflows of resources and deferred inflows of resources above represent the unamortized portion of changes to net pension liability/asset to be recognized in future periods in a systematic manner.

Deferred outflows of resources of $2,365,673 and $2,058,408 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability/asset in the years ending June 30, 2022 and 2021, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ended June 30,	
2022	$ 825,407
2023	$ 311,187
2024	$ 159,833
2025	$ 2,846

NOTE 9 – POST-EMPLOYMENT HEALTH BENEFITS

Plan description – The Health Authority participates in the California Employers' Retiree Benefit Trust (“CERBT”), a single employer agent plan as administered by CalPERS to prefund its post-employment healthcare benefits. The Health Authority's OPEB plan provides healthcare benefits to eligible employees and certain dependents. Retired employees who retire directly from the health plan are eligible to receive contributions from the Health Authority toward their monthly Public Employees’ Medical and Hospital Care Act (health plans offered by CalPERS) if they meet certain age and service eligibility requirements as outlined in the plan document and as approved by the Health Authority’s Governing Board.

Employees hired prior to May 1, 2018, who attain age 50, with a minimum of 5 years of CalPERS service, and are employed by the Health Authority at the time of retirement, are eligible for coverage. Employees hired on or after May 1, 2018, who attain age 50, with a minimum of 12 continuous years at the Health Authority, and are employed by the Health Authority at the time of retirement, are eligible for coverage.

Copies of CERBT's annual financial report may be obtained from the executive office at 400 Q Street, Sacramento, California 95811. A separate report for the Health Authority's participation in the CERBT trust is not available.

Funding policy – For employees hired prior to May 1, 2018, the Health Authority pays for 90% of the cost of retiree medical plan premiums, including the cost for spouse and dependent coverage. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the monthly premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and Medicare retirees, respectively) for retirees who elect PERS Care or out-of-state coverage. Upon the death of the retiree, the Health Authority will continue contributions described above for the surviving spouse or until surviving minor dependents reach age 26.

For retirees hired on or after May 1, 2018, the Health Authority pays for 90% of the cost of retiree-only medical plan premiums. Retirees are required to pay the other 10% of the cost of coverage. The Health Authority's contribution is capped at 90% of the employee-only premium cost of the second most expensive HMO plan available from CalPERS (basic and supplemental rates for non-Medicare and retirees, respectively) for retirees who elect PERS Care or out-of-state coverage.

Employees covered – At June 30, 2021 and 2020, the following employees were covered by the plan:

	2021	2020
Active	300	238
Retirees	58	54
Total participants	358	292

Contributions – The Health Authority must contribute the minimum required amount of $5,000 or the actuarially determined contribution, whichever is lower. The contribution requirements of the Health Authority are established and may be amended by the CERBT.

Net OPEB asset – The Health Authority's net OPEB asset at June 30, 2021 and 2020, was measured as of June 30, 2020 and 2019, respectively, and the total OPEB asset used to calculate the net OPEB asset was determined by an actuarial valuation as of June 30, 2020 and 2019, respectively.

The total OPEB asset in the June 30, 2020, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.00% for 2022 – Non-Medicare, decreasing to 4.00% in 2076, 6.10% for 2022 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-19.

The total OPEB liability in the June 30, 2019, actuarial valuation was determined using the following actuarial assumptions:

Actuarial cost method:	Individual Entry Age Normal Level Percent of Pay
Actuarial assumptions:	
Discount rate	6.75%
Inflation	2.75%
Investment rate of return	6.75%
Healthcare cost trend rates:	7.50% for 2019 – Non-Medicare, decreasing to 4.00% in 2076, 6.50% for 2019 – Medicare, decreasing to 4.00% in 2076

Mortality rates are based on statistics taken from the CalPERS 1997-2015 Experience Study Report. Mortality projected fully generational with Scale MP-17.

Discount rate – The discount rate used to measure the total OPEB asset was 6.75% at both June 30, 2020 and 2019, measurement dates. The projection of cash flows used to determine the discount rate assumed that Health Authority contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the OPEB plan's fiduciary net position was projected to be available to make all projected OPEB payments for current active and inactive employees. Therefore, the long-term expected rate of return on OPEB plan investments was applied to all periods of projected benefit payments to determine the total OPEB asset.

The Health Authority's retiree health plan assets are invested in the California Employers' Retirement Benefit Trust Fund Strategy 1 ("Strategy"). The table below reflects the Strategy's asset allocation.

Asset Class	Asset Allocation	Expected Real Rate of Return
Global equity	59.00%	4.82%
Fixed income	25.00%	1.47%
Treasury inflation-protected securities	5.00%	1.29%
Commodities	3.00%	0.84%
Real estate investment trusts	8.00%	3.76%
Assumed long-term rate of inflation		2.75%
Expected long-term net rate of return		6.75%

Changes in the net OPEB asset – The changes in the net OPEB asset for the years ended June 30, 2021 and 2020, were as follows:

	June 30, 2021		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB (Asset)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)
Changes during the year:			
Service cost	1,222,378	-	1,222,378
Interest on the total OPEB asset	867,980	-	867,980
Actual vs. expected experience	-	-	-
Assumption changes	-	-	-
Contributions from employer	-	3,018,143	(3,018,143)
Net investment income	-	435,252	(435,252)
Benefit payments	(483,793)	(483,793)	-
Administrative expense	-	(6,630)	6,630
Net change	1,606,565	2,962,972	(1,356,407)
Balance at June 30, 2021	$ 13,485,032	$ 15,872,084	$ (2,387,052)

	June 30, 2020		
	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability (Asset)
Balance at June 30, 2019	$ 12,492,170	$ 9,953,080	$ 2,539,090
Changes during the year:			
Service cost	1,089,286	-	1,089,286
Interest on the total OPEB asset	901,963	-	901,963
Actual vs. expected experience	(2,076,281)	-	(2,076,281)
Assumption changes	(90,590)	-	(90,590)
Contributions from employer	-	2,601,369	(2,601,369)
Net investment income	-	795,021	(795,021)
Benefit payments	(438,081)	(438,081)	-
Administrative expense	-	(2,277)	2,277
Net change	(613,703)	2,956,032	(3,569,735)
Balance at June 30, 2020	$ 11,878,467	$ 12,909,112	$ (1,030,645)

Sensitivity of the net OPEB asset to changes in the discount rate – The following presents the net OPEB liability of the Health Authority as of June 30, 2021 and 2020, as well as what the Health Authority's net OPEB liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current discount rate:

	June 30, 2021		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset)	$ (438,734)	$ (2,387,052)	$ (3,981,312)

	June 30, 2020		
	1% Decrease (5.75%)	Current Discount Rate (6.75%)	1% Increase (7.75%)
Health Authority's net OPEB (asset) liability	$ 676,268	$ (1,030,645)	$ (2,428,373)

Sensitivity of the net OPEB asset to changes in the healthcare cost trend rates – The following presents the net OPEB asset of the Health Authority, as well as what the Health Authority's net OPEB asset would be if it were calculated using healthcare cost trend rates that is one percentage point lower or one percentage point higher than the current healthcare cost trend rates:

	June 30, 2021		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset) liability	$ (4,396,093)	$ (2,387,052)	$ 161,692

	June 30, 2020		
	1% Decrease in Healthcare Costs Trend Rate	Current Healthcare Costs Trend Rate	1% Increase in Healthcare Costs Trend Rate
Health Authority's net OPEB (asset) liability	$ (2,684,513)	$ (1,030,645)	$ 1,053,799

OPEB expense and deferred outflows of resources and deferred inflows of resources related to OPEB – For the year ended June 2021, the Health Authority recognized OPEB expense of $1,008,472. At June 30, 2021, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2021	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,664,999)
Net differences between projected and actual earnings on pension plan investments	291,278	-
Changes in assumptions	73,122	(72,288)
OPEB contributions made subsequent to measurement date	2,844,693	-
	$ 3,209,093	$ (1,737,287)

For the year ended June 2020, the Health Authority recognized OPEB expense of $1,008,809. At June 30, 2020, the Health Authority reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	2020	
	Deferred outflows of resources	Deferred inflows of resources
Difference in experience	$ -	$ (1,876,357)
Net differences between projected and actual earnings on pension plan investments	-	(156,101)
Changes in assumptions	87,746	(81,439)
OPEB contributions made subsequent to measurement date	3,018,143	-
	$ 3,105,889	$ (2,113,897)

The Health Authority reported $2,844,693 and $3,018,143 as deferred outflows of resources related to contributions made subsequent to the measurement date for the years ended June 30, 2021 and 2020, respectively. This amount will be recognized as a reduction of net OPEB asset in the years ended June 30, 2022 and 2021, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

Year Ended June 30,	
2022	$ (169,478)
2023	$ (129,222)
2024	$ (124,433)
2025	$ (109,129)
2026	$ (205,886)
Thereafter	$ (634,739)

Payable to the OPEB plan – At June 30, 2021 and 2020, the Health Authority had no outstanding amount of contributions to the OPEB plan required for the years ended June 30, 2021 and 2020.

NOTE 10 – MEDICAL STOP LOSS INSURANCE

The Health Authority has entered into certain stop-loss agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Health Authority certain proportions of the cost of each member's annual hospital services excluding those that are capitated, in excess of specified deductibles, up to a maximum of $1,500,000 per member per contract year. Insurance premiums are recorded as medical expenses and recoveries are recorded as a reduction of these expenses. Premiums exceeded stop-loss recoveries by $861,145 and $474,183 in 2021 and 2020, respectively.

NOTE 11 – TANGIBLE NET EQUITY

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Health Authority is required to maintain a minimum level of tangible net equity. The required tangible net equity level was $33,804,554 and $32,471,000 at June 30, 2021 and 2020, respectively. The Health Authority's tangible net equity was $254,850,602 and $208,640,786 at June 30, 2021 and 2020, respectively.

NOTE 12 – RISK MANAGEMENT

The Health Authority is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Health Authority carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Health Authority's commercial coverage.

NOTE 13 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Health Authority is a party to claims and legal actions by enrollees, providers, and governmental and regulatory agencies. The Health Authority's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, Health Authority management is of the opinion that any liability that may ultimately result from claims or legal actions will not have a material effect on the financial position or results of operations of the Health Authority.

NOTE 14 – HEALTH CARE REFORM

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

Supplementary Information

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Proportionate Share of the Net Pension Liability/Asset

	2021	2020	2019	2018	2017	2016	2015
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Proportion of the net pension liability (asset)	0.00183%	-0.00992%	-0.02053%	0.01840%	0.07925%	0.07311%	0.07849%
Proportionate share of the net pension liability (asset)	$ 199,654	$ (1,017,002)	$ (1,978,644)	$ 1,824,796	$ 6,857,370	$ 5,018,386	$ 4,883,971
Covered-employee payroll*	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745	$ 9,121,825
Proportionate share of the net pension liability (asset) as a percentage of covered-employee payroll	0.75%	-4.29%	-9.91%	11.05%	62.28%	67.56%	53.54%
Proportionate share of plan's fiduciary net position as a percentage of the plan's total pension liability (asset)	75.10%	75.26%	75.26%	73.31%	74.06%	78.40%	80.43%

*For the year ending on the measurement date

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Pension Contributions

	2021	2020	2019	2018	2017	2016	2015
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016	2014-2015	2013-2014
Actuarially determined contribution	$ 2,365,673	$ 2,058,408	$ 1,669,920	$ 1,198,065	$ 1,287,320	$ 910,906	$ 886,335
Contributions in relation to the actuarially determined contribution	2,365,673	2,058,408	1,669,920	4,426,715	7,188,179	910,906	886,335
Contribution excess	$ -	$ -	$ -	$ (3,228,650)	$ (5,900,859)	$ -	$ -
Covered-employee payroll*	$ 29,826,808	$ 26,732,488	$ 23,706,126	$ 19,966,458	$ 16,512,291	$ 11,010,647	$ 7,427,745
Contributions as a percentage of covered-employee payroll	7.93%	7.70%	7.04%	22.17%	43.53%	8.27%	11.93%

*For the fiscal year ending on the date shown

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Changes in Net Other Post-Employment Benefit Asset/Liability

	2021	2020	2019	2018	2017
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Total OPEB liability					
Service cost	$ 1,222,378	$ 1,089,286	$ 1,119,648	$ 756,248	$ 736,008
Interest on the total OPEB liability	867,980	901,963	805,036	708,213	648,807
Actual vs. expected experience	-	(2,076,281)	-	(14,700)	-
Assumption changes	-	(90,590)	-	131,618	-
Benefit payments	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Net change in total OPEB liability	1,606,565	(613,703)	1,446,015	1,039,350	885,111
Total OPEB liability, beginning of year	11,878,467	12,492,170	11,046,155	10,006,805	9,121,694
Total OPEB liability, end of year	$ 13,485,032	$ 11,878,467	$ 12,492,170	$ 11,046,155	$ 10,006,805
Plan fiduciary net position					
Contributions from employer	$ 3,018,143	$ 2,601,369	$ 3,588,109	$ 1,142,027	$ 954,155
Net investment income	435,252	795,021	518,470	551,777	283,871
Benefit payments	(483,793)	(438,081)	(478,669)	(542,029)	(499,704)
Administrative expense	(6,630)	(2,277)	(12,267)	(2,784)	(2,239)
Net change in plan fiduciary net position	2,962,972	2,956,032	3,615,643	1,148,991	736,083
Plan fiduciary net position, beginning of year	12,909,112	9,953,080	6,337,437	5,188,446	4,452,363
Plan fiduciary net position, end of year	$ 15,872,084	$ 12,909,112	$ 9,953,080	$ 6,337,437	$ 5,188,446
Health Authority's net OPEB (asset) liability	$ (2,387,052)	$ (1,030,645)	$ 2,539,090	$ 4,708,718	$ 4,818,359
Plan fiduciary net position as a percentage of the total OPEB liability	117.70%	108.68%	79.67%	57.37%	51.85%
Covered-employee payroll*	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,216,515	$ 17,195,643
Health Authority's net OPEB (asset) liability as a percentage of covered-employee payroll	-8.93%	-4.23%	12.67%	27.35%	28.02%

*For the year ending on the measurement date

Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
Schedule of Other Post-Employment Benefit Contributions

	2021	2020	2019	2018	2017
Measurement period	2019-2020	2018-2019	2017-2018	2016-2017	2015-2016
Actuarially determined contribution	$ 624,728	$ 1,062,967	$ 1,269,369	$ 1,427,237	$ 1,217,313
Contributions in relation to the actuarially determined contribution	2,844,693	3,018,143	2,601,369	3,588,109	1,217,313
Contribution excess	$ (2,219,965)	$ (1,955,176)	$ (1,332,000)	$ (2,160,872)	$ -
Covered-employee payroll*	$ 28,680,020	$ 26,732,488	$ 24,360,228	$ 20,046,373	$ 17,195,643
Contributions as a percentage of covered-employee payroll	9.92%	11.29%	10.68%	17.90%	7.08%

*For the fiscal year ending on the date shown

Santa Clara Family Health Plan™

Unaudited Financial Statements
For Two Months Ended August 31, 2021

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$114 M		$226 M	
Medical Expense (MLR)	$104 M	91.2%	$205 M	90.7%
Administrative Expense (% Rev)	$5.6 M	4.9%	$11.1 M	4.9%
Other Income/(Expense)	$147K		$298K	
Net Surplus (Net Loss)	**$4.6 M**		**$10.2 M**	
Cash and Investments			$411 M	
Receivables			$545 M	
Total Current Assets			$966 M	
Current Liabilities			$738 M	
Current Ratio			1.31	
Tangible Net Equity			$260 M	
% of DMHC Requirement			**734.3%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $4.6M is $3.2M or 228.7% favorable to budget of $1.4M surplus. YTD: Surplus of $10.2M is $7.5M or 269.2% favorable to budget of $2.8M surplus.
Enrollment	Month: Membership was 285,472 (1,471 or 0.5% lower than budget of 286,943). YTD: Member Months YTD was 569,650 (2,218 or 0.4% lower than budget of 571,868).
Revenue	Month: $114.0M ($1.7M or 1.6% favorable to budget of $112.3M). YTD: $226.1M ($2.4M or 1.1% favorable to budget of $223.7M).
Medical Expenses	Month: $103.9M ($854K or 0.8% favorable to budget of $104.8M). YTD: $205.1M ($3.7M or 1.8% favorable to budget of $208.8M).
Administrative Expenses	Month: $5.6M ($841K or 13.0% favorable to budget of $6.5M). YTD: $11.1M ($1.8M or 14.0% favorable to budget of $12.9M).
Tangible Net Equity	TNE was $260.5M (represents approximately two months of total expenses).
Capital Expenditures	YTD Capital Investments of $493K vs. $3.3M annual budget, primarily software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 285,472 members is 1,471 or 0.5% lower than budget. Since the beginning of the fiscal year, total enrollment has increased by 2,802 members or 1.0%.
- Medi-Cal enrollment has been increasing since January 2020, largely due to COVID (beginning in March 2020 annual eligibility redeterminations were suspended and enrollment continues to increase as a result).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 1.0%, Medi-Cal Dual enrollment has increased 1.1%, and CMC enrollment has grown 1.6%.

	For the Month August 2021				For Two Months Ending August 31, 2021					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY22 vs. FY21
Medi-Cal	275,227	276,708	(1,481)	(0.5%)	549,257	551,498	(2,241)	(0.4%)	499,011	10.1%
Cal Medi-Connect	10,245	10,235	10	0.1%	20,393	20,370	23	0.1%	18,295	11.5%
Total	**285,472**	**286,943**	**(1,471)**	**(0.5%)**	**569,650**	**571,868**	**(2,218)**	**(0.4%)**	**517,306**	**10.1%**

Santa Clara Family Health Plan Enrollment By Network
August 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	35,601	13%	10,245	100%	45,846	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	137,005	50%	-	0%	137,005	48%
Palo Alto Medical Foundation	7,378	3%	-	0%	7,378	3%
Physicians Medical Group	46,561	17%	-	0%	46,561	16%
Premier Care	15,818	6%	-	0%	15,818	6%
Kaiser	32,864	12%	-	0%	32,864	12%
Total	**275,227**	**100%**	**10,245**	**100%**	**285,472**	**100%**
Enrollment at June 30, 2021	272,590		10,080		282,670	
Net Δ from Beginning of FY22	1.0%		1.6%		1.0%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

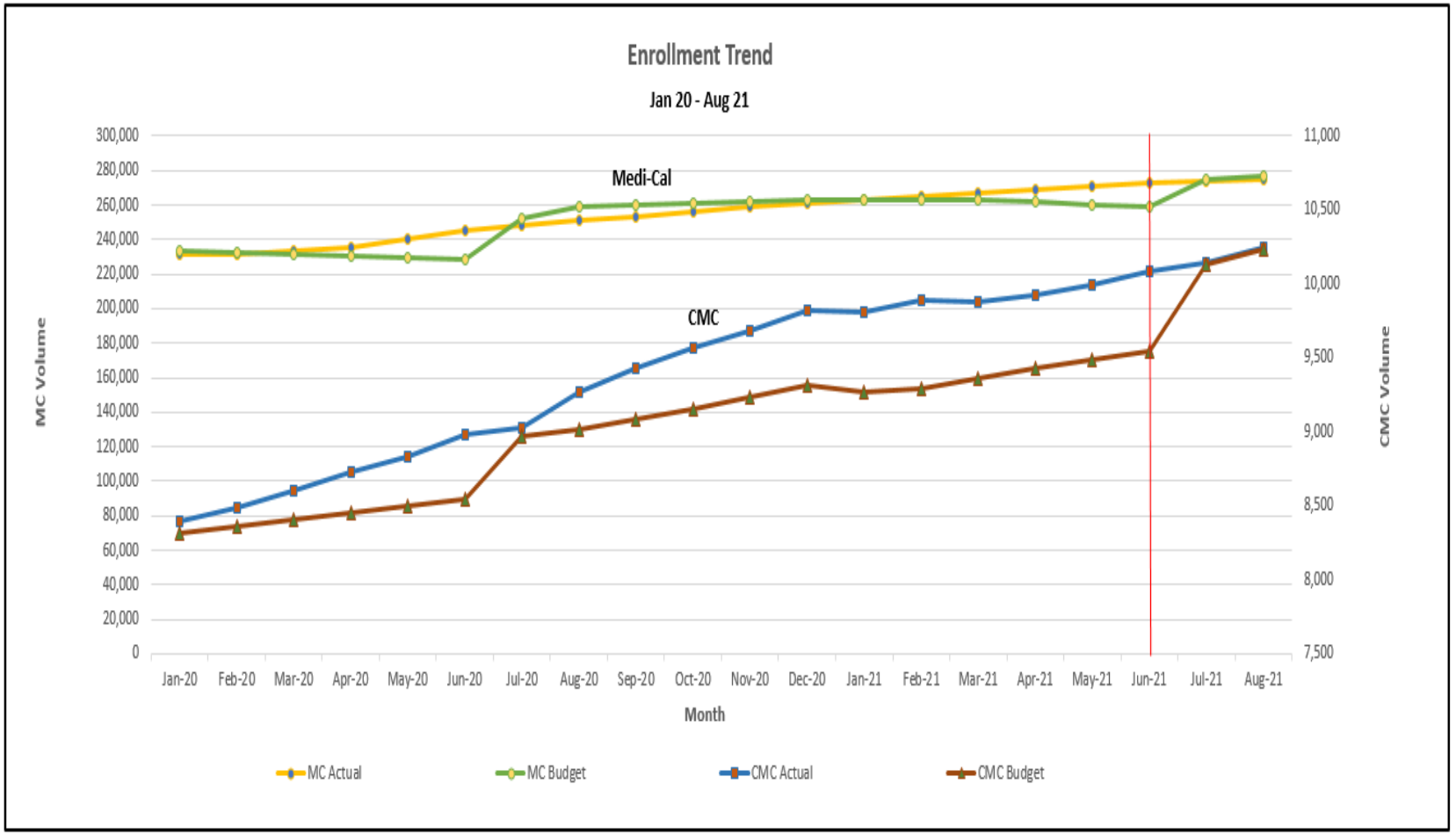
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD AUGUST-2021

		2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	FYTD var	%
NON DUAL	Adult (over 19)	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	284	0.9%
	Child (under 19)	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	608	0.6%
	SPD	22,099	22,079	22,149	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	-25	(0.1%)
	Adult Expansion	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	1,435	1.6%
	Long Term Care	406	407	409	389	393	388	380	373	375	367	365	414	408	43	11.8%
	Total Non-Duals	**225,442**	**227,647**	**230,802**	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**2,345**	**1.0%**
DUAL	Adult (over 21)	320	337	354	353	353	352	355	361	357	365	366	367	376	10	2.7%
	SPD	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	44	0.2%
	Long Term Care	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	55	5.2%
	SPD OE	289	358	410	498	537	590	662	742	802	863	952	1,063	1,135	183	19.2%
	Total Duals	**25,562**	**25,605**	**25,688**	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**292**	**1.1%**
	Total Medi-Cal	**251,004**	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**2,637**	**1.0%**
CMC	CMC Non-Long Term Care	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	142	1.4%
	CMC - Long Term Care	211	216	210	209	207	193	187	184	179	180	185	209	208	23	12.4%
	Total CMC	**9,266**	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**165**	**1.6%**
	Total Enrollment	**260,270**	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**2,802**	**1.0%**

Enrollment Trend

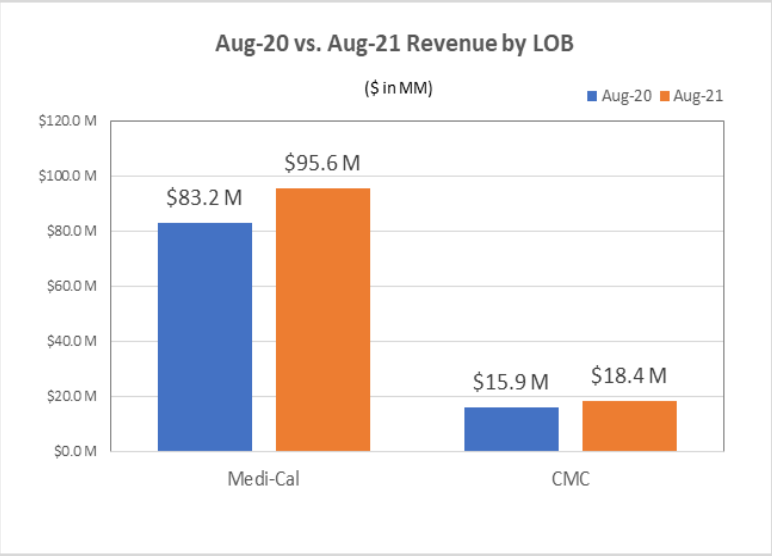


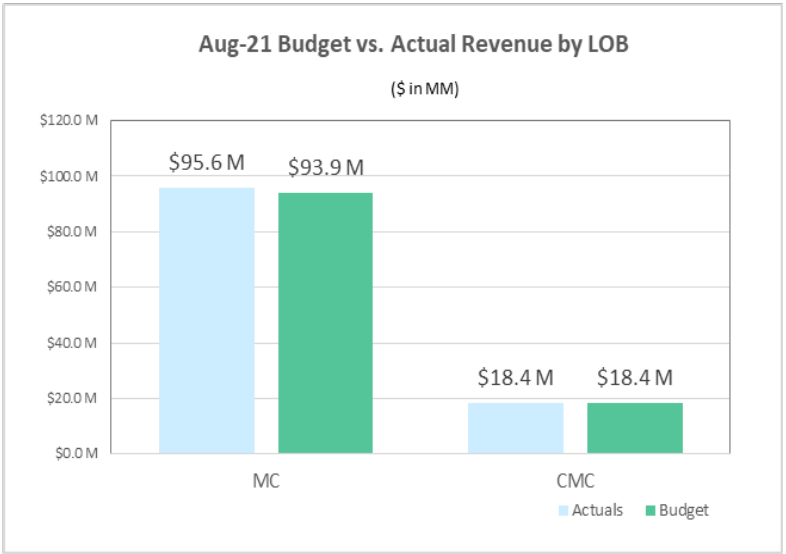
- Budgeted enrollment, represented by the green & brown lines, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the gold & blue lines, has grown steadily.

Current Month Revenue

Current month revenue of $114.0M was $1.7M or 1.6% favorable to budget of $112.3M. The current month variance was primarily due to the following:

- Medi-Cal revenue is $1.2M favorable to budget due to higher CY21 MLTSS, LTC and SPD rates, partly offset by lower enrollment than budget.
- Supplemental kick revenue was $679K favorable to budget due to increased BHT utilization and higher maternity deliveries.
- MCAL Prop-56 revenue is $183K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).
- CMC revenue was $23K net favorable to budget due to higher CY21 CCI rate, offset with lower Medicare Part C rate.

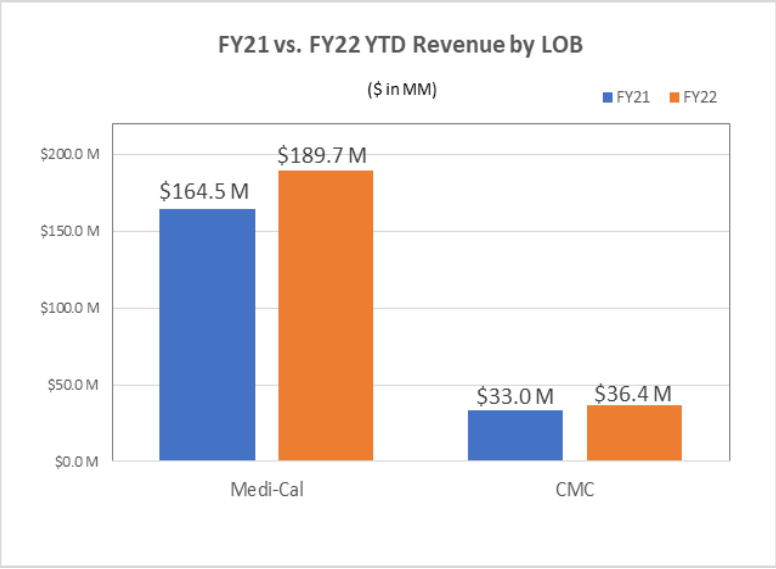


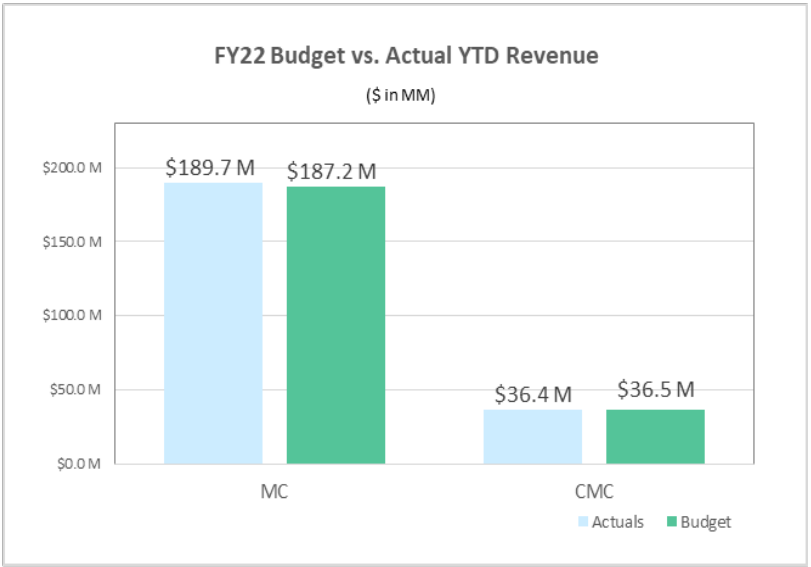


YTD Revenue

YTD revenue of $226.1M was $2.4M or 1.1% favorable to budget of $223.7M. The YTD variance was primarily due to the following:

- Supplemental kick revenue was $2.2M favorable to budget due to increased BHT utilization and higher maternity deliveries.
- Medi-Cal revenue is $750K favorable to budget due to higher CY21 MLTSS, LTC and SPD rates, offset with lower enrollment than budget.
- MCAL Prop-56 revenue is $352K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).
- CMC revenue was $150K net unfavorable to budget due to lower than anticipated Medicare Part C rate, offset with higher CY21 CCI rate.

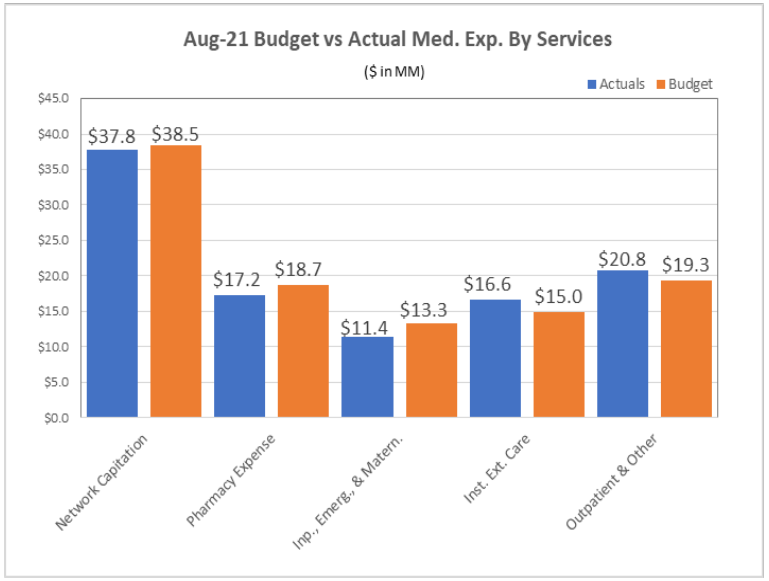


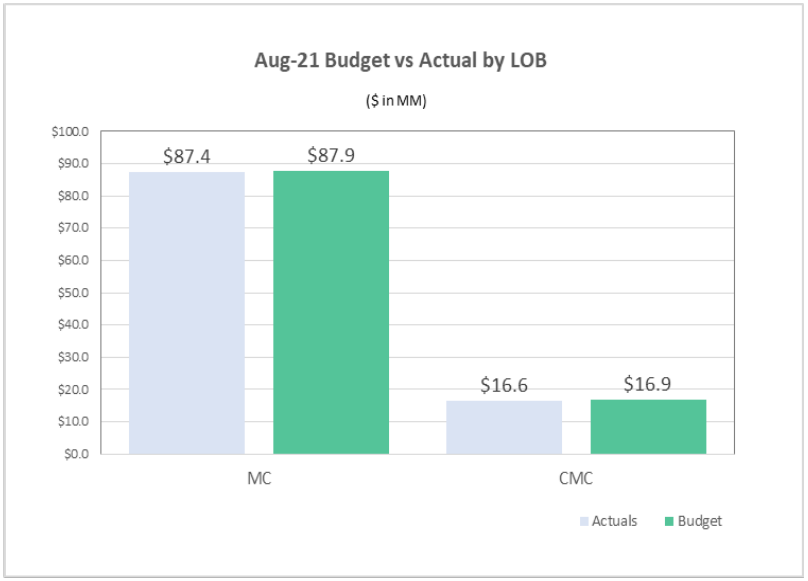


Current Month Medical Expense

Current month medical expense of $103.9M was $854K or 0.8% favorable to budget of $104.8M. The current month variance was due largely to:

- Fee-For-Service expenses reflected a $1.5M or 3.4% unfavorable variance due to higher than expected cost and increased utilization on supplemental services such as Behavioral Health Treatment reflected in higher IBNR estimates.
- Pharmacy expenses were $1.5M or 8.0% favorable to budget due to lower cost increases versus budget, especially in diabetic drugs, and lower utilization.
- Capitation expense was $628K or 1.6% favorable to budget due to lower capitated enrollment.
- Vision, Reinsurance and Other expenses were $194K or 5.2% favorable to budget due to timing of spending on Board Designated expenses and lower Reinsurance Recovery.

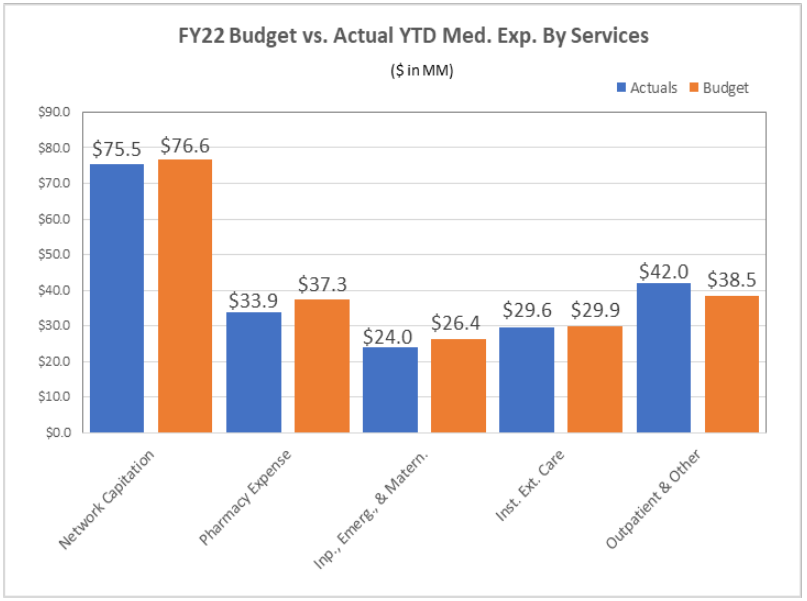


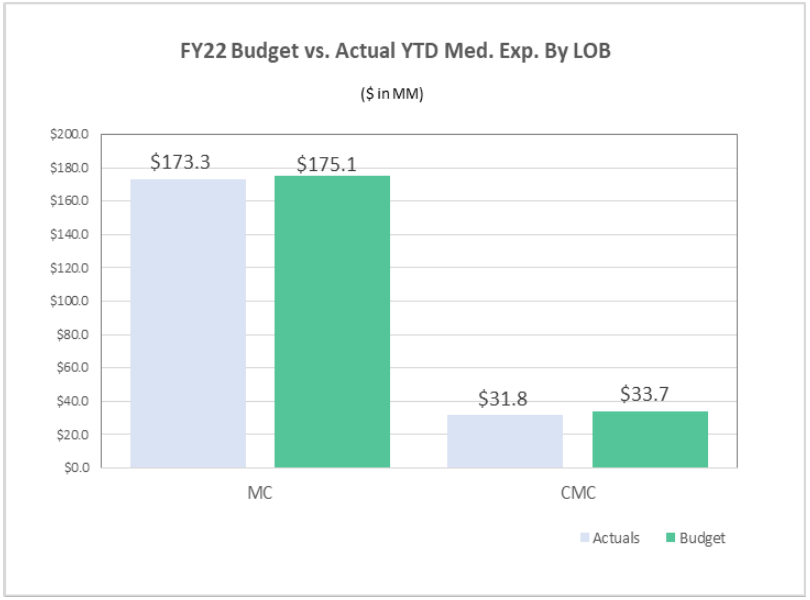


YTD Medical Expense

YTD medical expense of $205.1M was $3.7M or 1.8% favorable to budget of $208.8M.
The YTD variance was due largely to:

- Fee-For-Service expenses reflected a $1.4M or 1.6% unfavorable variance due to increased utilization on supplemental services such as Behavioral Health Treatment and high maternity deliveries (offset with favorable revenue variance).
- Pharmacy expenses were $3.4M or 9.0% favorable to budget, due to lower cost increases versus budget especially in diabetic drugs, and lower utilization.
- Capitation expense was $1.1M or 1.4% favorable to budget due to lower capitated enrollment.
- Vision, Reinsurance and Other expenses were $618K or 8.4% favorable to budget due to timing of spending on Board Designated expenses and higher claim recovery.

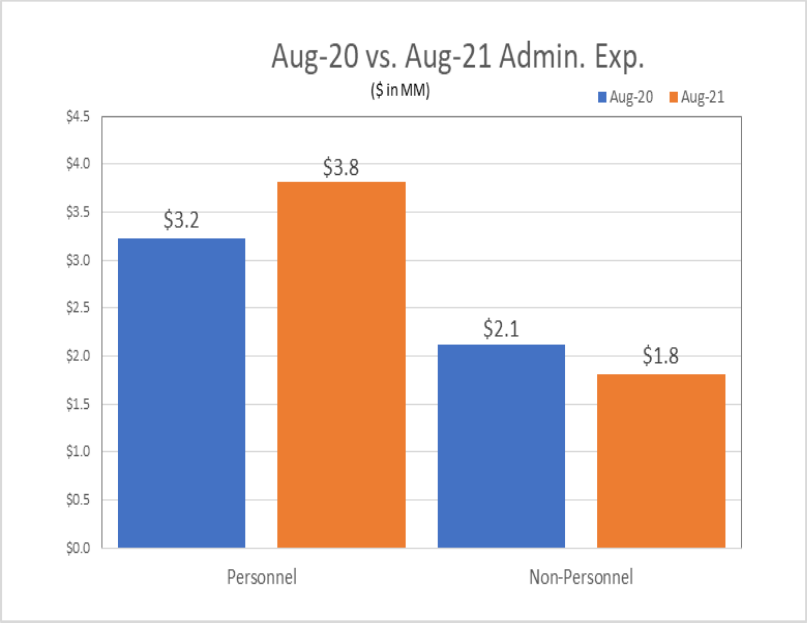


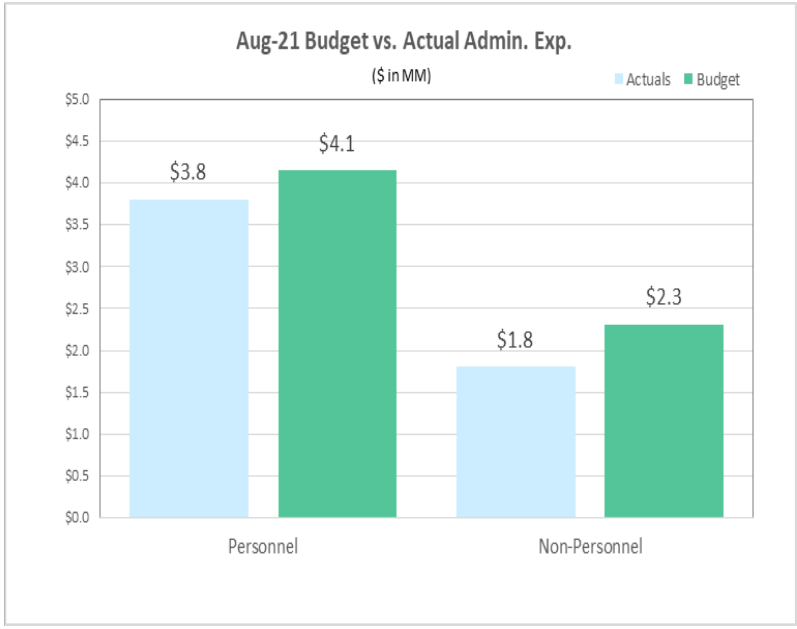


Current Month Administrative Expense

Current month expense of $5.6M was $841K or 13.0% favorable to budget of $6.5M. The current month variances were primarily due to the following:

- Personnel expenses were $338K or 8.2% favorable to budget due to lower headcount than budget including lower payroll tax and benefits.
- Non-Personnel expenses were $503K or 21.7% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees).

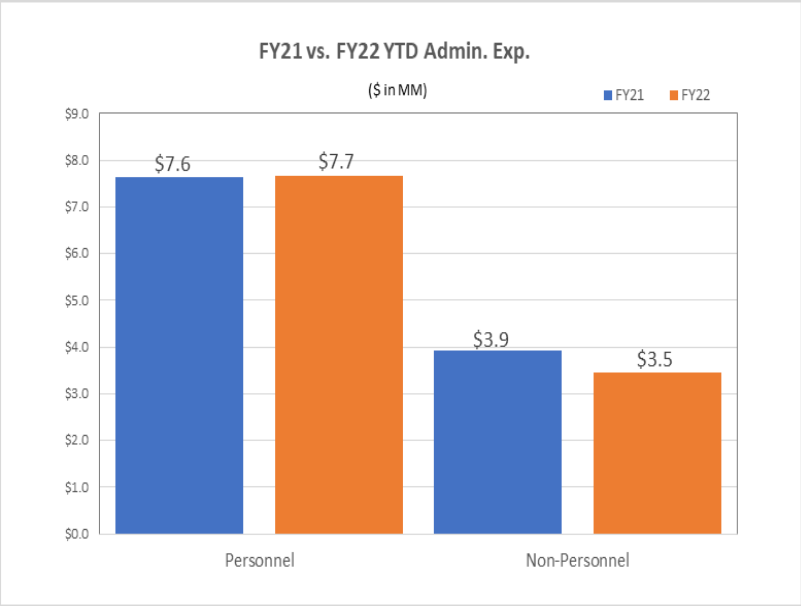


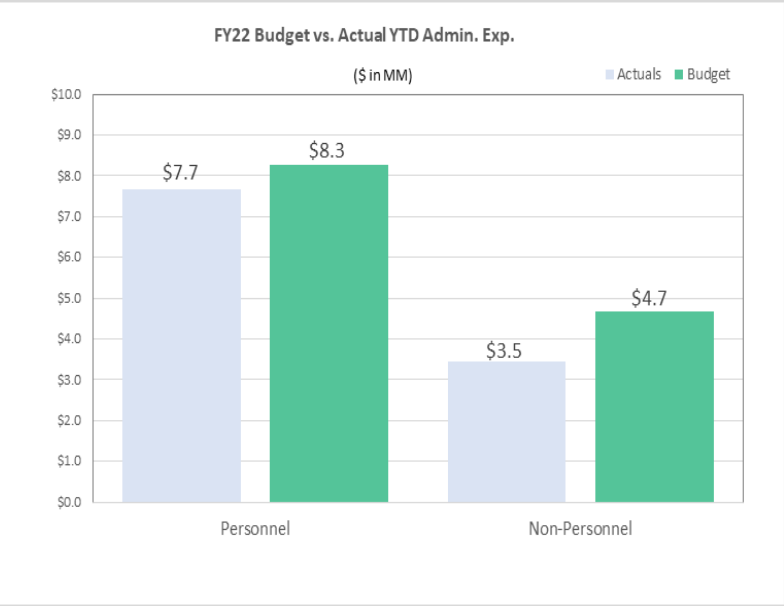


YTD Administrative Expense

YTD administrative expense of $11.1M was $1.8M or 14.0% favorable to budget of $12.9M. The YTD variance was primarily due to the following:

- Personnel expenses were $588K or 7.1% favorable to budget due to lower headcount than budget including lower payroll tax and benefits.
- Non-Personnel expenses were $1.2M or 26.2% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees).





Balance Sheet

- Current assets totaled $966M compared to current liabilities of $738M, yielding a current ratio (Current Assets/Current Liabilities) of 1.31:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance decreased by $2.6M compared to the cash balance as of year-end June 30, 2021 due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$182,649,335	0.76%	$90,096	$190,096
Wells Fargo Investments	$194,960,063	0.10%	$24,555	$41,944
	$377,609,397		$114,651	$232,040
Cash & Equivalents				
Bank of the West Money Market	$343,274	0.10%	$320	$1,217
Wells Fargo Bank Accounts	$32,406,504	0.01%	$343	$720
	$32,749,778		$663	$1,937
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.18%	$0	$0
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$410,684,675**		**$115,314**	**$233,976**

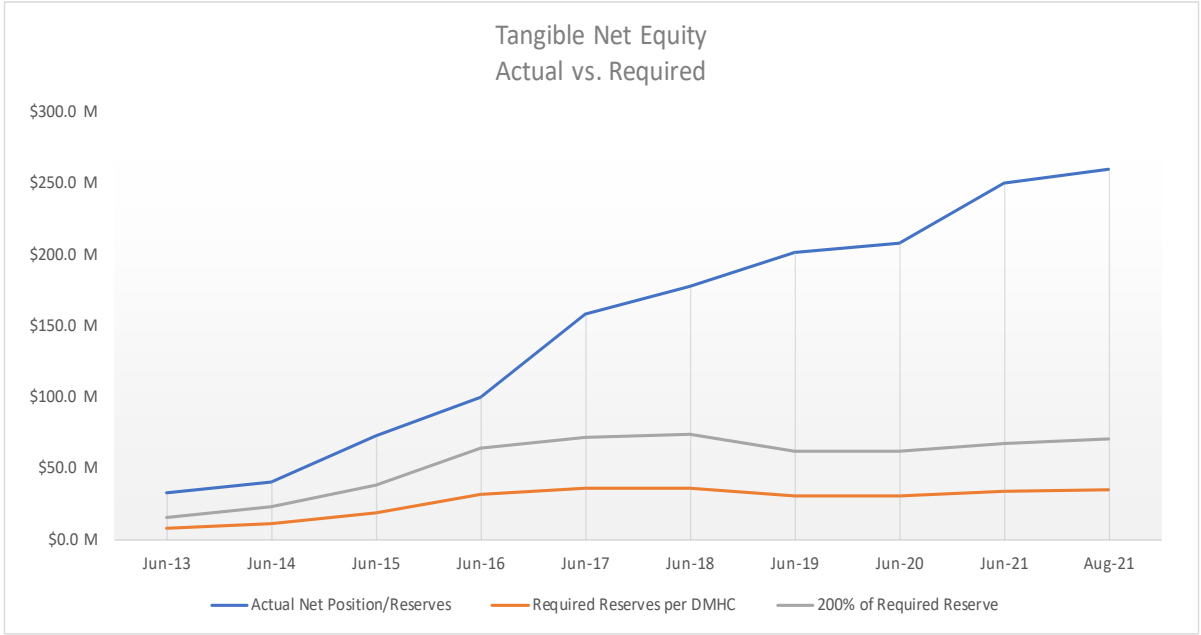
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- Overall cash and investment yield is lower than budget (0.38% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $260.5M - representing approximately two months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of August 31, 2021

	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	Aug-21
Actual Net Position/Reserves	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$260.5 M
Required Reserves per DMHC	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$35.5 M
200% of Required Reserve	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$70.9 M
Actual as % Required	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	734.3%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS AUGUST 2021

Financial Reserve Target #1: Tangible Net Equity

	Board Funds Committed	Approved Projects	Funds Expended	Balance	
Unrestricted Net Assets				**$216,279,816**	*
Board Designated Funds (Note 1):					
Special Project Funding for CBOs	$4,000,000	$961,743	$662,727	$3,337,274	
Innovation & COVID-19 Fund	$16,000,000	$4,880,000	$2,317,996	$13,682,004	
Subtotal	$20,000,000	$5,841,743	$2,980,723	$17,019,277	
Net Book Value of Fixed Assets				$26,857,935	
Restricted Under Knox-Keene Agreement				$325,000	
Total Tangible Net Equity (TNE)				$260,482,028	
Current Required TNE				$35,471,901	
TNE %				734.3%	
SCFHP Target TNE Range:					
350% of Required TNE (Low)				$124,151,654	
500% of Required TNE (High)				$177,359,506	
Total TNE Above/(Below) SCFHP Low Target				**$136,330,374**	
Total TNE Above/(Below) High Target				**$83,122,523**	

Financial Reserve Target #2: Liquidity

Cash & Investments	$410,684,675
Less Pass-Through Liabilities:	
Hospital Directed Payments	(23,619,810)
MCO Tax Payable to State of CA	(24,885,874)
Whole Person Care / Prop 56	(50,100,271)
Other Pass-Through Liabilities (Note 2)	(61,524,107)
Total Pass-Through Liabilities	**(160,130,062)**
Net Cash Available to SCFHP	250,554,613
SCFHP Target Liquidity (Note 3)	
45 Days of Total Operating Expense	(166,856,088)
60 Days of Total Operating Expense	(222,474,784)
Liquidity Above/(Below) SCFHP Low Target	**83,698,525**
Liquidity Above/(Below) High Target	**$28,079,829**

- **Unrestricted Net Assets represents less than two months of total expenses.**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund for Special Projects of $2.2M. In December 2019, the Governing Board also approved additional $1.8M for Special Project fund ($4M total) and $16M for Innovation & COVID-19 Fund.

Note 2: Other Pass-Through Liabilities include HQAF, Rate Range IGT, and DHCS overpayments.

Note 3: SCFHP Target Liquidity is based on total monthly budgeted expenses.

Capital Expenditures

- YTD Capital investments of $493K, largely due to software acquisition, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$5,922	$55,800
Hardware	$27,058	$1,060,000
Software	$418,035	$1,896,874
Building Improvements	$41,931	$62,000
Furniture & Equipment	$0	$179,101
TOTAL	**$492,946**	**$3,253,775**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Two Months Ending August 31, 2021

	Aug-2021 Actuals	% of Rev	Aug-2021 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Aug-2021 Actuals	% of Rev	YTD Aug-2021 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 95,610,089	83.9%	$ 93,888,422	83.6%	$ 1,721,667	1.8%	$ 189,732,470	83.9%	$ 187,181,204	83.7%	$ 2,551,266	1.4%
CMC MEDI-CAL	4,126,674	3.6%	3,719,223	3.3%	407,451	11.0%	7,917,367	3.5%	7,402,219	3.3%	515,148	7.0%
CMC MEDICARE	14,259,861	12.5%	14,643,931	13.0%	(384,070)	-2.6%	28,480,017	12.6%	29,144,785	13.0%	(664,768)	-2.3%
TOTAL CMC	18,386,535	16.1%	18,363,154	16.4%	23,382	0.1%	36,397,384	16.1%	36,547,004	16.3%	(149,620)	-0.4%
TOTAL REVENUE	**$ 113,996,624**	**100.0%**	**$ 112,251,576**	**100.0%**	**$ 1,745,048**	**1.6%**	**$ 226,129,854**	**100.0%**	**$ 223,728,208**	**100.0%**	**$ 2,401,646**	**1.1%**
MEDICAL EXPENSES												
MEDI-CAL	$ 87,374,767	76.6%	$ 87,852,770	78.3%	$ 478,002	0.5%	$ 173,257,233	76.6%	$ 175,112,016	78.3%	$ 1,854,783	1.1%
CMC MEDI-CAL	3,193,823	2.8%	2,968,554	2.6%	(225,269)	-7.6%	6,166,839	2.7%	5,905,223	2.6%	(261,616)	-4.4%
CMC MEDICARE	13,356,309	11.7%	13,958,003	12.4%	601,694	4.3%	25,639,492	11.3%	27,767,644	12.4%	2,128,152	7.7%
TOTAL CMC	16,550,132	14.5%	16,926,557	15.1%	376,425	2.2%	31,806,331	14.1%	33,672,867	15.1%	1,866,536	5.5%
TOTAL MEDICAL EXPENSES	**$ 103,924,900**	**91.2%**	**$ 104,779,327**	**93.3%**	**$ 854,427**	**0.8%**	**$ 205,063,564**	**90.7%**	**$ 208,784,883**	**93.3%**	**$ 3,721,319**	**1.8%**
MEDICAL OPERATING MARGIN	**$ 10,071,725**	**8.8%**	**$ 7,472,249**	**6.7%**	**$ 2,599,476**	**34.8%**	**$ 21,066,290**	**9.3%**	**$ 14,943,326**	**6.7%**	**$ 6,122,964**	**41.0%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 3,807,617	3.3%	$ 4,145,977	3.7%	$ 338,360	8.2%	$ 7,672,987	3.4%	$ 8,260,914	3.7%	$ 587,926	7.1%
RENTS AND UTILITIES	37,536	0.0%	42,067	0.0%	4,531	10.8%	74,120	0.0%	84,133	0.0%	10,013	11.9%
PRINTING AND ADVERTISING	8,388	0.0%	109,542	0.1%	101,154	92.3%	63,271	0.0%	217,083	0.1%	153,813	70.9%
INFORMATION SYSTEMS	293,417	0.3%	376,194	0.3%	82,777	22.0%	578,128	0.3%	752,388	0.3%	174,261	23.2%
PROF FEES/CONSULTING/TEMP STAFFING	805,896	0.7%	1,082,542	1.0%	276,647	25.6%	1,451,455	0.6%	2,196,820	1.0%	745,365	33.9%
DEPRECIATION/INSURANCE/EQUIPMENT	408,372	0.4%	407,277	0.4%	(1,095)	-0.3%	825,744	0.4%	841,320	0.4%	15,576	1.9%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	38,411	0.0%	62,242	0.1%	23,831	38.3%	81,214	0.0%	124,484	0.1%	43,270	34.8%
MEETINGS/TRAVEL/DUES	118,276	0.1%	132,918	0.1%	14,642	11.0%	197,920	0.1%	267,630	0.1%	69,710	26.0%
OTHER	99,074	0.1%	99,307	0.1%	232	0.2%	184,833	0.1%	198,613	0.1%	13,780	6.9%
TOTAL ADMINISTRATIVE EXPENSES	**$ 5,616,987**	**4.9%**	**$ 6,458,065**	**5.8%**	**$ 841,078**	**13.0%**	**$ 11,129,673**	**4.9%**	**$ 12,943,387**	**5.8%**	**$ 1,813,714**	**14.0%**
OPERATING SURPLUS (LOSS)	**$ 4,454,738**	**3.9%**	**$ 1,014,184**	**0.9%**	**$ 3,440,554**	**339.2%**	**$ 9,936,618**	**4.4%**	**$ 1,999,939**	**0.9%**	**$ 7,936,679**	**396.8%**
INTEREST & INVESTMENT INCOME	$ 115,314	0.1%	$ 350,000	0.3%	$ (234,686)	-67.1%	$ 233,976	0.1%	$ 700,000	0.3%	$ (466,024)	-66.6%
OTHER INCOME	31,681	0.0%	35,986	0.0%	(4,305)	-12.0%	63,697	0.0%	71,972	0.0%	(8,275)	-11.5%
NON-OPERATING INCOME	**$ 146,995**	**0.1%**	**$ 385,986**	**0.3%**	**$ (238,991)**	**-61.9%**	**$ 297,673**	**0.1%**	**$ 771,972**	**0.3%**	**$ (474,298)**	**-61.4%**
NET NON-OPERATING ACTIVITIES	**$ 146,995**	**0.1%**	**$ 385,986**	**0.3%**	**$ (238,991)**	**-61.9%**	**$ 297,673**	**0.1%**	**$ 771,972**	**0.3%**	**$ (474,298)**	**-61.4%**
NET SURPLUS (LOSS)	**$ 4,601,733**	**4.0%**	**$ 1,400,170**	**1.2%**	**$ 3,201,563**	**228.7%**	**$ 10,234,291**	**4.5%**	**$ 2,771,911**	**1.2%**	**$ 7,462,380**	**269.2%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of August 31, 2021

	Aug-2021	Jul-2021	Jun-2021	Aug-2020
Assets				
Current Assets				
Cash and Investments	410,684,675	398,162,794	408,072,066	316,296,570
Receivables	545,328,817	517,305,841	512,740,456	822,345,634
Prepaid Expenses and Other Current Assets	9,745,923	9,153,230	8,562,115	10,324,440
Total Current Assets	**965,759,416**	**924,621,866**	**929,374,636**	**1,148,966,644**
Long Term Assets				
Property and Equipment	52,015,817	51,843,223	51,522,871	49,078,265
Accumulated Depreciation	(25,157,882)	(24,811,725)	(24,466,207)	(21,274,764)
Total Long Term Assets	26,857,935	27,031,498	27,056,664	27,803,501
Total Assets	**992,617,351**	**951,653,364**	**956,431,300**	**1,176,770,145**
Deferred Outflow of Resources	**8,402,260**	**8,402,260**	**8,402,260**	**8,402,260**
Total Assets & Deferred Outflows	**1,001,019,611**	**960,055,624**	**964,833,560**	**1,185,172,405**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	5,606,815	5,700,450	8,471,129	7,871,178
Deferred Rent	47,735	48,033	48,331	47,822
Employee Benefits	3,210,465	3,212,807	3,127,996	2,324,666
Retirement Obligation per GASB 75	3,082,363	3,002,113	2,921,863	2,282,031
Deferred Revenue - Medicare	0	13,017,533	0	0
Whole Person Care / Prop 56	50,100,271	47,032,789	44,001,737	37,973,007
Payable to Hospitals	103,357	103,819	103,819	529,171
Payable to Hospitals	23,516,453	472,944	472,944	274,742,278
Pass-Throughs Payable	182	181	181	26,877
Due to Santa Clara County Valley Health Plan and Kaiser	19,402,761	21,173,902	22,785,679	10,742,452
MCO Tax Payable - State Board of Equalization	24,885,874	14,757,661	31,975,622	66,846,203
Due to DHCS	61,523,925	60,544,069	59,840,355	49,216,269
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,268,582
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	117,831,473	103,996,870	109,599,924	90,876,542
Total Current Liabilities	**737,596,633**	**701,348,130**	**711,634,538**	**971,041,103**
Non-Current Liabilities				
Net Pension Liability GASB 68	1,279,123	1,165,372.68	1,289,458	487,472
Total Non-Current Liabilities	**1,279,123**	**1,165,372.68**	**1,289,458**	**487,472**
Total Liabilities	**738,875,756**	**702,513,502**	**712,923,996**	**971,528,575**
Deferred Inflow of Resources	**1,661,827**	**1,661,827**	**1,661,827**	**1,661,827**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	3,337,274	3,337,274	3,337,274	3,459,274
Board Designated Fund: Innovation & COVID-19 Fund	13,682,004	13,730,001	13,730,001	13,880,001
Invested in Capital Assets (NBV)	26,857,935	27,031,498	27,056,664	27,803,501
Restricted under Knox-Keene agreement	325,000	325,000	325,000	305,350
Unrestricted Net Equity	206,045,525	205,823,965	164,191,849	163,192,661
Current YTD Income (Loss)	10,234,291	5,632,558	41,606,950	3,341,216
Total Net Assets / Reserves	**260,482,028**	**255,880,295**	**250,247,737**	**211,982,003**
Total Liabilities, Deferred Inflows and Net Assets	**1,001,019,611**	**960,055,624**	**964,833,560**	**1,185,172,405**

Cash Flow Statement

Santa Clara Family Health Plan

	Aug-2021
Cash Flows from Operating Activities	
Premiums Received	97,081,719
Medical Expenses Paid	(91,861,438)
Adminstrative Expenses Paid	7,327,200
Net Cash from Operating Activities	**12,547,480**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(172,594)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	146,995
Net Increase/(Decrease) in Cash & Cash Equivalents	**12,521,881**
Cash & Investments (Beginning)	398,162,794
Cash & Investments (Ending)	**410,684,675**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	4,454,738
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	346,157
Changes in Operating Assets/Liabilities	
Premiums Receivable	(28,022,975)
Prepaids & Other Assets	(592,693)
Accounts Payable & Accrued Liabilities	13,076,972
State Payable	11,108,070
IGT, HQAF & Other Provider Payables	(1,771,141)
Net Pension Liability	113,750
Medical Cost Reserves & PDR	13,834,603
IHSS Payable	0
Total Adjustments	**8,092,742**
Net Cash from Operating Activities	**12,547,480**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Two Months Ending August 31, 2021

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$189,732,470	$7,917,367	$28,480,017	$36,397,384	**$226,129,854**
MEDICAL EXPENSE	$173,257,233	$6,166,839	$25,639,492	$31,806,331	**$205,063,564**
(MLR)	91.3%	77.9%	90.0%	87.4%	90.7%
GROSS MARGIN	$16,475,237	$1,750,528	$2,840,525	$4,591,053	**$21,066,290**
ADMINISTRATIVE EXPENSE	$9,338,264	$389,677	$1,401,731	$1,791,409	**$11,129,673**
(% of Revenue Allocation)					
OPERATING INCOME/(LOSS)	$7,136,973	$1,360,850	$1,438,794	$2,799,644	**$9,936,618**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$249,760	$10,422	$37,491	$47,913	**$297,673**
(% of Revenue Allocation)					
NET INCOME/(LOSS)	$7,386,734	$1,371,273	$1,476,284	$2,847,557	**$10,234,291**
PMPM (ALLOCATED BASIS)					
REVENUE	$345.43	$388.24	$1,396.56	$1,784.80	**$396.96**
MEDICAL EXPENSES	$315.44	$302.40	$1,257.27	$1,559.67	**$359.98**
GROSS MARGIN	$30.00	$85.84	$139.29	$225.13	**$36.98**
ADMINISTRATIVE EXPENSES	$17.00	$19.11	$68.74	$87.84	**$19.54**
OPERATING INCOME/(LOSS)	$12.99	$66.73	$70.55	$137.28	**$17.44**
OTHER INCOME/(EXPENSE)	$0.45	$0.51	$1.84	$2.35	**$0.52**
NET INCOME/(LOSS)	$13.45	$67.24	$72.39	$139.63	**$17.97**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	549,257	20,393	20,393	20,393	569,650
REVENUE BY LOB	83.9%	3.5%	12.6%	16.1%	100.0%

Santa Clara Family Health Plan™

Appendix

Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD SEPTEMBER-2021

		2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	FYTD var	%
NON DUAL	Adult (over 19)	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	33,546	549	1.7%
	Child (under 19)	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	101,093	616	0.6%
	SPD	22,079	22,149	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	22,331	30	0.1%
	Adult Expansion	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	91,960	2,003	2.2%
	Long Term Care	407	409	389	393	388	380	373	375	367	365	414	408	401	36	9.9%
	Total Non-Duals	**227,647**	**230,802**	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**3,234**	**1.3%**
DUAL	Adult (over 21)	337	354	353	353	352	355	361	357	365	366	367	376	375	9	2.5%
	SPD	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	24,206	91	0.4%
	Long Term Care	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	1,092	32	3.0%
	SPD OE	358	410	498	537	590	662	742	802	863	952	1,063	1,135	1,223	271	28.5%
	Total Duals	**25,605**	**25,688**	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**403**	**1.5%**
	Total Medi-Cal	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**3,637**	**1.3%**
CMC	CMC Non-Long Term Care	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	10,122	227	2.3%
	CMC - Long Term Care	216	210	209	207	193	187	184	179	180	185	209	208	203	18	9.7%
	Total CMC	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**245**	**2.4%**
	Total Enrollment	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**3,882**	**1.4%**

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, November 18, 2021, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan - Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Sue Murphy, Chair
Bob Brownstein
Alma Burrell
Michele Lew

Members Absent
Dave Cameron

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Teresa Chapman, VP, Human Resources
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri. Controller
Chelsea Byom, Director, Marketing, Communications & Outreach
Tyler Haskell, Director, Government Relations
Johanna Liu, Director, Quality & Process Improvement
Khanh Pham, Director, Financial Reporting & Budgeting
Robyn Esparza, Administrative Assistant
Rita Zambrano, Executive Assistant

1. Roll Call

Sue Murphy, Chair, called the meeting to order at 10:30 am. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

Ms. Murphy presented the Consent Calendar and indicated all items would be approved in one motion.

a. Approve October 28, 2021 **Executive/Finance Committee** minutes
b. Accept **Network Detection and Prevention Update**
c. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953

It was moved, seconded, and the Consent Calendar was **unanimously approved.**

Motion: Ms. Lew
Second: Ms. Burrell
Ayes: Ms. Burrell, Michele Lew, Ms. Murphy
Absent: Mr. Brownstein, Mr. Cameron

4. September 2021 Financial Statements

Mr. Jarecki presented the September 2021 unaudited financial statements, which reflected a current month net surplus of $9.1 million ($7.8 million favorable to budget). **Enrollment** increased by 1,080 members from the prior month to 286,552 members (2,411 members or 0.85% lower than monthly budget). Membership growth continues due to the extended duration of the COVID pandemic during which member disenrollments have been suspended. YTD member months trailed budget by 4,629 member months or 0.5%). **Revenue** reflected a favorable current month variance of $605 thousand (0.5%) largely due to higher CY21 rates versus budget and mix of rates coupled with higher supplemental kick revenue due to higher utilization, partially offset by lower enrollment than budgeted. Due to delayed receipt of the DHCS revenue file, September revenue was estimated and is subject to change. YTD Revenue was $3.0 million (0.9%) favorable to budget due to the same factors. **Medical Expense** reflected a favorable current month variance of $7.5 million (7.1%) largely due to (1) reduced IBNP estimates for FY21 & FY22 of $3.8 million, (2) pharmacy expense favorable to budget by $2.7 million due to lower cost trends, (3) lower capitated enrollment of $678 thousand and (4) timing of certain other expenses, partially offset by (5) higher fee-for-service costs in certain categories and (6) higher supplemental kick utilization and expense. YTD Medical Expense was $11.2 million (3.6%) favorable to budget due to the same factors. **Administrative Expense** reflected an unfavorable current month variance of $132 thousand (2.0%) due to (1) pension and retiree medical estimate true-ups, (2) increased retroactive YTD team incentive partly offset by (3) lower headcount than budgeted and the (4) deferred timing of certain non-personnel expenses. YTD Administrative Expense was $1.7 million (8.6%) favorable to budget largely due to lower headcount than budgeted and deferred timing of certain non-personnel expenses. The **Balance Sheet** reflected a Current Ratio, a key measure of liquidity, of 1.32:1 versus the DMHC minimum current ratio requirement of 1.00:1. **Tangible Net Equity** of $274.25 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $230 million. Year-to-date **Capital Investments** of $674 thousand were made, predominately computer software licenses.

It was moved, seconded, and the September 2021 unaudited Financial Statements were **unanimously approved.**

Motion:	Ms. Lew
Second:	Ms. Burrell
Ayes:	Ms. Burrell, Ms. Lew, Ms. Murphy
Absent:	Mr. Brownstein, Mr. Cameron

5. D-SNP Enrollment, Marketing/Sales & Broker Systems Selection

Laura Watkins, VP, Marketing & Enrollment, reviewed the selection process for D-SNP enrollment, sales and broker systems vendors. She noted the RFP was distributed via email and nine vendors responded, with no single vendor able to provide all required functionality. Detailed evaluation criteria were established, including key functionality, ease of use, implementation, support, references, and value. Ms. Watkins recommended three-year contracts with Dynamic Healthcare Systems for Enrollment, and Engagent Health for Marketing/Sales & Broker Management.

It was moved, seconded, and unanimously approved to authorize the Chief Executive Officer to negotiate execute, and amend three-year contracts with Dynamic Healthcare Systems and Engagent Health not to exceed $800,000 for the Enrollment system and $1,150,000 for the Marketing/Broker Management system.

Motion:	Ms. Lew
Second:	Ms. Burrell
Ayes:	Ms. Burrell, Ms. Lew, Ms. Murphy
Absent:	Mr. Brownstein, Mr. Cameron

6. Pharmacy Benefits Manager (PBM) Request for Proposal (RFP)

Ngoc Bui-Tong, VP, Strategies and Analytics, reviewed the RFP process and recommendation for the Pharmacy Benefits Manager (PBM) vendor, noting that MedImpact was the leading bidder. MedImpact also offered 2023 Part D rates effective July 1, 2022, which will yield an additional $500k savings to the existing contract.

7. Innovation Fund COVID-19 Expenditure Request

Chelsea Byom, Director, Marketing, Communications & Outreach, presented a funding request for $30,000 for Children's Discovery Museum (CDM) COVID-19 Vaccination Clinics for Children, noting that the funding would enable CDM to host two COVID vaccination pop-up clinic days and provide CDM admission incentives to families whose children receive vaccinations. The Santa Clara County Public Health Department (PHD) estimates vaccinating a total of 500+ children plus other family members in need of their first, second, or booster vaccinations.

Bob Brownstein joined the meeting at 11:19 am.

It was moved, seconded, and the Children's Discovery Museum's COVID-19 Vaccination Clinics for Children funding request for $30,000 was **unanimously approved.**

Motion:	Ms. Burrell
Second:	Ms. Lew
Ayes:	Ms. Burrell, Ms. Lew, Ms. Murphy
Abstained:	Mr. Brownstein
Absent:	Mr. Cameron

8. Innovation Fund Expenditure Request

Ms. Bui-Tong presented an Innovation Fund request from the Behavioral Health Contractors Association of Santa Clara County (BHCA) for $160,160 ($80,080 per year for two years). Due to profound changes in the delivery of behavioral health in California, non-profit community-based providers that form the behavioral health services delivery system for Santa Clara County must learn how to adapt to these changes. The requested funding will allow BHCA to hire a temporary Policy Associate and purchase consulting services to assist the organizations to better prepare for the new landscape. BHCA members will use the information and tools to maximize new funding, ensure they meet new requirements, and remain viable safety-net providers for the community.

It was moved, seconded, and the Behavioral Health Contractors Association request for $160,160 ($80,080 per year for two years) to fund Readiness Support for Delivery System Changes was **unanimously approved.**

Motion:	Mr. Brownstein
Second:	Ms. Burrell
Ayes:	Mr. Brownstein, Ms. Burrell, Ms. Murphy
Abstained:	Ms. Lew
Absent:	Mr. Cameron

9. Quality Update

a. Laurie Nakahira, D.O., Chief Medical Officer, discussed the Medi-Cal Plan Quality Performance Review for CY 2020, noting the Medi-Cal Aggregated Quality Factor Score (AQFS) by Health Plan. She stated that the Plan ranked 10th out of 56 MCPs, and Anthem ranked 43rd.

Dr. Nakahira also presented the Medi-Cal Measure Rankings, noting SCFHP generally performed in the top 50% of managed care plans. Dr. Nakahira also presented a review of default assignment for Medi-Cal beneficiaries who do not select a managed care plan, stating that based on estimates, SCFHP's default assignment percentage would have increased had it not been frozen due to COVID.

b. Johanna Liu, PharmD, Director, Quality & Process Improvement, presented the 2021 Cal MediConnect CAHPS Survey results. CAHPS is a consumer satisfaction survey the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS). Results impact NCQA accreditation and health plan star ratings. COVID-19 has significantly impacted the CAHPS survey methodology and reporting for 2021.

Dr. Liu reviewed survey findings in detail and discussed findings by demographic, plus CAHPS improvement projects and opportunities for improvement. There was discussion of the findings by race, and Alma Burrell requested that the racial issues identified be discussed further as an action item on the agenda for the next meeting.

10. CEO Update

Christine Tomcala, Chief Executive Officer, shared the updated SCFHP COVID-19 summary by age category. Ms. Tomcala noted that although the percentage of vaccinated members is rising, closing the gap continues to be a challenge. There are several ongoing initiatives, and the State will be providing some funding for vaccine incentives.

11. Government Relations Update

Tyler Haskell, Director of Government Relations, provided an update on the infrastructure reconciliation bill working its way through Congress. The current draft contains 12 months continuous Medicaid eligibility for kids and postpartum women, a state plan option for maternal health homes, investments in black maternal health care, Medicaid coverage for inmates 30 days pre-release, and extra Medicaid funding for home and community-based services. Mr. Haskell also discussed a new federal COVID vaccination mandate for employees that is being challenged in several lawsuits. He provided a list of significant Medi-Cal initiatives being implemented and developed in 2022, including CalAIM, Medi-Cal Rx, and various new benefits and services.

12. Adjourn to Closed Session

a. Contract Rates
The Executive/Finance Committee met in Closed Session to discuss Plan partner rates.

13. Report from Closed Session

Ms. Murphy reported that the Executive/Finance committee met in Closed Session to discuss Plan partner rates.

14. Adjournment

The meeting was adjourned at 12:30 pm.

_____

Michele Lew, Secretary

Santa Clara Family Health Plan™

Network Detection and Prevention Report

November 2021

Executive/Finance Committee Meeting

Firewall Background

The following network intrusion reports show the malicious activities that were prevented from accessing SCFHP's network. It is important to note that these attempts are not specifically targeted at SCFHP, but rather are common attempts against entire areas of the Internet. The results are typical of many organizations.

None of the intrusion attempts on the SCFHP network were successful.

The attempts have been categorized in three severity levels:

Critical/High

These attacks are the most dangerous. They can take down our entire network or disable servers. Can take the form of various Backdoor, DDoS (Distributed Denial of Service), and DOS (Denial of Service) attacks.

Medium

These attacks can cause disruption to the network, such as increased network traffic that slows performance. For example, various DNS (Domain Naming Service), FTP (File Transfer Protocol), and Telnet attacks.

Low/Informational

These attacks are characterized more as informational events, such as various scans (port and IP internet protocol address), RPC (Remote Procedure Call), and SMTP (Simple Mail Transfer Protocol) attacks. The new informational category is from the recently implemented Palo Alto Firewall. These events are of low to no threats and are more of an FYI for reporting.

Attack Statistics Combined

Jul/Aug/Sep/Oct

	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
Severity Level	Jul	Aug	Sep	Oct	Jul	Aug	Sep	Oct	Jul	Aug	Sep	Oct
Critical	21	19	23	28	276	1009	486	3779	0.01	0.02	0.01	0.11
High	13	12	15	22	31,881	18,652	1,311,389	14,213	0.68	0.45	26.31	0.43
Medium	17	16	29	37	703,784	788,798	647,070	805,377	15.06	19.08	12.98	24.26
Low	11	10	11	15	182,668	133,700	160,527	80,248	3.90	3.23	3.22	2.42
Informational	35	36	37	40	3,755,839	3,192,440	2,864,729	2,415,961	80.35	77.22	57.48	72.78

Summary – Compare Oct 2021 to previous month of Sep 2021

- Critical Severity Level – number of threat attempts is **677.57%** higher
- High Severity Level - number of threat attempts is **98.92**% lower
- Medium Severity Level - number of threat attempts **24.47%** higher
- Low Severity Level - number of threat attempts is **15.67%** lower

11/12/2021

Top 5 Events for Aug - Oct

Critical Events – total 5274 events

Top 5 Critical vulnerability events
- 2775 events for “TCP Flood” **(Code-Execution)**
- 617 events for “Cisco IOS and IOS XE Software Cluster Management Protocol Remote Code Execution Vulnerability” (**Code-Execution**)
- 430 events for “Bash Remote Code Execution Vulnerability” (**Code-Execution**)
- 388 events for “ZeroAccess.Gen Command and Control Traffic” (**Code-Execution**)
- 316 events for “Realtek Jungle SDK Remote Code Execution Vulnerability” (**Code-Execution**)

High Events – total 1,344,254 events

Top 5 High vulnerability events
- 1,321,794 events for “HTTP Unauthorized Brute Force Attack” (**Brute Force**)
- 7458 events for “HTTP: User Authentication Brute Force Attempt” (**Brute Force**)
- 2862 events for “SIP INVITE Method Request Flood Attempt” (**Brute Force**)
- 1358 events for “DCS-2530L Unauthenticated Information Disclosure Vulnerability” (**Brute Force**)
- 241 events for “Microsoft Windows win.ini Access Attempt Detected” (**Brute Force**)

Medium Events – total 2,241,245 events

Top 5 Medium vulnerability events
- 2,052,749 events for “SCAN: Host Sweep” (**Info-Leak**)
- 154,923 events for “SIPVicious Scanner Detection” (**Info-Leak**)
- 16,550 events for “SCAN: TCP Port Scan” (**Info-Leak**)
- 11,885 events for “RPC Portmapper DUMP Request Detected” (**Info-Leak**)
- 1752 events for “Metasploit VxWorks WDB Agent Scanner Detection” (**Info-Leak**)

Definitions:

Code-Execution – Attempt to install or run an application.
Brute Force – Vulnerability attempt to obtain user credentials.
Info-Leak – attempt to obtain user or sensitive information.
Botnet – used to perform distributed denial-of-service attack (DDoS attack), steal data and send spam.

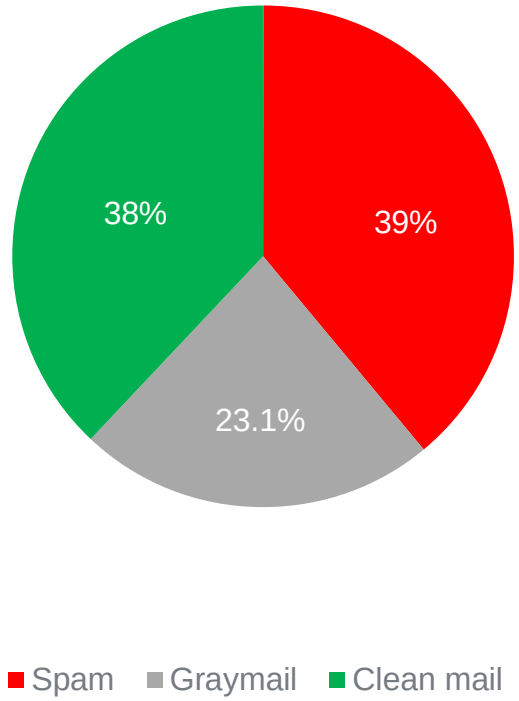
11/12/2021

Email Security – Monthly Statistics

Santa Clara Family Health Plan

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by Reputation Filtering	29.8%	59.3k
Stopped as Invalid Recipients	0.5%	920
Spam Detected	8.3%	16.4k
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	1
Messages with Malicious URLs	0.0%	1
Stopped by Content Filter	0.4%	832
Stopped by DMARC	3.9%	7,746
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**39.0%**	**77.5k**
Marketing Messages	13.0%	25.9k
Social Networking Messages	0.2%	484
Bulk Messages	9.8%	19.5k
Total Graymails:	**23.1%**	**45.9k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	38.0%	75.5k
Total Attempted Messages:		**198.9k**



October

During the month.

- 39.0% of threat messages had been blocked.
- 23.1% were Graymails *(Graymail is solicited bulk email messages that don't fit the definition of email spam).*
- 38.0% were clean messages that delivered.

11/12/2021

MEMORANDUM

Date: November 12, 2021

From: Tyler Haskell, Interim Compliance Officer

To: SCFHP Executive/Finance Committee

Re. AB 361 compliance

Background

Because the Governor's executive order suspending certain Brown Act requirements expired at the end of September, the Legislature passed AB 361, which was signed into law in September. AB 361 amends Government Code §54953 to permit teleconferencing by local agencies during a declared state of emergency without providing public access to each individual teleconference location. In order to do so, a local agency must, within 30 days of its first teleconference meeting following enactment of AB 361 and every 30 days thereafter, make the following findings by majority vote:

- The local agency has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

The Executive/Finance Committee met and made the above findings in October, and needs to do so again in order for the Governing Board and committees to continue meeting remotely during the ongoing state of emergency.

Recommended Action

Make the following findings and approve continued use of teleconferencing without providing public access to each teleconference location:

- Santa Clara Family Health Plan has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

Santa Clara Family Health Plan™

Unaudited Financial Statements

For Three Months Ended September 30, 2021

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$114 M		$340 M	
Medical Expense (MLR)	$98 M	86.2%	$303 M	89.2%
Administrative Expense (% Rev)	$6.7 M	5.9%	$17.8 M	5.2%
Other Income/(Expense)	$141K		$439K	
Net Surplus (Net Loss)	**$9.1 M**		**$19.3 M**	
Cash and Investments			$450 M	
Receivables			$523 M	
Total Current Assets			$985 M	
Current Liabilities			$743 M	
Current Ratio			1.32	
Tangible Net Equity			$274 M	
% of DMHC Requirement			**790.7%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $9.1M is $7.8M or 575.8% favorable to budget of $1.3M surplus. YTD: Surplus of $19.3M is $15.2M or 369.4% favorable to budget of $4.1M surplus.
Enrollment	Month: Membership was 286,552 (2,411 or 0.8% lower than budget of 288,963). YTD: Member Months YTD was 856,202 (4,629 or 0.5% lower than budget of 860,831).
Revenue	Month: $113.6M ($605K or 0.5% favorable to budget of $113.0M). YTD: $339.8M ($3.0M or 0.9% favorable to budget of $336.8M).
Medical Expenses	Month: $98.0M ($7.5M or 7.1% favorable to budget of $105.5M). YTD: $303.0M ($11.2M or 3.6% favorable to budget of $314.3M).
Administrative Expenses	Month: $6.7M ($132K or 2.0% unfavorable to budget of $6.6M). YTD: $17.8M ($1.7M or 8.6% favorable to budget of $19.5M).
Tangible Net Equity	TNE was $274.2M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $674K vs. $3.3M annual budget, primarily software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 286,552 members is 2,411 or 0.8% lower than budget. Since the beginning of the fiscal year, total enrollment has increased by 3,882 members or 1.4%.
- Medi-Cal enrollment has been increasing since January 2020, largely due to COVID (beginning in March 2020 annual eligibility redeterminations were suspended and enrollment continues to increase as a result).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 1.3%, Medi-Cal Dual enrollment has increased 1.5%, and CMC enrollment has grown 2.4%.

	For the Month September 2021				For Three Months Ending September 30, 2021					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY22 vs. FY21
Medi-Cal	276,227	278,628	(2,401)	(0.9%)	825,484	830,126	(4,642)	(0.6%)	752,263	9.7%
Cal Medi-Connect	10,325	10,335	(10)	(0.1%)	30,718	30,705	13	0.0%	27,723	10.8%
Total	**286,552**	**288,963**	**(2,411)**	**(0.8%)**	**856,202**	**860,831**	**(4,629)**	**(0.5%)**	**779,986**	**9.8%**

Santa Clara Family Health Plan Enrollment By Network
September 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	35,652	13%	10,325	100%	45,977	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	137,609	50%	-	0%	137,609	48%
Palo Alto Medical Foundation	7,343	3%	-	0%	7,343	3%
Physicians Medical Group	46,655	17%	-	0%	46,655	16%
Premier Care	15,805	6%	-	0%	15,805	6%
Kaiser	33,163	12%	-	0%	33,163	12%
Total	**276,227**	**100%**	**10,325**	**100%**	**286,552**	**100%**
Enrollment at June 30, 2021	272,590		10,080		282,670	
Net Δ from Beginning of FY22	1.3%		2.4%		1.4%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

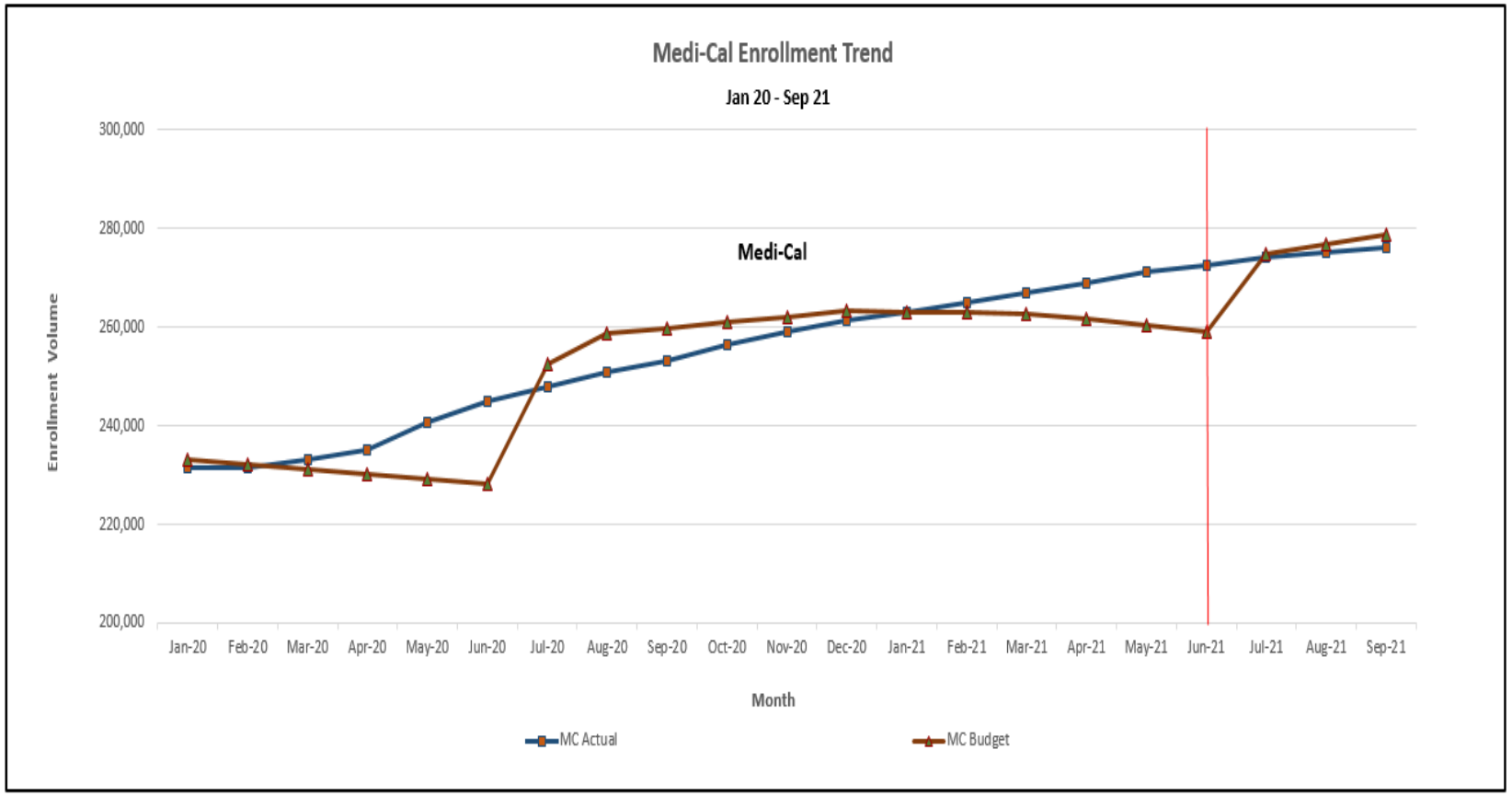
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD SEPTEMBER - 2021

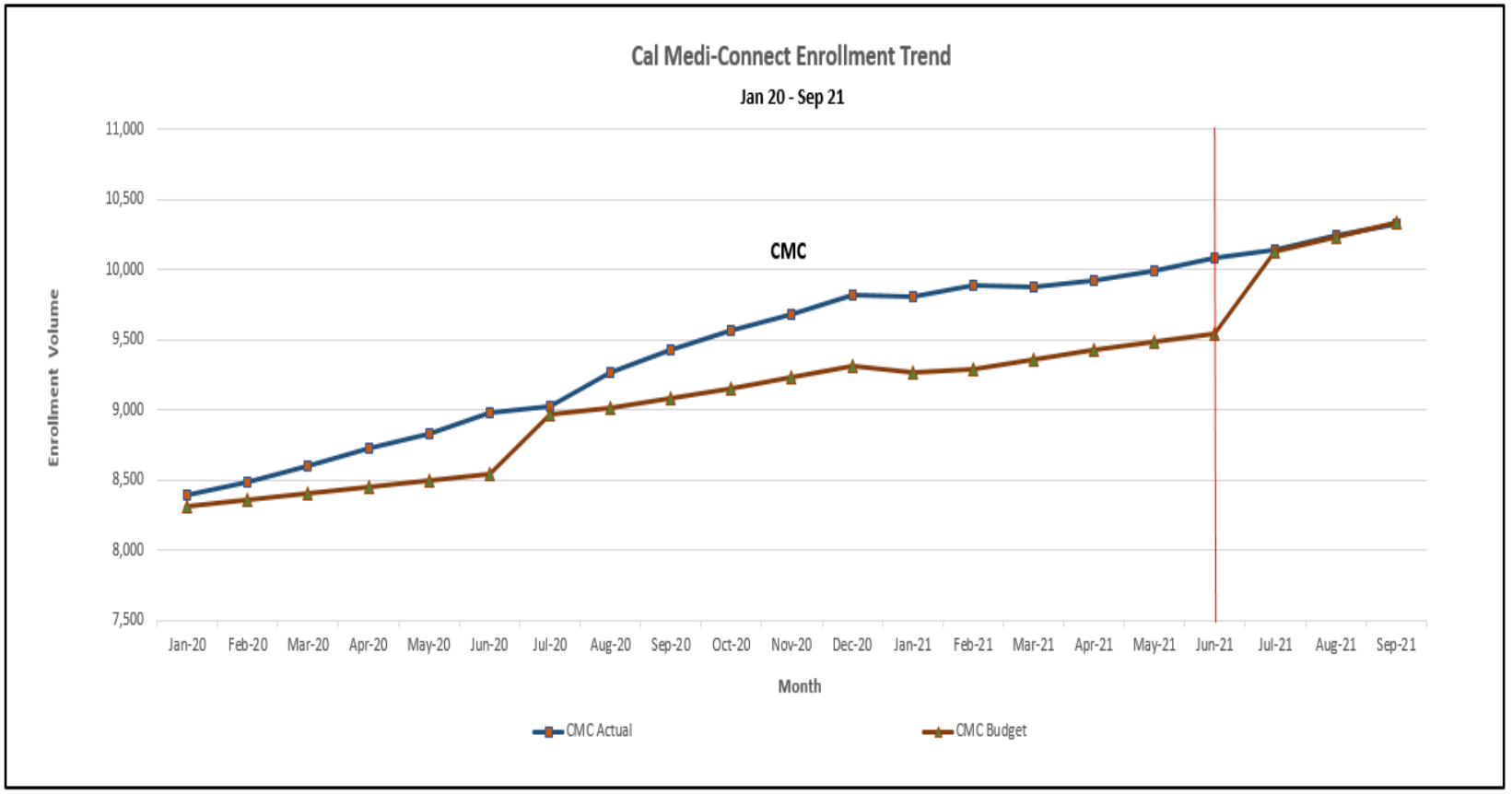
		2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	FYTD var	%
NON DUAL	Adult (over 19)	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	33,546	549	1.7%
	Child (under 19)	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	101,093	616	0.6%
	SPD	22,079	22,149	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	22,331	30	0.1%
	Adult Expansion	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	91,960	2,003	2.2%
	Long Term Care	407	409	389	393	388	380	373	375	367	365	414	408	401	36	9.9%
	Total Non-Duals	**227,647**	**230,802**	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**3,234**	**1.3%**
DUAL	Adult (over 21)	337	354	353	353	352	355	361	357	365	366	367	376	375	9	2.5%
	SPD	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	24,206	91	0.4%
	Long Term Care	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	1,092	32	3.0%
	SPD OE	358	410	498	537	590	662	742	802	863	952	1,063	1,135	1,223	271	28.5%
	Total Duals	**25,605**	**25,688**	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**403**	**1.5%**
	Total Medi-Cal	**253,252**	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**3,637**	**1.3%**
CMC	CMC Non-Long Term Care	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	10,122	227	2.3%
	CMC - Long Term Care	216	210	209	207	193	187	184	179	180	185	209	208	203	18	9.7%
	Total CMC	**9,428**	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**245**	**2.4%**
	Total Enrollment	**262,680**	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**3,882**	**1.4%**

Medi-Cal Enrollment Trend



- Budgeted enrollment, represented by the green line, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the gold line, has grown steadily.

Cal Medi-Connect Enrollment Trend

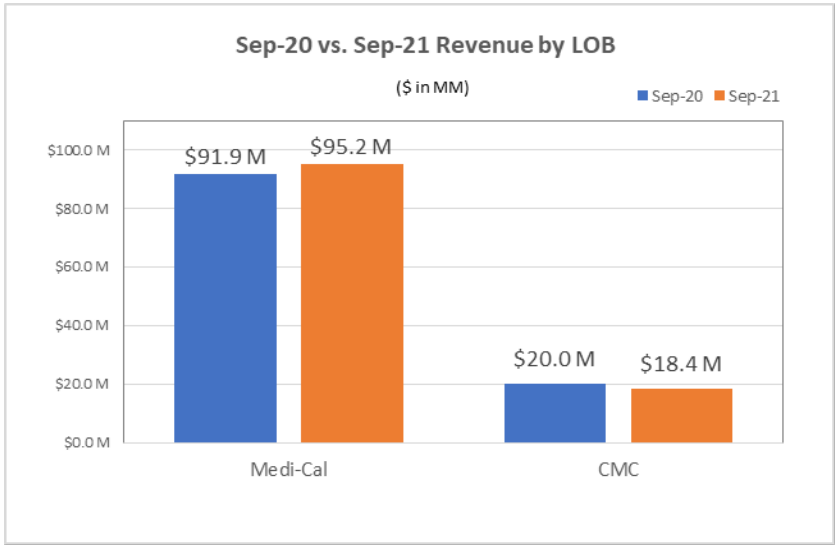


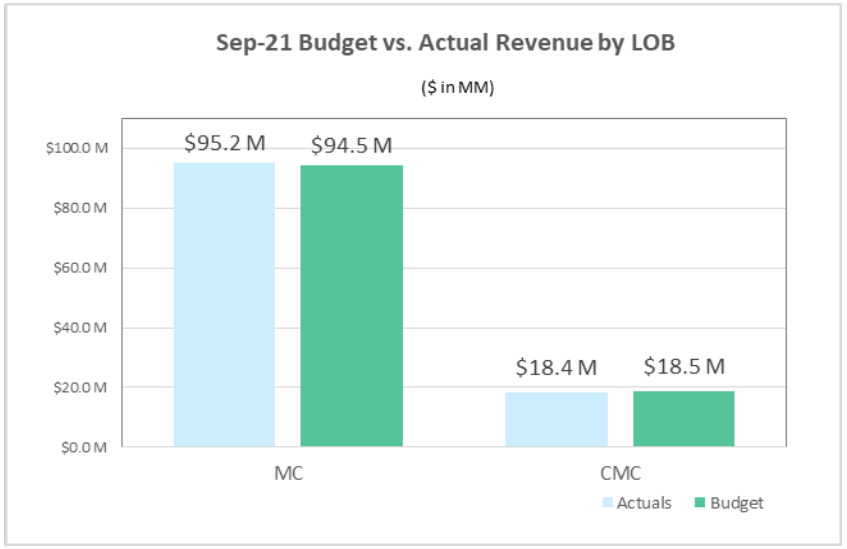
- Budgeted enrollment, represented by the brown line, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the blue line, has grown steadily.

Current Month Revenue

Due to delayed receipt of DHCS revenue file for September 2021, current month revenue is estimated at $113.6M, which was $605K or 0.5% favorable to budget of $113.0M. The current month variance was primarily due to the following:

- Supplemental kick revenue was $825K favorable to budget due to increased Behavioral Health Therapy and Health Home utilization.
- CMC revenue was $151K net unfavorable to budget due to lower Medicare Part C rate, offset with higher CY21 CCI rate.
- MCAL Prop-56 revenue was $198K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).
- Medi-Cal revenue was $129K favorable to budget due to higher CY21 MLTSS, LTC and SPD rates, offset by lower enrollment than budget.

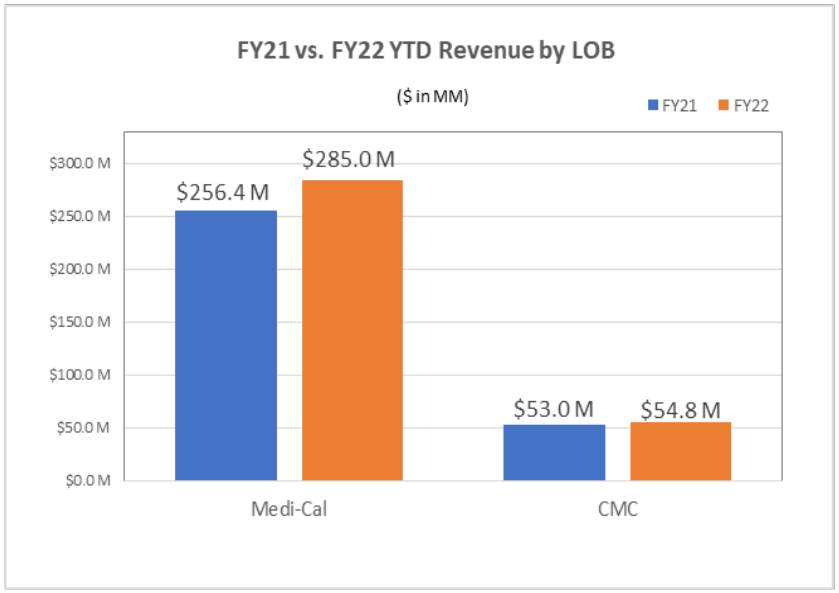


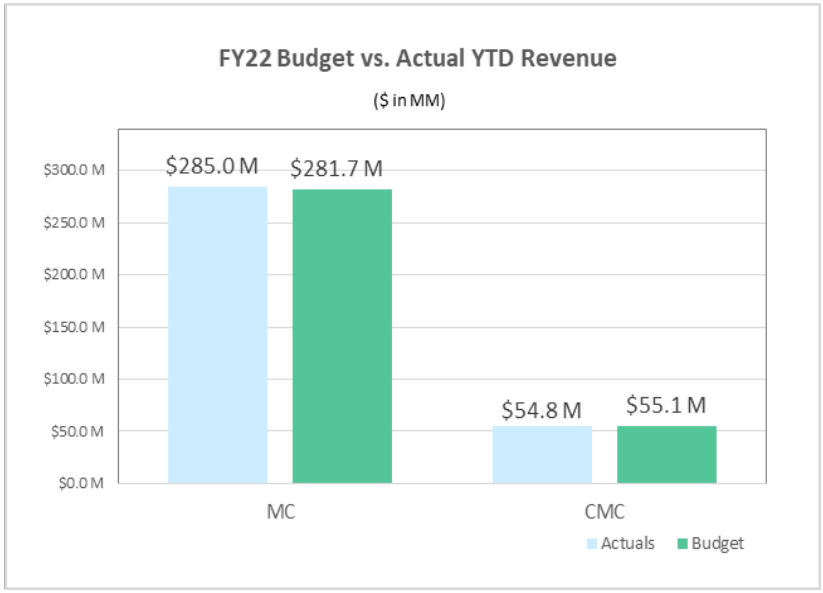


YTD Revenue

YTD revenue of $339.8M was $3.0M or 0.9% favorable to budget of $336.8M, inclusive of estimated September revenue. The variance was primarily due to the following:

- Supplemental kick revenue was $3.0M favorable to budget due to increased utilization in BHT, Health Homes, Hep-C and higher maternity deliveries.
- Medi-Cal revenue is $851K favorable to budget due to higher CY21 MLTSS, LTC and SPD rates, offset by lower enrollment than budget.
- MCAL Prop-56 revenue is $550K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).
- CMC revenue was $301K net unfavorable to budget due to lower than anticipated Medicare Part C rate, offset by higher CY21 CCI rate.

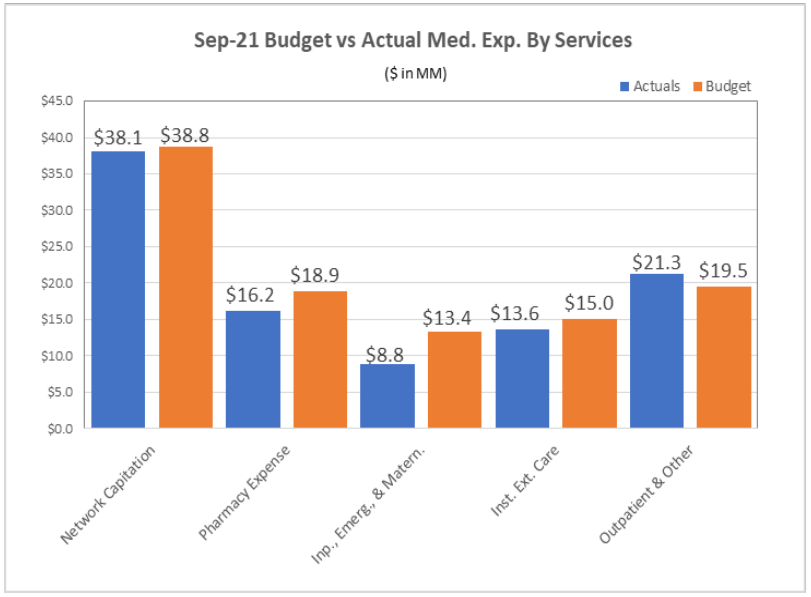


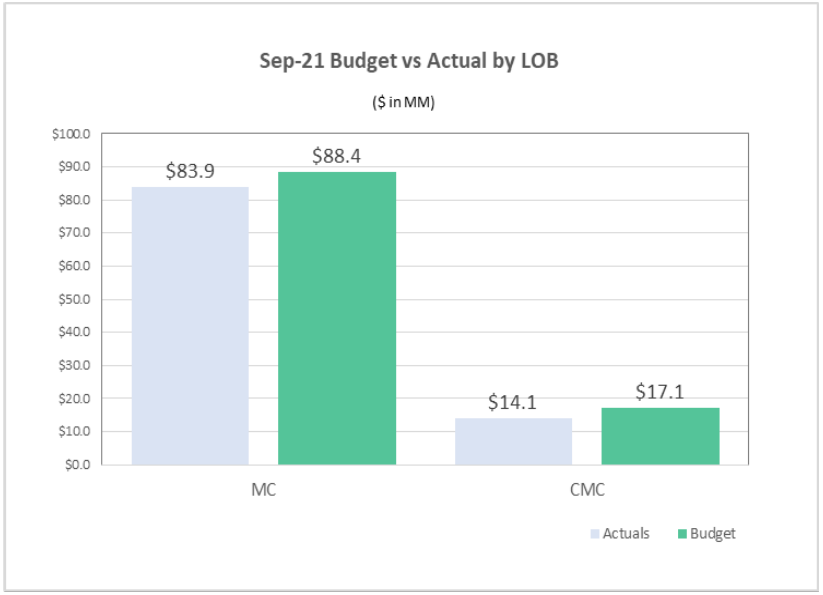


Current Month Medical Expense

Current month medical expense of $98.0M was $7.5M or 7.1% favorable to budget of $105.5M. The variance was due largely to:

- Fee-For-Service expenses reflected a $3.8M or 8.7% favorable variance largely due to reduced IBNP estimates for FY21 & FY22, partly offset by unfavorable variances in certain categories of service.
- Pharmacy expenses were $2.7M or 14.5% favorable to budget due to lower utilization and PMPM versus budget, especially in diabetic drugs, and higher CMC pharmacy rebate received.
- Capitation expense was $678K or 1.8% favorable to budget due to lower capitated enrollment.
- Vision, Reinsurance and Other expenses were $275K or 7.4% favorable to budget due to timing of spending on Board Designated expenses and lower Reinsurance Recovery.

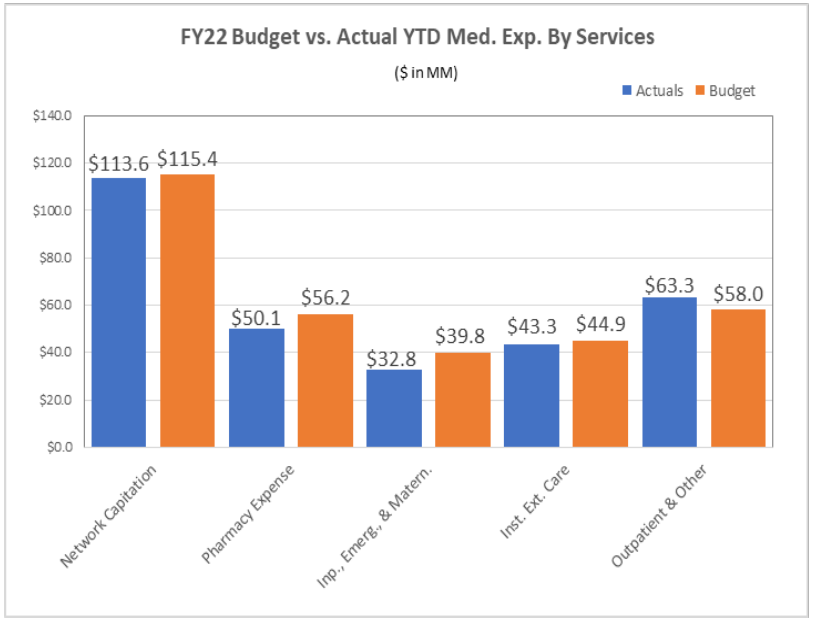


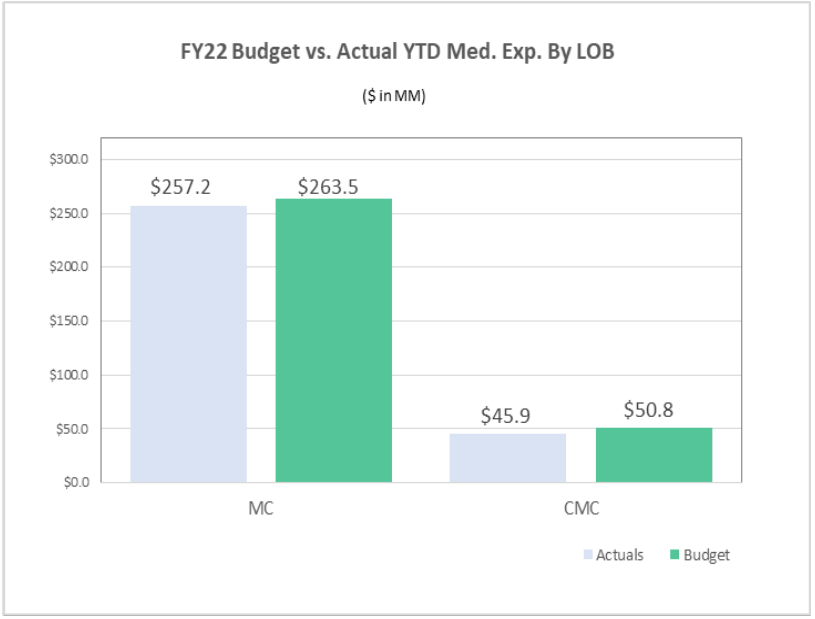


YTD Medical Expense

YTD medical expense of $303M was $11.2M or 3.6% favorable to budget of $314.3M. The variance was due largely to:

- Pharmacy expenses were $6.1M or 10.9% favorable to budget, due to lower cost increases versus budget especially in diabetic drugs, increased CMC rebate and lower utilization.
- Fee-For-Service expenses reflected a net $2.5M or 1.9% favorable variance due to lower enrollment and revised IBNP estimates, offset with increase supplemental services such as Behavioral Health Therapy, Health Home and high maternity deliveries (offset with favorable revenue variance).
- Capitation expense was $1.8M or 1.5% favorable to budget due to lower capitated enrollment.
- Vision, Reinsurance and Other expenses were $893K or 8.0% favorable to budget due to timing of spending on Board Designated expenses and higher claim recovery.

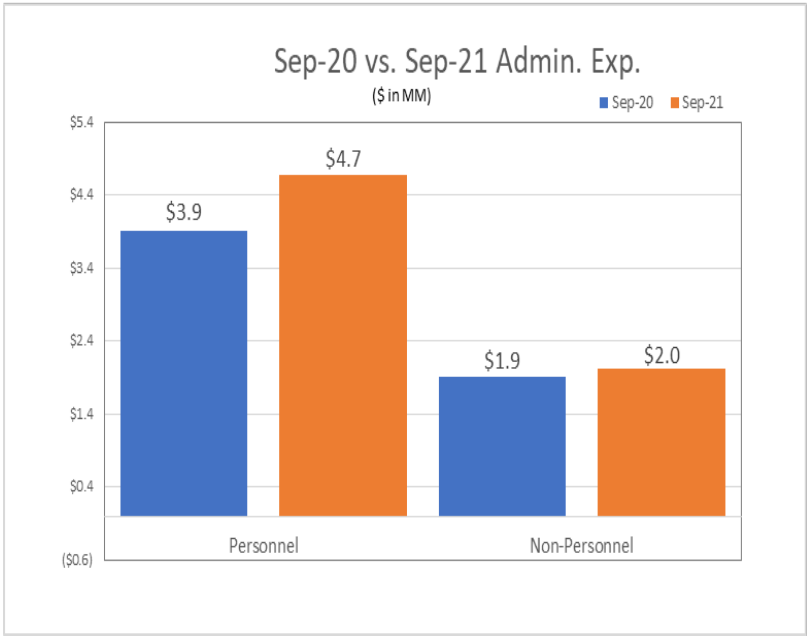


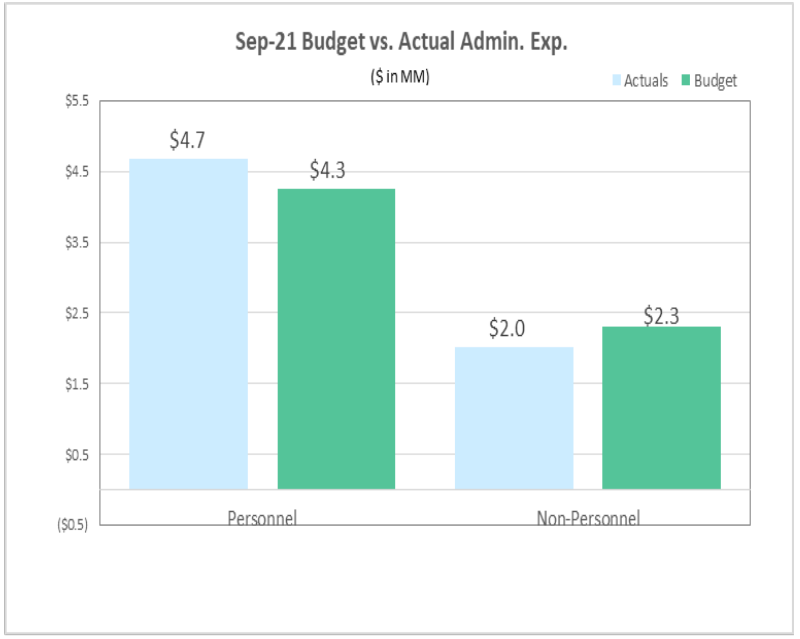


Current Month Administrative Expense

Current month expense of $6.7M was $132K or 2.0% unfavorable to budget of $6.6M. The current month variances were primarily due to the following:

- Personnel expenses were $420K or 9.8% unfavorable to budget due to pension & retiree medical true-ups, increased team incentive reserve on a YTD basis, partly offset by lower headcount than budget including lower payroll tax and benefits.
- Non-Personnel expenses were $288K or 12.5% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees).

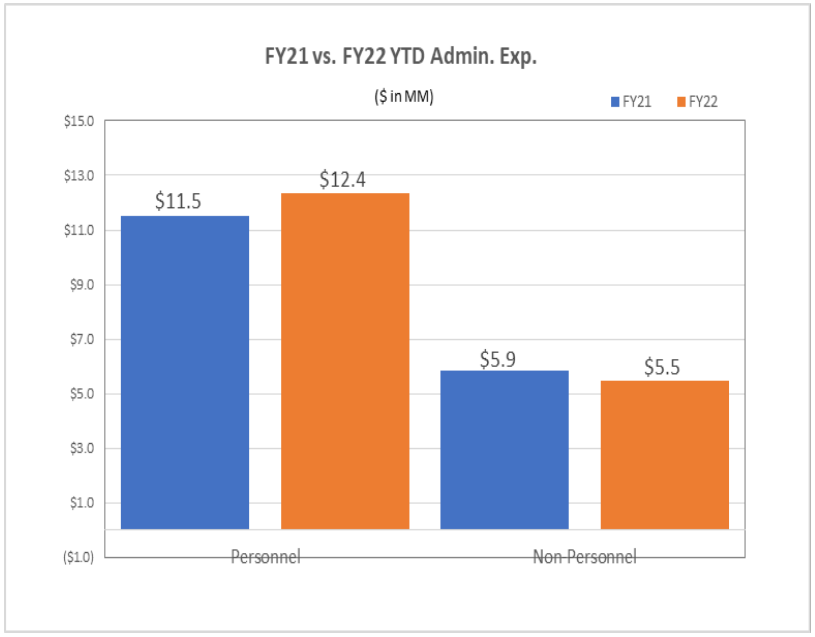


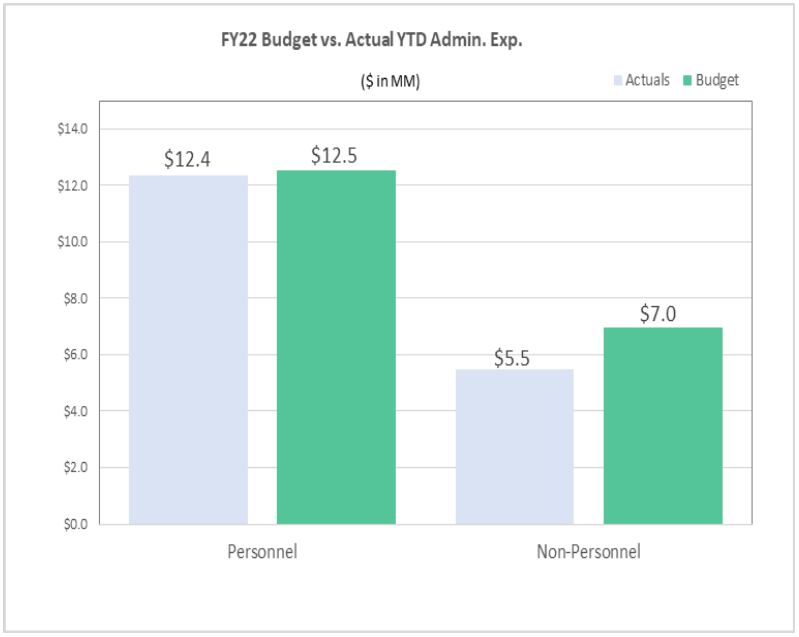


YTD Administrative Expense

YTD administrative expense of $17.8M was $1.7M or 8.6% favorable to budget of $19.5M. The variance was primarily due to the following:

- Personnel expenses were $168K or 1.3% favorable to budget due to lower headcount than budget including lower payroll tax and benefits, offset with revised pension and retiree medical true-ups.
- Non-Personnel expenses were $1.5M or 21.7% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees).





Balance Sheet

- Current assets totaled $984.5M compared to current liabilities of $743.3M, yielding a current ratio (Current Assets/Current Liabilities) of 1.32:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by $41.7M compared to the cash balance as of year-end June 30, 2021, due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$182,649,335	0.76%	$100,000	$290,096
Wells Fargo Investments	$241,732,401	0.08%	$9,379	$51,322
	$424,381,736		$109,379	$341,418
Cash & Equivalents				
Bank of the West Money Market	$174,425	0.10%	$404	$1,621
Wells Fargo Bank Accounts	$24,855,373	0.01%	$329	$1,049
	$25,029,797		$733	$2,670
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.18%	$0	$0
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$449,737,033**		**$110,112**	**$344,088**

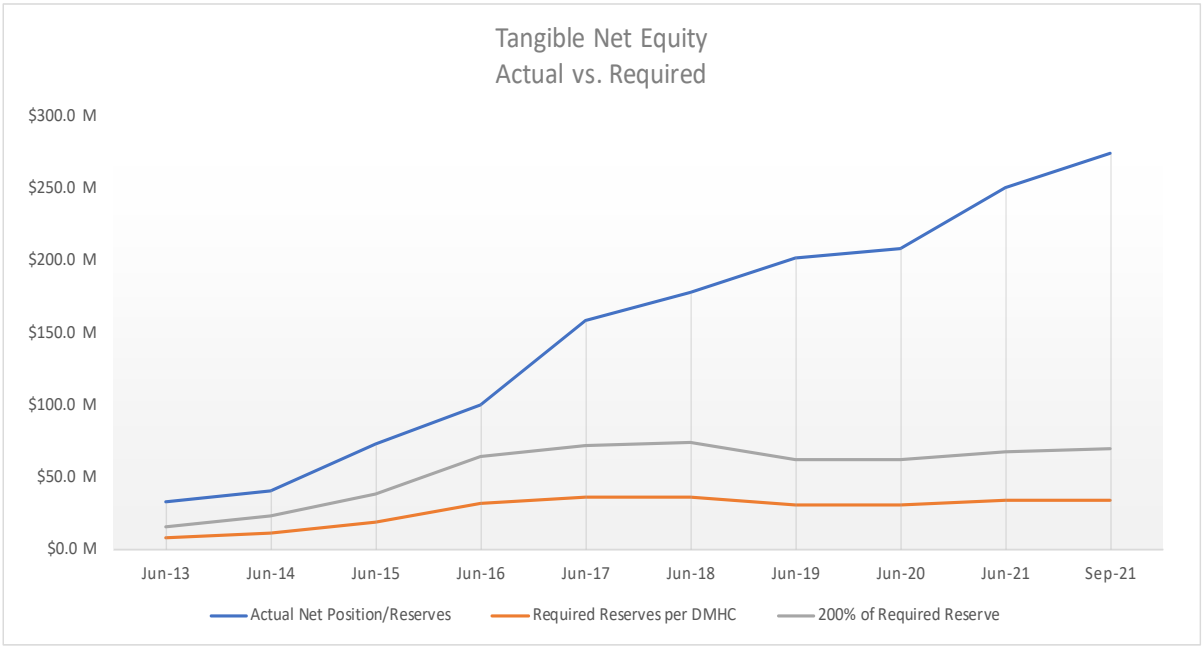
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- Overall cash and investment yield is lower than budget (0.38% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $274.2M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of September 30, 2021

	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	Sep-21
Actual Net Position/Reserves	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$274.2 M
Required Reserves per DMHC	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$34.7 M
200% of Required Reserve	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$69.4 M
Actual as % Required	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	790.7%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS SEPTEMBER 2021

Financial Reserve Target #1: Tangible Net Equity	Board Funds Committed	Approved Projects	Funds Expended	Balance
Unrestricted Net Assets				**$230,145,925** *
Board Designated Funds (Note 1):				
Special Project Funding for CBOs	$4,000,000	$961,743	$662,727	$3,337,274
Innovation & COVID-19 Fund	$16,000,000	$4,880,000	$2,317,996	$13,682,004
Subtotal	$20,000,000	$5,841,743	$2,980,723	$17,019,277
Net Book Value of Fixed Assets				$26,692,788
Restricted Under Knox-Keene Agreement				$325,000
Total Tangible Net Equity (TNE)				$274,182,990
Current Required TNE				$34,677,004
TNE %				790.7%
SCFHP Target TNE Range:				
350% of Required TNE (Low)				$121,369,514
500% of Required TNE (High)				$173,385,019
Total TNE Above/(Below) SCFHP Low Target				**$152,813,477**
Total TNE Above/(Below) High Target				**$100,797,971**
Financial Reserve Target #2: Liquidity				
Cash & Investments				$449,737,033
Less Pass-Through Liabilities:				
Hospital Directed Payments				(23,619,810)
MCO Tax Payable to State of CA				(35,014,087)
Whole Person Care / Prop 56				(48,292,369)
Other Pass-Through Liabilities (Note 2)				(67,081,672)
Total Pass-Through Liabilities				**(174,007,938)**
Net Cash Available to SCFHP				275,729,095
SCFHP Target Liquidity (Note 3)				
45 Days of Total Operating Expense				(168,101,964)
60 Days of Total Operating Expense				(224,135,952)
Liquidity Above/(Below) SCFHP Low Target				**107,627,131**
Liquidity Above/(Below) High Target				**$51,593,143**

- **Unrestricted Net Assets represents two months of total expenses.**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund for Special Projects of $2.2M. In December 2019, the Governing Board also approved additional $1.8M for Special Project fund ($4M total) and $16M for Innovation & COVID-19 Fund.

Note 2: Other Pass-Through Liabilities include HQAF, Rate Range IGT, and DHCS overpayments.

Note 3: SCFHP Target Liquidity is based on total monthly budgeted expenses.

Capital Expenditures

- YTD Capital investments of $674K, largely software licenses, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$60,124	$55,800
Hardware	$102,369	$1,060,000
Software	$418,035	$1,896,874
Building Improvements	$93,844	$62,000
Furniture & Equipment	$0	$179,101
TOTAL	**$674,372**	**$3,253,775**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Three Months Ending September 30, 2021

	Sep-2021 Actuals	% of Rev	Sep-2021 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Sep-2021 Actuals	% of Rev	YTD Sep-2021 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 95,241,399	83.8%	$ 94,485,358	83.6%	$ 756,041	0.8%	$ 284,973,869	83.9%	$ 281,666,562	83.6%	$ 3,307,307	1.2%
CMC MEDI-CAL	4,025,482	3.5%	3,755,826	3.3%	269,656	7.2%	11,942,849	3.5%	11,158,045	3.3%	784,803	7.0%
CMC MEDICARE	14,366,352	12.6%	14,787,008	13.1%	(420,656)	-2.8%	42,846,369	12.6%	43,931,793	13.0%	(1,085,423)	-2.5%
TOTAL CMC	18,391,834	16.2%	18,542,834	16.4%	(151,000)	-0.8%	54,789,218	16.1%	55,089,838	16.4%	(300,620)	-0.5%
TOTAL REVENUE	**$ 113,633,233**	**100.0%**	**$ 113,028,192**	**100.0%**	**$ 605,041**	**0.5%**	**$ 339,763,087**	**100.0%**	**$ 336,756,401**	**100.0%**	**$ 3,006,687**	**0.9%**
MEDICAL EXPENSES												
MEDI-CAL	$ 83,929,560	73.9%	$ 88,409,749	78.2%	$ 4,480,189	5.1%	$ 257,186,793	75.7%	$ 263,521,765	78.3%	$ 6,334,972	2.4%
CMC MEDI-CAL	3,112,247	2.7%	2,997,124	2.7%	(115,123)	-3.8%	9,279,085	2.7%	8,902,346	2.6%	(376,739)	-4.2%
CMC MEDICARE	10,938,538	9.6%	14,096,724	12.5%	3,158,185	22.4%	36,578,031	10.8%	41,864,368	12.4%	5,286,338	12.6%
TOTAL CMC	14,050,785	12.4%	17,093,848	15.1%	3,043,063	17.8%	45,857,116	13.5%	50,766,715	15.1%	4,909,598	9.7%
TOTAL MEDICAL EXPENSES	**$ 97,980,345**	**86.2%**	**$ 105,503,597**	**93.3%**	**$ 7,523,251**	**7.1%**	**$ 303,043,909**	**89.2%**	**$ 314,288,479**	**93.3%**	**$ 11,244,570**	**3.6%**
GROSS MARGIN	**$ 15,652,888**	**13.8%**	**$ 7,524,596**	**6.7%**	**$ 8,128,292**	**108.0%**	**$ 36,719,178**	**10.8%**	**$ 22,467,921**	**6.7%**	**$ 14,251,257**	**63.4%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 4,680,967	4.1%	$ 4,261,417	3.8%	$ (419,550)	-9.8%	$ 12,353,954	3.6%	$ 12,522,331	3.7%	$ 168,377	1.3%
RENTS AND UTILITIES	33,749	0.0%	42,067	0.0%	8,318	19.8%	107,869	0.0%	126,200	0.0%	18,331	14.5%
PRINTING AND ADVERTISING	148,616	0.1%	107,542	0.1%	(41,074)	-38.2%	211,887	0.1%	324,625	0.1%	112,738	34.7%
INFORMATION SYSTEMS	298,296	0.3%	376,194	0.3%	77,898	20.7%	876,424	0.3%	1,128,583	0.3%	252,159	22.3%
PROF FEES/CONSULTING/TEMP STAFFING	867,565	0.8%	1,097,072	1.0%	229,507	20.9%	2,319,020	0.7%	3,293,893	1.0%	974,872	29.6%
DEPRECIATION/INSURANCE/EQUIPMENT	355,870	0.3%	395,317	0.3%	39,448	10.0%	1,181,614	0.3%	1,236,637	0.4%	55,023	4.4%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	77,981	0.1%	62,242	0.1%	(15,739)	-25.3%	159,195	0.0%	186,727	0.1%	27,531	14.7%
MEETINGS/TRAVEL/DUES	111,938	0.1%	121,371	0.1%	9,432	7.8%	309,859	0.1%	389,001	0.1%	79,143	20.3%
OTHER	121,190	0.1%	101,157	0.1%	(20,034)	-19.8%	306,024	0.1%	299,770	0.1%	(6,254)	-2.1%
TOTAL ADMINISTRATIVE EXPENSES	**$ 6,696,173**	**5.9%**	**$ 6,564,379**	**5.8%**	**$ (131,794)**	**-2.0%**	**$ 17,825,846**	**5.2%**	**$ 19,507,766**	**5.8%**	**$ 1,681,920**	**8.6%**
OPERATING SURPLUS/(LOSS)	**$ 8,956,715**	**7.9%**	**$ 960,216**	**0.8%**	**$ 7,996,499**	**832.8%**	**$ 18,893,332**	**5.6%**	**$ 2,960,155**	**0.9%**	**$ 15,933,177**	**538.3%**
INTEREST & INVESTMENT INCOME	$ 110,112	0.1%	$ 350,000	0.3%	$ (239,888)	-68.5%	$ 344,088	0.1%	$ 1,050,000	0.3%	$ (705,912)	-67.2%
OTHER INCOME	31,272	0.0%	35,986	0.0%	(4,714)	-13.1%	94,969	0.0%	107,957	0.0%	(12,989)	-12.0%
NON-OPERATING INCOME	**$ 141,383**	**0.1%**	**$ 385,986**	**0.3%**	**$ (244,602)**	**-63.4%**	**$ 439,057**	**0.1%**	**$ 1,157,957**	**0.3%**	**$ (718,901)**	**-62.1%**
NET SURPLUS (LOSS)	**$ 9,098,098**	**8.0%**	**$ 1,346,202**	**1.2%**	**$ 7,751,896**	**575.8%**	**$ 19,332,389**	**5.7%**	**$ 4,118,113**	**1.2%**	**$ 15,214,277**	**369.4%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of September 30, 2021

	Sep-2021	Aug-2021	Jul-2021	Sep-2020
Assets				
Current Assets				
Cash and Investments	$ 449,737,033	$ 410,684,675	$ 398,162,794	$ 624,723,291
Receivables	523,104,967	544,807,886	516,784,910	520,171,179
Prepaid Expenses and Other Current Assets	11,700,387	9,900,313	9,307,620	10,630,246
Total Current Assets	**$ 984,542,387**	**$ 965,392,874**	**$ 924,255,325**	**$ 1,155,524,716**
Long Term Assets				
Property and Equipment	$ 52,197,243	$ 52,015,817	$ 51,843,223	$ 49,650,861
Accumulated Depreciation	(25,504,456)	(25,157,882)	(24,811,725)	(21,539,191)
Total Long Term Assets	26,692,788	26,857,935	27,031,498	28,111,670
Total Assets	**$ 1,011,235,174**	**$ 992,250,809**	**$ 951,286,823**	**$ 1,183,636,385**
Deferred Outflow of Resources	**$ 7,162,621**	**$ 7,413,357**	**$ 7,413,357**	**$ 8,402,260**
Total Assets & Deferred Outflows	**$ 1,018,397,795**	**$ 999,664,166**	**$ 958,700,180**	**$ 1,192,038,645**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 7,115,339	$ 5,588,358	$ 5,681,993	$ 8,837,491
Deferred Rent	47,437	47,735	48,033	47,728
Employee Benefits	3,245,599	3,210,465	3,212,807	2,430,308
Retirement Obligation per GASB 75	1,978,037	1,897,787	1,817,537	2,366,099
Deferred Revenue - Medicare	0	0	13,017,533	0
Whole Person Care / Prop 56	48,292,369	50,100,271	47,032,789	39,655,575
Payable to Hospitals	103,357	103,357	103,819	529,171
Payable to Hospitals	23,516,453	23,516,453	472,944	274,742,278
Pass-Throughs Payable	182	182	181	26,877
Due to Santa Clara County Valley Health Plan and Kaiser	24,985,401	20,402,761	22,173,902	18,334,201
MCO Tax Payable - State Board of Equalization	35,014,087	24,885,874	14,757,661	51,653,884
Due to DHCS	67,081,490	60,193,218	59,213,361	49,264,236
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,268,582
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	103,669,528	115,818,873	101,984,270	100,043,325
Total Current Liabilities	**$ 743,334,237**	**$ 734,050,292**	**$ 697,801,789**	**$ 975,493,781**
Non-Current Liabilities				
Net Pension Liability GASB 68	341,250	(10,335.32)	(124,085)	852,456
Total Non-Current Liabilities	**$ 341,250**	**$ (10,335)**	**$ (124,085)**	**$ 852,456**
Total Liabilities	**$ 743,675,487**	**$ 734,039,957**	**$ 697,677,704**	**$ 976,346,237**
Deferred Inflow of Resources	**$ 539,318**	**$ 539,318**	**$ 539,318**	**$ 1,661,827**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,337,274	$ 3,337,274	$ 3,337,274	$ 3,459,274
Board Designated Fund: Innovation & COVID-19 Fund	13,682,004	13,682,004	13,730,001	13,880,001
Invested in Capital Assets (NBV)	26,692,788	26,857,935	27,031,498	28,111,670
Restricted under Knox-Keene agreement	325,000	325,000	325,000	305,350
Unrestricted Net Equity	210,813,536	210,648,389	210,426,828	162,884,493
Current YTD Income (Loss)	19,332,389	10,234,291	5,632,558	5,389,795
Total Net Assets / Reserves	**$ 274,182,990**	**$ 265,084,892**	**$ 260,483,159**	**$ 214,030,582**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,018,397,795**	**$ 999,664,166**	**$ 958,700,180**	**$ 1,192,038,645**

Cash Flow Statement

Santa Clara Family Health Plan

	Sep-2021	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$ 152,352,637	$ 340,487,953
Medical Expenses Paid	(105,547,051)	(305,761,983)
Adminstrative Expenses Paid	(7,713,187)	7,174,313
Net Cash from Operating Activities	**$ 39,092,400**	**$ 41,900,283**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	$ (181,426)	$ (674,372)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	141,383	439,057
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ 39,052,357**	**$ 41,664,967**
Cash & Investments (Beginning)	410,684,675	408,072,066
Cash & Investments (Ending)	**$ 449,737,033**	**$ 449,737,033**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Surplus/(Loss)	$ 8,956,715	$ 18,893,332
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	346,573	1,038,248
Changes in Operating Assets/Liabilities		
Premiums Receivable	21,702,918	(10,885,442)
Prepaids & Other Assets	(1,800,073)	(2,983,882)
Accounts Payable & Accrued Liabilities	(165,834)	26,353,806
State Payable	17,016,485	11,610,308
IGT, HQAF & Other Provider Payables	4,582,640	1,199,722
Net Pension Liability	351,585	341,250
Medical Cost Reserves & PDR	(12,149,345)	(3,917,796)
IHSS Payable	0	0
Total Adjustments	**$ 30,135,685**	**$ 23,006,950**
Net Cash from Operating Activities	**$ 39,092,400**	**$ 41,900,283**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Three Months Ending September 30, 2021

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$284,973,869	$11,942,849	$42,846,369	$54,789,218	**$339,763,087**
MEDICAL EXPENSE	$257,186,793	$9,279,085	$36,578,031	$45,857,116	**$303,043,909**
(MLR)	90.2%	77.7%	85.4%	83.7%	89.2%
GROSS MARGIN	$27,787,076	$2,663,763	$6,268,339	$8,932,102	**$36,719,178**
ADMINISTRATIVE EXPENSE	$14,951,301	$626,588	$2,247,957	$2,874,545	**$17,825,846**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$12,835,775	$2,037,175	$4,020,382	$6,057,557	**$18,893,332**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$368,256	$15,433	$55,368	$70,801	**$439,057**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$13,204,031	$2,052,609	$4,075,750	$6,128,358	**$19,332,389**
PMPM (ALLOCATED BASIS)					
REVENUE	$345.22	$388.79	$1,394.83	$1,783.62	**$396.83**
MEDICAL EXPENSES	$311.56	$302.07	$1,190.77	$1,492.84	**$353.94**
GROSS MARGIN	$33.66	$86.72	$204.06	$290.78	**$42.89**
ADMINISTRATIVE EXPENSES	$18.11	$20.40	$73.18	$93.58	**$20.82**
OPERATING INCOME/(LOSS)	$15.55	$66.32	$130.88	$197.20	**$22.07**
OTHER INCOME/(EXPENSE)	$0.45	$0.50	$1.80	$2.30	**$0.51**
NET INCOME/(LOSS)	$16.00	$66.82	$132.68	$199.50	**$22.58**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	825,484	30,718	30,718	30,718	856,202
REVENUE BY LOB	83.9%	3.5%	12.6%	16.1%	100.0%

Santa Clara Family Health Plan™

Appendix

Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD OCTOBER - 2021

		2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	FYTD var	%
NON DUAL	Adult (over 19)	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	33,546	33,809	812	2.5%
	Child (under 19)	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	101,093	101,125	648	0.6%
	SPD	22,149	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	22,331	22,381	80	0.4%
	Adult Expansion	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	91,960	92,393	2,436	2.7%
	Long Term Care	409	389	393	388	380	373	375	367	365	414	408	401	391	26	7.1%
	Total Non-Duals	**230,802**	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**4,002**	**1.6%**
DUAL	Adult (over 21)	354	353	353	352	355	361	357	365	366	367	376	375	396	30	8.2%
	SPD	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	24,206	24,244	129	0.5%
	Long Term Care	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	1,092	1,083	23	2.2%
	SPD OE	410	498	537	590	662	742	802	863	952	1,063	1,135	1,223	1,308	356	37.4%
	Total Duals	**25,688**	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**538**	**2.0%**
	Total Medi-Cal	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**4,540**	**1.7%**
CMC	CMC Non-Long Term Care	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	10,122	10,160	265	2.7%
	CMC - Long Term Care	210	209	207	193	187	184	179	180	185	209	208	203	208	23	12.4%
	Total CMC	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**288**	**2.9%**
	Total Enrollment	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**4,828**	**1.7%**

Santa Clara Family Health Plan™

Dual-Eligible Special Needs Plan (DSNP)

Enrollment, Marketing/Sales and Broker Management Systems

Vendor Selection and Contracting

November 18, 2021

D-SNP Operational Requirements

Expand capabilities to ensure compliance with D-SNP regulatory requirements

- Enrollment
  - The enrollment function for Cal MediConnect is managed by DHCS, with DHCS responsible for managing transactions with CMS
  - With the transition to a D-SNP in 2023, SCFHP will be responsible for managing enrollment and disenrollment transactions with CMS, along with financial reconciliation, direct sales and broker support functions
- Marketing/Sales and Broker Management
  - SCFHP does not have a direct sales/application process or broker management system
- Additional Context
  - Systems implementation costs are budgeted for FY21/22, to ensure timely readiness
  - SCFHP's existing IT systems do not support D-SNP requirements

Vendors

RFP distributed via email and evaluated by Enrollment & Eligibility, IT, Medicare Outreach, Operations, Marketing & Communications

- RFP sent to 12 vendors
- 9 vendors responded
- No single vendor can provide all required functionality; separate systems needed for Enrollment vs. Marketing/Sales and Broker Management
- Detailed evaluation criteria established, including key functionality, ease of use, implementation, support, references, value
- Three-year costs for finalists range from:
  - Enrollment: $740,000 to $1,920,000
  - Marketing/Sales and Broker Management: $1,090,000 to $2,380,000

Vendor Selection

Recommendations:

- Enrollment: Dynamic Healthcare Systems
- Marketing/Sales & Broker Management: Engagent Health

These vendors provide:

- Strong, comprehensive functionality
- Clear, easy to navigate user interface
- Ease of integration with other systems
- Focus on regulatory compliance
- Strong references
- Best value

Vendor Selection

Possible Action

- Authorize Chief Executive Officer to negotiate, execute, and amend three-year contracts with Dynamic Healthcare Systems and Engagent Health not to exceed $800,000 for the Enrollment system and $1,150,000 for the Marketing/Broker Management system

Santa Clara County Health Authority
COVID-19 Funding Request Summary

Organization Name:	Children's Discovery Museum (CDM)
Project Name:	CDM Covid-19 Vaccination Clinics for Children
Contact Name and Title:	Marilee Jennings, Executive Director Children's Discovery Museum
Requested Amount:	$30,000
Time Period for Project Expenditures:	January 1, 2022 – March 31, 2022
Proposal Submitted to:	Executive/Finance Committee
Date Proposal Submitted for Review:	November 18, 2021

Summary of Proposal:

The Children's Discovery Museum (CDM) is working in partnership with the Santa Clara County Public Health Department (PHD) to host pop-up COVID vaccination clinics at the CDM. Approval of the vaccination for children ages 5-11 is a significant next step forward in Santa Clara County's aggressive fight against the pandemic. Although vaccination rates in the County are high in comparison to national averages, we continue to experience lower rates among residents enrolled in Medi-Cal. Presently, only 63% of Santa Clara Family Health Plan Medi-Cal members age 12 and older are fully vaccinated.

To incent families to get their children vaccinated, CDM will offer passes for free admission to CDM to families whose members receive vaccinations at the CDM pop-up clinics. CDM will partner with Santa Clara Family Health Plan for outreach to SCFHP members who live in proximity to CDM and who have vaccination-eligible children who have not yet received a vaccination, and through other channels will actively promote these clinics to low-income families with children.

CDM is highly regarded as a trusted resource for parents. That CDM is aligning with public health officials and pediatricians in supporting COVID-19 vaccines may make a difference for hesitant parents. This unique opportunity provides the urgency inherent in a "use it or lose it" moment. CDM recognizes that implementing this project and including a Museum admission incentive requires partnerships. After receiving no earned revenue during 393 days of closure due to COVID restrictions, and now operating at 50% of capacity due to COVID, CDM does not have reserves to absorb the

operating costs from giving free admission, but can play a role in our community's vaccination efforts by serving as host and organizer for these clinic days.

Summary of Projected Outcome/Impact:

This funding proposal would enable CDM to host two COVID vaccination pop-up clinic days and provide CDM admission incentives to families whose children received vaccinations. Santa Clara County PHD estimates that they can vaccinate 250 children per vaccination pop-up, along with any other family members in need of first, second or booster vaccinations, vaccinating a total of 500+ children plus other family members.

Evaluation Relative to SCFHP COVID-19 Funding Criteria

Criteria	Met/Not Met
1. Demonstrate the need is directly related to the COVID-19 pandemic.	Met
2. Demonstrate the project targets those in the most acute need.	Met
3. Indicate if a one-time need; if longer-term program, how will the need be sustained with resources other than SCFHP.	Met (Pop-up vaccination clinics are a temporary need. If these initial clinics are successful, CDM may request funding for vaccination clinics targeting children <5 years, once vaccine is approved for this age group.)
4. Demonstrate the applicant is making maximum use of own resources, including reserves and emergency funds.	Met (CDM was closed for 393 days due to COVID, and does not have resources to self-fund this project)
5. Indicate if funding is being sought from other potential sources.	Met (CDM has received funding for another clinic day from The Health Trust and Community Foundation Silicon Valley; CDM has requests/outreach in process with San Jose City Council and Mayor, Santa Clara County Supervisor, Anthem Blue Cross)
6. Indicate if a loan/advance could meet the need.	N/A
7. Indicate if the request is health care-related (e.g., provider network stabilization).	Met. This request would fund a project to increase COVID-19 vaccination rates, specifically among children.
8. Funds are not to be used for other expenses and may not supplant normal recurring funding.	Met
9. Funds are to be used exclusively for direct service provision and not for indirect overhead.	Met

Children's
Discovery
Museum
of San Jose

November 10, 2021

Ms. Christine Tomcala
Chief Executive Officer
Santa Clara Family Health Plan
6201 San Ignacio Avenue
San Jose, CA 95119

Dear Christine:

I am writing to seek Santa Clara Family Health Plan's financial support and marketing partnership to offer two COVID-19 vaccination clinics for families at Children's Discovery Museum and provide each participating family the incentive of a free Museum visit. The Santa Clara County Public Health Department (PHD) has conducted a site visit of the Museum and has agreed to operate pre-scheduled day-long "pop-up" vaccination clinics, and Museum volunteers will distribute the family passes. In partnership with Viva Calles through San Jose's Department of Parks, Recreation and Neighborhood Services, families will also have the opportunity to engage in a variety of outdoor activities on the Museum's front patio before and after their vaccinations and Museum visits. Details are below.

Need for the Program

Approval of the Pfizer COVID-19 vaccination for children ages 5-11 and arrival of the vaccine in Santa Clara County provide a significant next step in our County's aggressive fight against the pandemic. Although vaccination rates in the County are high in comparison to national averages, we continue to experience lower rates among residents enrolled in Medi-Cal. Presently, only 63% of Santa Clara Family Health Plan Medi-Cal members age 12 and older are fully vaccinated.

Of even greater concern is survey data recently released from the Kaiser Family Foundation reporting that only 3% of parents said they are ready to vaccinate their children when a vaccine is available. Of the remaining parents, 3% declared that they do not plan on vaccinating their children, and 4% indicated that they will take a "wait and see" approach. Even among parents who have received a COVID-19 vaccination, many are planning to be more cautious with their children than they were with themselves. The study also pointed to the importance of "trusted sources" to help parents decide to vaccinate.

California Governor Newsom has mandated that all schoolchildren be vaccinated once final FDA approval has been secured. This means that unvaccinated children will not be allowed to attend school in person and will be forced to distance learn. Widely reported from many sources has been the negative impact of remote learning on the majority of students during the 2020-21 academic year. For example, students were on average five months behind in mathematics and four months behind in reading by the end of the school year. Furthermore, the pandemic widened preexisting opportunity and achievement gaps, hitting historically disadvantaged students hardest.

It is imperative to keep all children in the classroom to prevent even more learning loss, which will depress their prospects and constrict their opportunities far into adulthood. This is especially true for children from low income families, who already face significant obstacles to success in school.

180 Woz Way
San Jose, CA 95110
(408) 298-5437
FAX (408) 298-6826

Rationale for Proposed Project

Children's Discovery Museum of San Jose (CDM) can make a difference in encouraging parents of children enrolled in Medi-Cal to vaccinate their children by providing:

1. A compelling family incentive – free admission pass to the 80,000 square foot Museum for the whole family to use either on the day of the vaccination or another day of their choice. Museum admission is $15 per person, making the value of the pass up to $60 for a family of four.

2. A location that offers easy access – within walking distance of hundreds of families with children enrolled in Medi-Cal; accessible by public Light Rail and bus; and with more than 400 parking spots for private vehicles;

3. Kid-friendly activities before and after the vaccination and Museum visit – hosted by San Jose's Parks and Rec Department and their partners who are expert in serving children; and

4. COVID-19 vaccinations for other family members, too – with County PHD workers equipped to offer adult and youth vaccines and booster shots, as appropriate.

For busy working parents, the Museum's "pop-up" clinic offers a one-stop approach, where family members receive their COVID-19 vaccine and then engage in hours of family fun and learning with over 150 interactive exhibits.

For children who are feeling anxious about getting a shot, the promise of a chance to play in the Museum offers a powerful trade-off. Many children will find the courage for the vaccination by imagining themselves playing with the colorful balls in the *Water Ways* exhibit or sliding down the slide in *Bill's Backyard*.

For families falling into the "wait and see" vaccination category, this unique opportunity provides the urgency inherent in a "use it or lose it" moment. Although CDM aspires to offer multiple clinics over the next several months, they will be limited in scope and only available if funding is secured. CDM is also highly regarded as a trusted resource for parents. That we are aligning with public health officials and pediatricians in supporting COVID-19 vaccines may make a difference for hesitant parents.

Target Audience and People Served

Working with Santa Clara Family Health Plan (SCFHP), we will identify and mail directly to SCFHP members with children, teens and adults who have not been fully vaccinated for COVID-19. These are also families who likely cannot afford regular Museum visits, and for whom a free family pass will feel special and exciting. A specially designed co-branded flier in SCFHP's threshold languages (English, Spanish, Vietnamese, Chinese, and Tagalog), along with comprehensive social media and email campaigns to CDM's 30,000+ mail list, will market the Museum visit incentive and also the urgency of only two vaccine clinic days currently scheduled at Children's Discovery Museum in an effort to drive participation. SJ Parks & Rec plans to advertise the events to their supporters as well. Our marketing plan also calls for maximizing information distribution to our many community partners to help us get the word out.

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Santa Clara County PHD estimates that they can vaccinate 250 children per vaccination "pop-up," along with any other family members in need. CDM will distribute a family pass to each participating family, which will total more than 1,000 Museum visitors.

Dates and Logistics

Santa Clara County Public Health has committed to offering "pop-up" vaccination clinics in CDM's private Amphitheatre, which offers a separate entrance and exit as well as a special entrance into the Museum. There is space to set up 5-6 private vaccination rooms and a waiting room for 15-minute observations. The entrance to the Amphitheatre is through an extensive covered walkway that extends all the way to the Light Rail Station for those using public transportation. The walkway and patio in front of the Museum are where SJ Parks and Rec will set up activity stations to engage families before and after their vaccinations and Museum visits. The proposed days are January 9, 2022 and January 30, 2022.

Budget

CDM seeks sponsorship of $30,000 to host two vaccination clinics and underwrite free admission for a total of 2,000 children and adults @ $15/each. We will also use some of this budget to design, print, and translate the fliers used to promote the event. CDM will not generate any revenues on vaccination days from ticket sales as the Museum will only be open for those families receiving vaccinations. This will ensure that we do not exceed maximum occupancy under COVID-19 guidelines still in place for unvaccinated persons.

CDM is not in a position to offer the free tickets without sponsorship. Because the Museum is intensely hands-on and interactive, with COVID and younger children not yet vaccinated, we must limit our attendance to 50% capacity, which cuts in half our ability to generate income from ticket sales. Also due to COVID-19 restrictions, we have lost all other sources of earned revenue. For example, we cannot offer in-person workshops, birthday parties, or events, and because our café is in the center of the Museum and the risk of guests removing their masks to eat is simply too high, we closed food service. Unsponsored free passes take away revenues that would have been generated from selling tickets for our limited slots, but our expenses to pay staff, cover utilities and insurance, and ensure sanitization and maintenance remain in place.

After being closed for 393 days, we are already using our reserves simply to stay open, as the attached budget indicates. Our Board passed a deficit budget of $(350,000) because we are so vital to children's well-being and learning. Creating new programs like the pop-up clinics and funding free passes ourselves would put CDM in even greater jeopardy.

We are requesting $15,000 per pop-up clinic day based on 250 kids being vaccinated and giving each family a free family pass. Our standard approach is to budget based on a family of four, but we will welcome all family members knowing that the families we are targeting for these vaccination days typically are larger, especially if they bring the grandparents, too. We also know that not all families will be able to stay for a Museum visit after the vaccination, so we will make the pass valid for 6 months. Each $15,000 sponsorship will cover admission fees for 1,000 people (1,000 = 250 vaccinated children x 4 members in the family).

We are requesting sponsor funding in advance of the pop-up clinic days, so that CDM does not experience the loss of cash revenue on those days.

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Additional Fundraising

CDM is actively fundraising to host COVID-19 clinics with the Museum visit incentive, and is prepared to offer 1-2 clinics per month until every eligible child is vaccinated. With support from The Health Trust and Community Foundation Silicon Valley, we have funded Clinic #1, which is slated for December 4, 2021 and will target families in the Gardner/Washington neighborhoods near CDM.

We also have an application pending with Council Member Raul Peralez's office, requests to San Jose Mayor Sam Liccardo and County Supervisor Cindy Chavez to access federal ARP funds, and a new introduction from SCFHP to counterparts at Anthem Blue Cross to discuss this initiative.

Our plan is to document our learning from these events because half of CDM's child audience is under the age of 5. We want to be able to repeat these vaccination clinics when the FDA approves a vaccine for that age group. We are very excited about our partnership with SCFHP to reach Medi-Cal families both now and then later when the next vaccine rolls out.

Measuring Success

Together with Santa Clara County PHD, we have set goals of hosting two "pop-up" clinics and vaccinating a total of 500 children, plus other family members, and distributing family passes that will result in 2,000 Museum visits. Our primary audience focus is on Medi-Cal families, whose vaccination rates are below County averages. Every child and/or parent who overcomes their fears and accepts a vaccination puts Santa Clara County one step further in the fight to stop the spread of COVID-19 in our community.

Thank you for your consideration and please reach out with questions or ideas.

Sincerely,

Marilee Jennings
Executive Director

180 Woz Way
San Jose, CA 95110
(408) 298-5437
FAX (408) 298-6826

CHILDREN'S DISCOVERY MUSEUM OF SAN JOSE

BUDGET SUMMARY
September 1, 2021 - August 31, 2022

	Cash Basis	% OF BUDGET	Accrual Basis	% OF BUDGET
REVENUES				
CONTRIBUTIONS				
Individuals	$ 189,115		$ 189,115	
Corporations	$ 147,014		$ 97,014	
Foundations	$ 55,000		$ 50,000	
Public	$ 1,500,046		$ 2,159,079	
Event Income	$ 1,045,513		$ 1,003,013	
TOTAL CONTRIBUTIONS	$ 2,936,688		$ 3,498,221	
IN-KIND CONTRIBUTIONS	$ -		$ 967,592	
TOTAL CONTRIBUTED REVENUE	$ 2,936,688	64.43%	$ 4,465,813	72.60%
EARNED INCOME				
Admissions	$ 1,142,274		$ 1,142,274	
Admissions - Group Visits	$ -		$ -	
FoodShed Sales	$ -		$ -	
Birthday Parties	$ -		$ -	
Memberships (<=$175)	$ 479,230		$ 479,230	
Gross Small Exhibit Sales & Rental	$ -		$ -	
Facility Use	$ -		$ -	
Exhibit Rental	$ -		$ -	
Program Fees - Education	$ -		$ -	
Program Fees - Outreach	$ -		$ -	
Program Fees - In-House	$ -		$ -	
Other Income	$ -		$ -	
TOTAL EARNED INCOME	$ 1,621,504		$ 1,621,504	
INVESTMENT INCOME				
Interest & Dividends	$ -		$ 64,203	
TOTAL INVESTMENT INCOME	$ -		$ 64,203	
TOTAL EARNED INCOME	$ 1,621,504	35.57%	$ 1,685,707	27.40%
COST OF GOODS SOLD	$ -	0.00%	$ -	0.00%
TOTAL REVENUES	**$ 4,558,192**		**$ 6,151,519**	
EXPENSES				
Personnel	$ 3,268,751	66.65%	$ 3,454,474	48.56%
Occupancy	$ 955,740	19.49%	$ 2,277,265	32.01%
Communication & Publication	$ 242,600	4.95%	$ 242,600	3.41%
Other Costs	$ 222,914	4.54%	$ 222,914	3.13%
In-Kind	$ -	0.00%	$ 916,664	12.89%
Capitalized Expenses	$ 214,706	4.38%	$ -	0.00%
TOTAL UNRESTRICTED EXPENSES	**$ 4,904,711**		**$ 7,113,917**	
NET SURPLUS/<DEFICIT>	$ (346,519)		$ (962,398)	

Post adoption of FASB (ASU) 2018.08

Approved by Board of Directors
9-17-21

Santa Clara County Health Authority
Board Designated Innovation Fund Request Summary

Organization Name:	Behavioral Health Contractors' Association (BHCA) of Santa Clara County
Project Name:	Readiness Support for Delivery System Changes
Contact Name and Title:	Elisa Koff-Ginsborg, Executive Director Behavioral Health Contractors' Association (BHCA)
Requested Amount:	$160,160 ($80,080 per year for two years)
Time Period for Project Expenditures:	January 1, 2022 – December 31, 2023
Proposal Submitted to:	Executive/Finance Committee
Date Proposal Submitted for Review:	November 18, 2021

Summary of Proposal:

The delivery of behavioral health services in California is in the midst of profound changes. CalAIM, a multi-year initiative by the Department of Health Care Services to improve the quality of life and health outcomes of members, will fundamentally redesign service delivery and payments. Additionally, the State is investing unprecedented amounts in behavioral health services using expanded channels including health plans and schools. Non-profit providers that form the Behavioral Health services delivery system for Santa Clara County must learn how to navigate this new landscape, while still recovering from the impact of COVID, and adapting to major changes in the Medi-Cal Managed Care rules and the Drug Medi-Cal Waiver.

BHCA is seeking funding to hire a temporary Policy Associate and purchase consulting services to be resources for its members to enhance their readiness for the new landscape.

Summary of Projected Outcome/Impact:

This project will provide non-profit community-based behavioral health providers with ready access to easily digestible information on changes in the legislative, funding and regulatory arenas, and to resources and tools to assist with operationalizing these changes. Most non-profit community-based behavioral health providers do not have the resources to do this work on their own. BHCA members will be able to use the information and tools to maximize the new funding, ensure they meet the new requirements, and remain viable safety net providers for the community.

BHCA
Behavioral Health
Contractors' Association
of Santa Clara County

1530 The Alameda, Suite 301
San Jose, CA 95126
www.bhcascc.org

Purpose

The delivery of Behavioral Health services in California is in the midst of profound changes. Non-profit providers that form the Behavioral Health County Safety-Net must navigate a new landscape, on top of recovering from the impact of COVID, having adapted to major changes in the Medical Managed Care rules and the Drug MediCal Waiver. CalAIM,a multi-year initiative by the Department of Health Care Services to improve the quality of life and health outcomes of our population, will fundamentally redesign service delivery and payments, at a time the State is investing unprecedented amounts in behavioral health services using expanded channels including health plans and schools. Concurrently, providers are facing the largest workforce shortage in recent history. As the behavioral health professions evolve, we are seeing new classifications such as certified peer specialist and behavioral health coach that enrich services but require attention in order to integrate into existing service teams. Funding from the SCFHP would increase the capacity of the Behavioral Health Contractors' Association (BHCA) for the duration of these most intense shifts in the delivery of behavioral health services. This additional capacity will allow BHCA to support the non-profit behavioral health providers to ready their organizations to comply with new rules and opportunities. The public behavioral health system in Santa Clara County relies on the network of community based organizations to provide 70% of these essential services to beneficiaries. BHCA's support during these turbulent times plays an essential role in this system surviving. The funds we are seeking will allow BHCA to provide needed additional support to help agencies to thrive, even during these challenging times.

Unprecedented change

- CalAIM is a multi-year plan to transform Medi-Cal into a more consistent and seamless system through the integration of social services and data reporting to improve quality outcomes. CalAIM initiatives will be administered at the local level which will require county-based agencies to coordinate for a timely and successful implementation. Providers will need DHCS guidance and support to ensure a smooth transition for Medi-Cal members already receiving services.

- The influx of new funding, particularly through health plans and schools is only paralleled by the passage of Prop 63 and the establishment of the Mental Health Services Act. Significant initiatives include:
  - Children and Youth Behavioral Health Initiative **$4B** over five years. Multiple grants for incentives, infrastructure, workforce, and technology.
  - Community Schools Partnership Grants **$2.8B** over 7 years.
  - Mental Health Student Services Act (MHSSA**) $205M** over 3 years.
  - Competitive grant opportunities for schools, MCOs, and community-based providers.

- HSBC provides opportunities for Medi-Cal beneficiaries to receive services in their own home instead of being placed in long-term care placement or a nursing home. HCBS program initiatives begin January 21, 2022, providing a short window for implementation by behavioral health agencies.

- The National Council for Mental Wellbeing conducted a survey to assess the impacts of the pandemic on behavioral health providers. Respondents said the increased demand for mental health treatment, crisis services, and social support services have caused long patient waitlists

and staff burnout. Agencies have started offering incentives to attract new staff to keep up with the increase of service demand. Locally this has had limited success given the competitive marketplace. The emotional toll of the pandemic linked with social, economic and political unrest is causing unprecedented demands in behavioral health services and overwhelming providers.

- The California state budget includes more than $1.3 billion for expanding behavioral health services including more support for community health workers, growing a diverse workforce, and providing care for underserved populations.

Background

BHCA is a Santa Clara County-wide network of community-based, non-profit organizations providing essential mental health and substance use prevention, treatment, recovery, and supportive transitional housing services to children, adolescents, and adults, under contract with Santa Clara County's Behavioral Health Services Department.

BHCA is entirely funded by membership dues. BHCA hired their first part-time staff person in 2012. For 8 years BHCA managed with an Executive Director working 25 hours a week as the only staff. During the pandemic it became clear this was no longer sufficient. BHCA members raised dues significantly to expand the Executive Director position to full-time and create a .4 FTE administrative and policy assistant starting July 2021. While this is adequate staffing on an on-going basis, it precludes tracking of and supporting members in digesting and adapting to the rapidly changing landscape described above.

Vision:

- Support non-profit community-based behavioral health providers to have ready access to easily digestible information on changes including Cal-AIM, HBCS, new school and health plan based funding opportunities, new types of services providers designated by the Department of Health Care Services and other shifts in the behavioral health system of care. BHCA seeks to to ensure providers are strapped with the tools and knowledge to be successful
- Support non-profit community-based behavioral health providers in maximizing new funding to focus on underserved communities through an equity and inclusion lens. The pandemic shone a light on the glaring disparities in access to care particularly among communities of color, the LGBTQ+ community, and residents living in rural communities.
- Nurture relationships between BHCA members, and schools, and the SCFHP. This will allow all the entities to collaborate through this system expansion. They will be poised for the changes as they roll-out.

Grant Support

BHCA will undertake several measures to achieve the above vision.

- Addition of .5 FTE Policy Associate -- This staff person will be responsible for tracking, interpreting and communicating all new State initiatives.

- Membership in Open Minds. Open Minds is the leading provider of information,executive education and of consulting specializing in the sectors of the health and human service industry serving complex consumers. Their focus is on evolving markets with new policies and regulations and helping organizations transform their practices to be successful. Open Minds provides practical support to BH providers on navigating an evolving Medicaid managed care system and value-based payment market, as well as how to build a system that accurately measures performance. Membership includes access to one-hour quick consults with leading experts, webinars, access to training and a library that houses best practices, research and presentations and materials from all previous Institutes. BHCA staff will be able to access all of these and bring local challenges to experts with both State knowledge and national expertise for problem solving and consultation.
- Consultants, Trainings and Conferences. BHCA will draw from a range of national, State and local experts to provide consultation and trainings for member agencies relevant to operating in shifting behavioral health system including topics such as preparing for value-based payments, developing infrastructure for government funding beyond County MediCal/MHSA, the impact of the rules around specialty mental health rates, integrating new service provider classifications such as certified peer specialist and behavioral health coach into current service teams, and other best practices. Funding will also support BHCA staff attending national conferences of the National Council on Mental Well-Being and Open Minds Institutes for exposure to best practices and networking with others grappling with similar challenges.

Budget			**Comments**
Year One			
Policy Associate .5 FTE	$54,080		Includes Benefits
Open Minds Membership	$10,000		
Consultants/Training/Conferences	$16,000		
Total Cost	**$80,080**		
Year Two			
Policy Associate .5 FTE	$54,080		Includes Benefits
Open Minds Membership	$10,000		
Consultants/Training/Conferences	$16,000		
Total Costs	**$80,080**		
Two-year Total	**$160,160**		

Responses to SCFHP's Questions Regarding the Proposal for BHCA
11/12/21

Please share how the changing landscape/rules/grants will affect Medi-Cal managed care.

The changing landscape will upend Medi-Cal Managed care as we know it. Payment structure, documentation requirements, and what is incentivized is being dramatically revised which will result in providers having to redo entire business models, change systems and retrain staff. New funding through schools and health plans will introduce new complexities in remaining in compliance with Medicaid regulations and new funders' requirements (such as determining how to provide services when Medi-Cal requires that they pay the lowest rate for comparable services). It is currently unclear how comparable services are defined and whether intensity of is a factor. Those agencies that are unable to adjust to new parameters will no longer be able to provide and bill for Medi-Cal services.

Sustainability. Is this .5 FTE just for two years, then the staff person will be let go?

This person will be hired with a 2 year contract. Given all the expected changes, it is impossible to determine our needs this far in advance. For example, most of the Cal AIM changes will be developed within the next two years. We will reassess the situation and determine what is needed at that time.

Metrics. How many people will go through trainings? How many organizations will go through trainings? How many people/organizations will participate in conferences? How/why are these numbers different than if there were not this funding (e.g., wouldn't individual organizations pay for their staff to attend a conference, or participate in a training?)

As a member-based organization, BHCA currently supports 32 member agencies. Our experience is that when we provide trainings we have very high participation. Most agencies send at least one representative, with many agencies sending multiple representatives. For that reason we estimate that every training will have between 40 and 48 attendees. Highly specialized trainings, such as those appropriate to one profession such as CFOs, may have fewer. Conferences would only be attended by BHCA staff, at most 2 people per event. There are two major conferences (the national conference of the National Council for Mental Wellness and the Open Minds Conference)and we anticipate 2-3 additional conferences focused on specific aspects of the changing landscape. BHCA will continue to participate in convenings with our State association using already budgeted funding. While some BHCA members are also members of the State association and the National Council, and pay their own costs for attending these conferences, many agencies are not, and so cannot avail themselves of the learnings without BHCA acting as the information intermediary. In regard to the training sponsored by BHCA, our association does not have the infrastructure to organize registrations and process individual payments. Smaller organizations would be unlikely to have the resources to attend these types of training as most agencies focus their training budgets on line staff directly serving clients. As a result many smaller, community specific agencies targeting historically underserved populations would seek local, low cost trainings like we hope to provide while passing on the more expensive, larger trainings.

Outcomes reporting expected. What changes were made as a result of utilizing the resources? How many grants were applied for? How many affected MCAL managed care members were served? How did the organization's/members' organization increase in capacity—provider, type, competency?

We anticipate that agencies will be able to re-tool their business plans in order to survive in the new environment. Contract providers represent seventy (70%) percent of the public behavioral health system in Santa Clara County. The County Behavioral Health Services Department estimates the public system serves 35,000 clients. This includes those served by County staff. Our estimate is that BHCA providers serve about 24,000 with funding from the Behavioral Health Services Department. If agencies are able to make this transition and enter into new structured contracts, our County's safety-net system of care will remain intact. Without support, those agencies unable to make the transition won't be able to continue to provide these essential services. This will have a profound impact not only on those they serve, but will be incredibly destabilizing to the public behavioral health system. With this support agencies will be able to adapt to the incredibly rapidly changing public behavioral health environment, adapting to the changes under CalAIM, and modifying models and practices to utilize new funding streams to provide vitally needed services that complement specialty behavioral health care.

All training attendees will complete evaluation surveys for each training and members will be surveyed on the utility of the information being disseminated on an on-going basis. This will be used both as reporting data but also for continual improvement of training and information dissemination. BHCA will survey members to identify how many of the new State funding opportunities they are able to apply for and elicit feedback on what impact BHCA's expanded capacity had on them.

BHCA will gather data from member agencies and highlight the impact on clients being served in both MediCal managed care and other systems as changes are evolving.
If BHCA doesn't have additional capacity to act as the conduit of information and support for its members on these unprecedented changes, the consequences will be highly problematic. A few larger agencies may have the staff and infrastructure to participate in State and regional level discussions, allowing them to stay abreast of the significant changes required. However, many agencies, particularly the smaller and ethnic specific agencies, do not have the bandwidth to participate in this same way, and they may get left behind, unable to accommodate the timely changes required. But it is not just the smaller,ethnic serving organizations whose viability is at risk. There is concern that large for-profit companies may be looking to enter the public behavioral health system, as they have in other states. Colleagues in other states have experienced these entities being profit driven, rather than mission and service driven, and they certainly aren't as familiar with the diverse communities of Santa Clara County as the BHCA agencies who have been embedded within our communities for many decades.

Regular Meeting of the

Santa Clara County Health Authority
Compliance Committee

Thursday, November 18, 2021, 2:00 PM – 3:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Tyler Haskell, Interim Compliance Officer
Sue Murphy, Board Member
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, chief Information Officer
Christine Tomcala, Chief Executive Officer
Chris Turner, Chief Operations Officer
Ngoc Bui-Tong, VP, Strategies and Analytics
Laura Watkins, VP, Marketing and Enrollment

Members Absent
Teresa Chapman, VP, Human Resources

Staff Present
Chelsea Byom, Director, Marketing and Communications
Barbara Granieri, Controller
Alexandra Gutierrez, Compliance Coordinator
Mai-Phuong Nguyen, Oversight Manager
Daniel Quan, Manager, Medicare Compliance
Alejandro Rodriquez, Compliance Analyst
Megha Shah, Compliance Analyst
Anna Vuong, Manager, Medi-Cal Compliance
Sue Won, Compliance Audit Program Manager
Alicia Zhao, Audit Program Manager
Rita Zambrano, Executive Assistant

1. Roll Call

Sue Murphy, Chair, Called the meeting to order at 2:00 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The meeting minutes of the August 26, 2021 Compliance Committee were reviewed.

It was moved, seconded, and the August 26, 2021 Compliance Committee minutes were **unanimously approved.**

Moved:	Mr. Haskell
Second:	Mr. Jarecki
Ayes:	Ms. Bui-Tong, Mr. Haskell, Mr. Jarecki, Ms. Murphy, Dr. Nakahira, Mr. Tamayo, Ms. Tomcala, Ms. Turner, Ms. Watkins
Absent:	Ms. Chapman

4. Oversight Activity Report

a. Tyler Haskell, Interim Compliance Officer, informed the Committee about a recent administrative penalty assessed against SCFHP by the Department of Managed Health Care (DMHC) relating to two deficiencies in the 2017 Timely Access and Network Adequacy Compliance Report. He discussed the recently-begun Compliance Program Effectiveness audit required annually by CMS, and the outcome of no finding relating

to a recent self-disclosure the Plan made to CMS about a technology issue that was preventing care coordination faxes from being sent to providers. Neal Jarecki, CFO, discussed an upcoming DMHC audit that will cover finance, claims, and pharmacy benefit management.

b. Daniel Quan, Compliance Director, provided an update of our internal compliance monitoring dashboard, for which we are currently meeting our targets 93.3% of the time on a fiscal year-to-date basis. Mr. Quan reported that three oversight audits are in the planning stage (Carenet, Arvato, and Human Resources), while three were recently completed (CHDP Gateway, Enrollment & Eligibility, and Production Services).

5. Fraud, Waste, and Abuse Report

Mai-Phuong Nguyen, Oversight Manager, provided an update on fraud, waste, and abuse (FWA) program activities and presented a year-to-date summary of cases. Compliance received 38 FWA leads, mostly from the Grievances and Appeals and Health Services teams, resulting from their reviews of unusual prior authorization activity. Other common sources are members alleging services not rendered. Through FWA activity, Compliance has recouped approximately $20,000 in 2021.

6. Compliance Policy

Mr. Haskell presented the annual review of the Compliance Program, Standards of Conduct, and Compliance policies and procedures. He stated that the only substantive edits were made to the Standards of Conduct in the section pertaining to gifts, which was changed to align with State Form 700 requirements. This section may be further updated at a future Compliance Committee meeting.

It was moved, seconded, and the Compliance Program, Standards of Conduct, and CP.07, CP.10, CP.12, CP.15, CP.17, DE.04, DE.05, and DE.12 Policies were **unanimously approved.**

Motion:	Mr. Haskell
Second:	Mr. Jarecki
Ayes:	Ms. Bui-Tong, Mr. Haskell, Mr. Jarecki, Ms. Murphy, Dr. Nakahira, Mr. Tamayo, Ms. Tomcala, Ms. Turner, Ms. Watkins
Absent:	Ms. Chapman

7. Adjournment

The meeting was adjourned at 3:00pm.

_____

Sue Murphy, Chair

SANTA CLARA COUNTY HEALTH AUTHORITY
d/b/a
SANTA CLARA FAMILY HEALTH PLAN

Compliance Program
2021

Governing Board approval date: December 17, 2020

Compliance Program Overview

Santa Clara County Health Authority d/b/a Santa Clara Family Health Plan ("SCFHP" or "Plan") has developed this Compliance Program to provide guidance and ensure its activities as a Medi-Cal and a Cal MediConnect Managed Care Plan are conducted in an ethical and legal manner, in accordance with the 3-way Contract between the United States Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and the Plan; the Plan's Medi-Cal contract with DHCS; the Plan's Standards of Conduct and policies and procedures; and with applicable State and Federal law and regulations. The Compliance Program includes seven core elements and focus on the following areas: oversight of first tier, downstream and related entities (FDRs), and fraud, waste and abuse (FWA) prevention, detection and correction principles. These elements serve as the directional basis and source of guidance for development of operational and oversight policies and procedures for all Plan lines of business. This Compliance Program also articulates the framework and guiding principles for how the Plan will effectively ensure its compliance with applicable program requirements. The Compliance Program reflects the Plan's commitment to compliance with all applicable program requirements, including all applicable Federal and State standards. It is updated annually, and as appropriate from time-to time, and such updates are reviewed, approved and adopted by the Plan's Compliance Committee and Governing Board ("Board").

The Compliance Program described herein governs the activities of the Plan's employees (including temporary staff), contractors and volunteers, as well as Board and Committee members, collectively referred to as "Personnel."

The Compliance Program also applies to any subcontractors, vendors, agents or entities otherwise defined as FDRs under the Centers for Medicare & Medicaid Services (CMS) regulations and guidance, to whom Plan has delegated administrative or health care service functions relating to the Plan's 3-Way contract, and their employees (including temporary staff) and contractors who provide health and/or administrative services in connection with Plan's Cal Medi-Connect plan or that relate to Plan's Medicare functions.

The information contained in this Compliance Program is effective as of the date of approval by the Board.

Element I: Written Policies and Procedures and Standards of Conduct

SCFHP's Standards of Conduct is a policy and reference guide that describes the Plan's Standards of Conduct and Code of Ethics, including by way of practical application of the organization's core values and cultural attributes. This document sets forth the expectation of employees to report instances of potential non-compliance and Fraud Waste and Abuse ("FWA"). The Standards of Conduct, together with Plan's policies and procedures, are accessible to all employees within a shared location and demonstrate the Plan's commitment to comply with all applicable Federal and State laws and regulations. It is the Plan Leadership's expectation that all Personnel and FDRs shall adhere to the Plan's Standards of Conduct and policies and procedures, as well as applicable law, in the course of performing their duties on behalf of the Plan and its enrolled beneficiaries. This expectation is promoted through communications and training, and enforced through disciplinary, contractual and other standards.

The Standards of Conduct emphasize the need to maintain a high ethical standard for individual and organizational behavior and legal business practices. In addition, the Standards of Conduct and our policies and procedures provide practical guidance for Personnel and FDRs for effectuating compliance with law and promoting ethical and business practices in their daily roles. In doing so, the Standards of Conduct and our policies and procedures support the Plan's FWA prevention, detection and correction efforts, including but not limited to :

- Federal and state False Claims Acts;
- Federal and state Anti-Kickback Statutes;
- Health Insurance Portability and Accountability Act of 1996, as amended;
- Prohibition on inducements to beneficiaries; and
- Plan Conflict of Interest rules.

The Standards of Conduct, as well as SCFHP's policies and procedures, also describes the process that any and all Personnel and FDRs (and their employees) are expected to use to report possible compliance and FWA issues to management, or anonymously using the Plan's free hotline, and includes a statement of non-intimidation and non-retaliation for good faith participation in the Compliance Program. Disciplinary actions, such as suspension or termination of employment, termination of contractual relationship or removal from office or Board membership may be taken for failure to comply with the Standards of Conduct. Reported issues are investigated and resolved in accordance with Plan's established policies and procedures.

FDRs to whom Plan has delegated administrative or health care service functions relating to the Plan's Three-way contract may either adopt the Plan's policies and procedures (as relevant to delegated functions) and Standards of Conduct (as provided upon contracting and annually thereafter) or implement their own policies, procedures, and/or standards of conduct consistent with Plan's and in full compliance with DHCS, DMHC and CMS requirements. FDRs shall distribute such Standards of Conduct and/or policies and procedures to their employees upon hire, appointment or contracting, at any time material revisions are made, and annually thereafter. The FDR's compliance program, policies, procedures and standards of conduct are subject to review upon audit by the Plan.

The Standards of Conduct is presented to Personnel at the time of hire, appointment or contracting and any time material revisions are made. All Personnel must attest that they have read and agree to comply with the Standards of Conduct and guidelines. Such attestations are kept with the employee or other individual's record. Attestations of FDRs and their employees concerning receipt of the relevant materials are maintained by the FDRs and can be audited by the Plan at any time.

In addition to the Standards of Conduct, Plan has issued and implemented policies and procedures that are detailed and specific, and describe the operation of the Compliance Program. Compliance policies and procedures are reviewed and updated as necessary, but no less than annually, to incorporate any relevant changes in applicable laws, regulations and other program requirements. Proposed revisions are developed under the direction of the Chief Compliance Officer, referred to the Compliance Committee for review and approval, and reported to the Board.

Element II: Compliance Officer, Compliance Committee and High Level Oversight

The success of the Compliance Program is the responsibility of many individuals within the Plan. The Chief Compliance Officer, Senior Management, the Compliance Committee and the Board all play an important role in the implementation and success of the Compliance Program. As used in this Compliance Program, the phrase "Senior Management" refers to the Chief Executive Officer, the Chief Operating Officer, the Chief Financial Officer, the Chief Medical Officer, the Chief Information Officer, the Vice President of Human Resources, the Vice President of Marketing and Enrollment, and such other executive level staff as may join the organization.

The sections below serve to describe the responsibilities of the Chief Compliance Officer, Compliance Committee, the Board and Senior Management.

A. The **Chief Compliance Officer** (CCO) serves as the Compliance Officer (as the term is used within Chapters 9 and 21 of the Prescription Drug Benefit Manual and Medicare Managed Care Manual, respectively) and is an employee of, and reports directly to, the Plan's CEO and Board. The CCO has detailed involvement in, and familiarity with, the Plan's operational and compliance activities (but shall be independent from, and not have direct responsibility over program operations). The CCO is responsible for implementing the Compliance Program to define the program structure, educational requirements, reporting and compliant mechanisms, response and correction procedures, and compliance expectations of all Personnel and FDRs, in accordance with regulatory requirements.. The CCO is also a member of Senior Management and has direct access to the Plan's Chief Executive Officer (CEO) and the Board, and is provided with sufficient resources and authority to effectively carry out his or her duties.

The CCO shall have the authority to:

- Provide periodic written and/or in-person reports (as appropriate) directly to the Governing Board;
- Interview or delegate the responsibility to interview Plan employees and other relevant individuals;
- Review and retain company contracts and other documents pertinent to the Medi-Cal and Cal MediConnect programs;
- Review or delegate the responsibility to review the submission of data to CMS and DHCS to ensure that it is accurate and in compliance with their respective reporting requirements;
- Independently seek advice from legal counsel;
- Report misconduct and potential FWA to CMS, its designee and/or law enforcement;
- Conduct and direct audits and investigations of any first tier entities, downstream entities, or related entities;
- Conduct and/or direct audits of any area or function involved with Medi-Cal or Cal MediConnect plans (excluding those conducted under the purview of SCFHP's Executive/Finance Committee, such as external financial audits);
- Recommend policy, procedure and process changes;
- Enforce compliance program requirements at all levels of the Plan organization.

The duties for which the CCO is responsible include, but are not limited to:

- Communicating regularly with and reporting to the Board, Senior Management and the Compliance Committee on the status of the Compliance Program, including issues identified, investigated and resolved;
- Developing, implementing, managing, and monitoring the effectiveness of the Compliance Program and ensuring that the Board and Senior Management are aware of performance metrics and potential issues and their potential solutions;
- Identification and resolution of potential or actual instances of noncompliance or FWA;
- Creating, coordinating, and/or participating in educational training programs to ensure Personnel and FDRs are knowledgeable of Plan's Compliance Program, Standards of Conduct, operational and compliance policies and procedures, and applicable statutory, regulatory, and other program requirements;
- Monitoring Federal and State legal and regulatory developments (including but not limited to, Fraud Alerts and Advisory Opinions issued by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) and Health Plan Management Systems (HPMS) memos and updating the Compliance Program as appropriate);
- Developing, maintaining and promoting use of retribution-free methods and programs for reporting in good faith suspected Medicare program non-compliance, misconduct or potential FWA by Personnel, FDRs or others;
- Working with Human Resources to ensure that the Plan conducts appropriate background checks, including routine screening, against all required exclusion lists;
- Developing risk analyses that are used to focus Compliance Program efforts in a manner designed to promote overall effectiveness;
- Developing and monitoring the implementation of, and adherence to, compliance policies and procedures through the creation and implementation of a compliance work plan (Work Plan) that defines internal monitoring, audit requirements, schedule and methodology;
- Maintaining documentation and tracking of each report of potential non-compliance and FWA received through any of the reporting methodologies or as self-identified through monitoring, auditing or other means;
- Conducting self-evaluations of the Compliance Program to assess overall effectiveness and identify areas for improvement;
- Conducting (or evaluating information obtained from) exit interviews; and,
- Responding to reports of potential instances of FWA, including through coordination of internal investigations and the development of appropriate corrective or disciplinary actions, or referral to law enforcement, as necessary.

B. The **Compliance Committee** assists the Plan's Board in the oversight of the Compliance Program and is accountable to provide support and guidance necessary to the CCO in overseeing the outcomes and performance of activities initiated under the Compliance Program. The Compliance Committee,

through the CCO, shall periodically report directly to the Board on the activities and status of the Compliance Program, including issues identified, investigated, and resolved by the Compliance Program.

The Compliance Committee shall include individuals from a variety of backgrounds to support the CCO in implementing the Compliance Program. Such members shall have both decision-making authority and understanding of vulnerabilities within their areas of expertise. Members shall include representatives from areas including, but not necessarily limited to, finance, health plan operations (including enrollment, appeals and grievances, and customer service), medical management, pharmacy services, quality improvement, marketing and sales, information technology and legal counsel. The Compliance Committee is a Brown Act Committee. The CCO will act as the Compliance Committee chairperson.

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

The Committee has been delegated by the Board to uphold certain responsibilities, including but not limited to:

- Meeting on a quarterly basis, or more frequently as necessary, to enable reasonable oversight of the Compliance Program;
- Development, implementation and annual review and approval of compliance policies;
- Reviewing and approving relevant compliance documents, including but not limited to:
    - CCO's performance goals;
    - Compliance and FWA training;
    - Compliance risk assessment;
    - Compliance and FWA monitoring and auditing Work Plan and audit results; and
    - Corrective action plans resulting from audits or other means of identification (and monitoring of their effectiveness);
- Developing strategies to promote compliance and the detection of any potential compliance violations, especially as they relate to core beneficiary protection issues such as, but not limited to, appeals and grievances, enrollment, transition, coverage determinations and exceptions;
- Reviewing effectiveness of the system of internal controls, such as dashboards, scorecards, self-assessment tools, etc. designed to reveal compliance issues or FWA issues, and metrics concerning operational compliance with key Medicare regulatory requirements, such as, but not limited to, those governing enrollment, appeals and grievances, and prescription drug benefit administration; and
- Ensuring that SCFHP has an easy to use system for employees and FDRs to ask compliance questions and report potential instances of noncompliance and potential FWA confidentially or anonymously (if desired) without fear of retaliation

The Compliance Committee will collect and review measurable evidence (using tools such as dashboards reports, scorecards and key performance indicators) concerning Compliance Program

performance as a concrete means of measuring/demonstrating the extent to which the Compliance Program is detecting and correcting noncompliance and FWA on a timely basis, and providing insights into any potential needed process improvements. The CCO will provide the Compliance Committee with data showing the status of organizational compliance through:

- Use of monitoring tools to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, Warning Letters, CMS sanctions, marketing material approval rates, training completion/pass rates, results of CMS readiness checklist review, past performance review metrics, etc.;
- Implementation of new or updated Medicare program requirements (*e.g.*, tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation;
- Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, or beneficiaries through customer service calls or the Complaint Tracking Module (CTM), including those relating to alleged marketing misrepresentations, etc.;
- Timely response to reported instances of potential noncompliance and FWA (including issues raised by CMS), and effective resolution (*i.e.*, non-recurring issues);
- Application of consistent, timely and appropriate disciplinary action; and
- Detection of noncompliance and FWA issues through monitoring and auditing:
    - Whether root cause was determined and corrective action appropriately and timely implemented and tested for effectiveness;
    - Detection of FWA trends and schemes via, for instance, daily claims reviews, outlier reports, pharmacy audits, etc.; and
    - Actions taken in response to non-compliance or FWA reports submitted by FDRs.

C. The governing body providing appropriate oversight of the Compliance Program is SCFHP's Board. The Board reviews and approves the Compliance Program and subsequent updates as revisions are made. As mentioned previously, the Board has delegated certain responsibilities to the Compliance Committee, but the Board as a whole remains accountable for Compliance Program oversight.

In addition to the above, the duties for which the Board is responsible include, but are not limited to, active oversight of the effectiveness of the Compliance Program and compliance results as follows:

- Understanding the Compliance Program structure, content and operation (including through appropriate training that educates Board Members regarding the Compliance Program operations, compliance risks and strategies and methods of gauging Compliance Program effectiveness);
- Evaluation of SCFHP's Senior Management team's commitment to ethics and the Compliance Program;
- Reviewing, understanding and questioning information provided within reports presented to them, including by the CCO, at least quarterly, on the activities of the Compliance Program. Such activities include, but are not limited to, actively considering:

  - Compliance Program outcomes (such as results of internal and external audits);
  - The effectiveness of corrective action plans implemented in response to identified issues;
  - Governmental compliance enforcement activity, such as Notices of Non-Compliance, Warning Letters, Corrective Action Plan requests, contract actions and/or other sanctions;
  - Reports of potential noncompliance and/or FWA issues identified, investigated, and resolved;
  - Identified risks and mitigation performed; and
  - The results of performance and effectiveness assessments (including self-assessments) of the Compliance Program;
- Conducting follow-up on issues and taking appropriate action when necessary; and
- Approval of Standards of Conduct and Compliance Program (and modifications thereto).

The Board shall document in meeting minutes and related records its active engagement in the oversight of the Compliance Program and include documentation of the Board's discussion, follow-up on issues and actions taken in response and to ensure an effective Compliance Program.

D. Senior Management

The CCO shall provide SCFHP's CEO with periodic reports of risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies. The CCO shall notify the CEO and the Senior Management team, as appropriate, of all governmental compliance enforcement activity, including the issuance of Notices of Non-compliance, Warning Letters, Corrective Action Plan requests, and contract actions and/or other sanctions, and seek consultation and assistance regarding how best to respond to and address the same.

Element III: Effective Training and Education

A. General Compliance Training

SCFHP provides a comprehensive education and training program to ensure communication and understanding of the Compliance Program and SCFHP's Standards of Conduct and Compliance policies and procedures. The education, training and communication program is designed to ensure that all Personnel (including without limitation the CEO, Senior Management and Board members), and any other applicable individual acting on behalf of SCFHP in connection with its Medicare program(s), such as FDRs and their employees, are fully capable of carrying out their duties in compliance with the Compliance Program, Standards of Conduct and relevant policies and procedures. The education program includes general Compliance Program awareness training, and specific training and education tailored to individuals' roles and responsibilities, delivered by the Compliance Department or operational business units. For example, employees whose job primarily focuses on enrollment or claims would receive additional training in these areas.

Compliance Program education and training occurs within ninety (90) days of hire (or appointment to Board), and, at a minimum, annually thereafter. The education and training may be provided through a variety of teaching methods, including classroom study, computer-based training, and distance learning. Additional tools may be used to communicate the Compliance Program process, such as use of posters, written Compliance Program updates, internet and intranet resources, and topical newsletters and other publications. SCFHP shall document and/or maintain records of Personnel who complete the required Compliance Program education and training in a format that is easily accessible. SCFHP shall implement controls to ensure that all Personnel are trained, as required. SCFHP shall review and update the general Compliance Program training, as necessary, whenever there are material changes in statute, regulation or Medicare Part C or Part D program guidance, and at least annually.

B. FWA Training

SCFHP provides Personnel with standard FWA training within ninety (90) days of initial hiring (or appointment to the Board), and annually thereafter. SCFHP may require that particular individuals participate in specialized or refresher training on issues posing FWA or other risks relevant to the individual's particular job function. Training may be required, as appropriate, when the Plan's program requirements change, when an individual is found to be non-compliant or needs additional training, or when training is appropriate to address an identified organizational deficiency or with respect to an area where FWA was identified in the past or presents heightened risk.

C. First Tier, Downstream and Related Entity Training

SCFHP requires FDRs, to whom SCFHP has delegated administrative or health care service functions relating to SCFHP's regulatory contract(s), to conduct training that meets CMS training requirements and is consistent with SCFHP's training materials. SCFHP shall accept the

certificate of completion of the CMS Standardized General Compliance Program Training and Education Module as satisfaction of the training requirement.

Any FDR that has met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier is deemed to have met, and fully satisfied, SCFHP's training and educational requirements related to FWA. In such context, no additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or FDR or employee of an FDR has met SCFHP's FWA training requirements. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed. Such deemed individuals must, however, participate in the CMS general Medicare compliance training. FDRs that do not qualify for deeming status must take both the General Compliance and the FWA training programs offered by CMS.

Element IV: Effective Lines of Communication

SCFHP has established numerous mechanisms to ensure effective lines of communication exist between the CCO, members of the Compliance Committee, Personnel (including the Board) and SCFHP's FDRs (and their employees).

For instances, in order to facilitate communication among all Personnel, FDRs and the CCO, SCFHP offers a phone hotline, available 24 hours a day, 7 days a week, which can be used anonymously if preferred, through which an individual may seek guidance or disclose information about potential compliance or FWA issues. Through Compliance Program activities, Personnel and FDRs are encouraged to ask compliance and FWA related questions through various means, such as direct contact with the CCO, in order to assist such individuals in evaluating and dealing with suspected, detected or reported compliance or FWA issues. The CCO shall treat all communications confidential. The CCO also communicates with Personnel, FDRs and enrollees concerning compliance and FWA issues through various educational mechanisms, as discussed more fully below.

A. Procedures for Reporting Noncompliant or Unethical Behavior

All Personnel and FDRs are required to report compliance concerns and suspected or actual violations related to SCFHP's programs to SCFHP. The reporting process set forth in this Compliance Program, as well as CCO name and contact information, is communicated to Personnel and FDRs and their employees through various means, including general Compliance Program training. An individual may confidentially report compliance and FWA concerns in multiple ways, at their option, including: 1) directly to his/her supervisor or manager (as applicable), 2) to SCFHP's CCO, or 3) anonymously using SCFHP's toll-free phone hotline reporting tool (available 24/7). SCFHP's non-intimidation and non-retaliation policy provides the individual who makes a report, complaint, or inquiry in good faith with protection from retaliatory action, including with respect to reporting of False Claims Act complaints and/or reporting to appropriate officials. SCFHP has a no tolerance policy for intimidation of, or retaliation taken against, individuals making such good faith reports, complaints or inquiries and shall take disciplinary action against individuals who are determined to have intimidated or retaliated against such individuals.

SCFHP recognizes that enrollees, contracted providers and FDRs are important sources for identifying potential non-compliance and/or FWA. SCFHP widely publicizes the methods by which individuals and entities outside the SCFHP organization can report possible instances of fraud, waste, abuse or non-compliance to the organization and can ask questions, including through the hotline (which is accessible to all).

Hotline information is provided to enrollees through the quarterly enrollee newsletter FDRs receive quarterly informational bulletins containing, as a standing item, hotline availability and reasons for use (including for compliance questions). The CCO's contact information is also always contained within these materials. SCFHP customer service representatives, who intake

calls from both enrollees and FDRs, including providers, have also been trained to recognize potential instances of non-compliance or FWA, and to properly memorialize and direct issues within the Plans Sponsor organization for appropriate follow-up by the CCO or others.

B. Education

The CCO engages in active communication with Personnel, FDRs and enrollees concerning a wide range of compliance issues, including the standards for compliance with laws, regulation and guidance; changes in legal authorities and/or compliance policies and procedures; and guidance on how to identify and report FWA issues. Such communication is accomplished through various educational means, including through newsletters and posters, SCFHP Websites, formal training, and individual and group meetings.

C. Follow-Up and Tracking

Once received, issues of potential non-compliance or FWA will be documented and forwarded to the CCO and/or his or her designee for investigation/resolution and reporting to the Compliance Committee and the applicable State and/or Federal agency, or law enforcement, as required.

D. Integrated Communications

To enhance SCFHP's day-to-day communication, understanding and focus on its actual compliance, and to ensure that potential compliance and FWA issues are examined early and corrective actions are implemented timely, each department maintains a set of compliance "dashboard" metrics that are routinely shared with the CCO. These dashboard results are i) reported to department staff to increase their attention to compliance, and ii) reported to the CCO for monitoring and auditing activities (such as trend analysis and identification of anomalies), and to provide status of any corrective actions undertaken and implemented (including barriers to implementation). Reports on these and other compliance activities will be routinely reviewed by Senior Management and reported to the Compliance Committee and the Board at each meeting, as appropriate.

Element V: Well-Publicized Disciplinary Standards

Compliance training, in its various forms (*e.g.* mandatory formal training, newsletters, websites and posters), demonstrates practical application of the Standards of Conduct. These training programs provide instruction regarding various regulations and laws pertinent to our business, as well as "Questions and Answers" that describe the expectation that SCFHP has of Personnel when confronted with certain situations, including appropriate reporting and the duty to assist in issues resolution. These programs set forth the expectation by SCFHP of Personnel and FDRs and their employees to report illegal or unethical behavior and potential compliance and/or FWA issues, as well as to assist in their resolution. They also encourage Personnel to contact the CCO or others if they have questions concerning potential compliance or FWA issues.

In various communications, SCFHP explains the ramifications faced by SCFHP for non-compliance with regulations and laws affecting its business, as well as disciplinary action to be taken against individual(s) or entities who have either committed a crime and/or participated in or knew about potential non-compliance, unethical behavior and/or FWA, but failed to report it to SCFHP. *Disciplinary action will be assessed based on the infraction and could range from retraining of the individual/entity, up to termination of employment/Board membership/contract.*

Enforcement of the standards will be timely, consistent and effective when non-compliance or unethical behavior (such as fraud) is determined. As set forth in Element IV, Part A, employees have an affirmative obligation to identify non-compliance and unethical behaviors, and failure to meet this obligation will result in appropriate action according to the disciplinary standards. Records of enforcement of standards will be maintained for ten years for all disciplinary actions based on compliance violations or FWA (or the failure to report the same), and such records will capture the date the violation was reported, a description of the violation, the date(s) of investigation, a summary of findings, the disciplinary action taken and the date it was taken. SCFHP may, from time-to time, review such records to ensure that discipline is appropriate to the seriousness of the offense, fairly and consistently applied, and imposed within a reasonable time frame after the infraction and/or discovery of such.

Finally, compliance is a measurement on SCFHP's annual employee performance evaluation to reinforce the importance that compliance plays in each individual's role within the organization. Issues of non-compliance will be considered by SCFHP in connection with whether to renew or continue any particular arrangement with an FDR.

Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks and FWA

SCFHP will establish and implement an effective system for identification of non-compliance or unethical behavior (such as activities involving fraud and abuse) and evaluation of the Compliance Program through risk analysis, engagement in monitoring and auditing activities and review of reported issues (including any issues identified by CMS). The system will include, among other things, routine and targeted internal monitoring and auditing of operational areas and auditing and monitoring of FDRs. SCFHP may from time-to-time engage external auditors to assist with focused review of particular areas where it deems such appropriate (*e.g.*, because of expertise required or resource limitations).

Multiple methods will be employed to facilitate monitoring and auditing of operational areas in a focused and efficient manner, including without limitation conducting risk assessments, developing annual Work Plans, engaging in on-site audits or desk reviews, conducting monitoring, including through periodic reports, and analyzing and responding to such monitoring and auditing results.

A. Risk Assessment

SCFHP will regularly conduct a risk assessment of all business operational areas, and those of FDRs to whom SCFHP has delegated functions under its regulatory contract(s). Each operational area (including those delegated to FDRs) will be assessed for the types and levels of risks the area presents to the Medi-Cal and CMC programs, to SCFHP and to its Medicare-Medi-Cal beneficiaries, paying close attention to those areas CMS considers high risk, such as but not limited to:

- enrollment and disenrollment non-compliance;
- appeals and grievances;
- benefit and formulary administration;
- credentialing;
- quality assessment;
- organization determinations;
- coverage determinations;
- transition and protected class policy;
- utilization management;
- accuracy of claims processing;
- previously identified areas of vulnerability for potentially fraudulent claims;
- outbound enrollment verification calls;
- marketing and enrollment violations, agent/broker misrepresentation, and selective marketing; and
- FDR oversight and monitoring.

In addition, SCFHP's risk assessment(s) will take into account information received from the OIG's annual work plan and Medicare Managed Care Manual and Medicare Prescription Drug

Benefit Manual chapter guidance updates, as well as other CMS program guidance, Fraud Alerts, CMS audits and other CMS indicators regarding plan performance (such as Warning Letter, Deficiency Notices, audit results, etc.). The risk assessment will expressly take into account CMS guidance provided concerning its prior year audits findings and any recent interim sanction or civil monetary penalties assessed by the agency, as well as DHCS Policy, All Plan and Dual Plan Letters, and DHCS and DMHC audit findings. The CCO will rank those risks identified during this process in order to identify those areas presenting the greatest potential risk to SCFHP. Risks identified through CMS audits and oversight, as well as SCFHP's own monitoring, auditing and investigations, will be considered priority items in the overall risk analysis. The CCO will develop the proposed annual Work Plan in consultation with the Compliance Committee and/or departmental staff as appropriate, taking into account the results of the risk assessment.

B. Annual Monitoring and Auditing Work Plan

An annual Work Plan, based on the results of the risk assessment, will be developed and brought to the Compliance Committee for review, input and approval. The Work Plan will include the audits to be performed (both of SCFHP and FDRs), the audit schedule, methodology to be used, if it is to be performed desktop and/or onsite, and the responsible party for performing the audit, as well as specify routine monitoring to be conducted. Such monitoring and auditing activities are designed to test controls and prevent, detect and correct compliance issues and FWA through verification of compliance standards and adherence to State and Federal laws, contractual requirements, Medicare regulatory requirements, Part C and Part D program instruction, SCFHP Compliance Program policy and procedures, and Standards of Conduct. During the course of the year, the CCO may propose modifications to the Work Plan to the Compliance Committee, as developments warrant (such as changes in law or identified compliance or FWA issues).

C. Audits

The Compliance Department, which is independent from the Plan’s daily operations, will perform, or will arrange for independent, external parties to perform, audits of SCFHP’s internal operations and FDRs. The CCO shall coordinate with auditors regarding audit design and related considerations, and receive regular reports from the auditors regarding audit status and results. Auditors will be directed to use a standard audit report format addressing audit objectives, scope and methodology, findings (including regarding condition, cause and effect), and recommendations. They will use care in selecting sample and sample size, based on whether a targeted or statistically valid sample is intended. Auditors shall be knowledgeable about CMS and DHCS operational requirements for the operational areas (whether internal or of FDRs) under review. Operations staff may assist auditors, as long as such assistance does not interfere with the auditors' independent review. Such assistance can take the form of gathering data for samples or providing other basic information to auditors. Auditors shall have access to relevant Personnel, records and areas of operation under review, including the operational departments at SCFHP, as well as FDR employees and operations. All Personnel and FDRs have a duty to cooperate with monitoring and auditing efforts directed by the CCO.

D. Monitoring

Routine operational metrics relative to regulatory standards and compliance measures will be maintained by the business units and the results reported to the CCO. Monitoring will also be conducted in each instance to determine whether corrective action plans are effective in addressing the compliance issue identified.

E. Analyzing and Responding to Monitoring and Auditing Results

Results of audits and monitoring, and any required root cause analyses and corrective action plans will be reported by the CCO (or his or her designee) to the Compliance Committee and, as appropriate, Senior Management (including the CEO) and/or the Board. Audit findings will also serve to identify Personnel, business units and/or FDRs requiring additional training (general or focused); the need for clarification or amendment of policies and/or procedures; the need for correction of system logic; and/or other necessary actions. The CCO shall be responsible for overseeing follow-up reviews of areas found to be non-compliant, as necessary, to determine if implemented corrective action has fully addressed the underlying problem identified. If applicable and appropriate, the CCO will consider whether to voluntarily self-report audit findings of non-compliance and/or potential fraud or misconduct related to the Plan's programs to CMS or its designee, such as the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), DHCS or DMHC.

F. Excluded Parties

SCFHP, in an effort to prevent FWA, shall screen Personnel against United States Department of Health & Human Services' (DHHS) OIG List of Excluded Individuals and Entities and the General Services Administration's (GSA) Excluded Parties Lists System, prior to hiring or contracting and monthly thereafter, to ensure that such individual or entity does not appear on such list(s) (*i.e.*, is not an excluded individual or entity). SCFHP also requires its FDRs to have a similar policy and audits accordingly to ensure compliance with such requirements.

G. Compliance Program Effectiveness

SCFHP is committed to a process of continual process improvement with respect to its Compliance Program. As such, SCFHP will conduct an annual audit of the effectiveness of the Compliance Program. After completion of a baseline compliance program effectiveness audit, such audit will be conducted by external auditors (or Personnel not part of the Compliance department). To assist in determining effectiveness, the Compliance Committee will annually evaluate whether activities under the Work Plan were completed in a timely and appropriate manner, actual performance of the CCO against performance goals (if relevant), CMS compliance assessments *(e.g.*, Warning Letters, Notices of Non-compliance, CAP requests, audits, sanctions), results of CMS readiness checklist assessment, and past performance review measurements as they relate to compliance. Results of this audit will be shared with the Compliance Committee, Senior Management and the Board. Either the CCO, Compliance Committee and/or the Board may recommend modifications, such as enhancing or increasing internal monitoring frequency in areas that have previous low threshold results or areas that have become the subject of increased

scrutiny (through regulation, audit or guidance), by state and/or federal regulatory agencies, including but not limited to CMS or the OIG.

Element VII: Procedures and System for Prompt Response to Compliance and FWA Issues

SCFHP has established and will maintain a process for assuring prompt response to reports or other identification of potential non-compliance and/or FWA, including timely investigation of potential problems, implementation of corrective actions to address past issues and mitigate future occurrences; appropriate self-reporting of fraud and misconduct, and processes to ensure appropriate action is taken with regard to identified overpayments.

A. Investigations of Compliance and FWA Issues

SCFHP will establish and implement procedures and a system for promptly responding to potential compliance and FWA issues as they are raised. Compliance or FWA problems identified in the course of self-evaluations, reports or complaints to the SCFHP, audits and/or other means and verified through investigation will be corrected promptly and thoroughly to address the issue, reduce the potential for recurrence, and promote ongoing compliance with CMS requirements. External legal counsel, auditing, and other expert resources may be engaged to provide additional services and guidance, as applicable. SCFHP will immediately cease, or instruct its FDR to immediately cease, questionable practices upon knowledge or clear indication of a violation. In addition:

- SCFHP will conduct a timely, reasonable inquiry into any evidence of misconduct related to a payment or delivery of items or services under the contract with CMS and/or DHCS (with such inquiry initiated within 2 weeks after the date the potential non-compliance or FWA incident is identified);
- SCFHP will conduct appropriate corrective actions (for example, repayment of overpayments and/or disciplinary actions against responsible individuals) in response to the potential violations referenced above; and,
- SCFHP will have procedures to consider whether to voluntarily self-report fraud or misconduct related to the Plan's programs to CMS or its designee (such as NBI MEDIC), DHCS and DMHC in appropriate situations, consistent with guidelines and time frames.

SCFHP and its Pharmacy Benefit Manager (PBM) shall monitor Fraud Alerts and will review its contractual agreements (or direct the PBM to review contractual agreements) with the identified parties, as appropriate, to determine whether any additional action should be taken. SCFHP and/or its PBM will review past paid claims from the identified entities to determine if there are any claims that it may have paid that were not payable (*e.g.*, related to an Excluded Individual) and should be removed for prior sets of prescription drug event drug submissions.

Responses to detected offenses will vary according to the offense and circumstance; however the response will always be in accordance with requirements of regulation and law. The CCO shall maintain a record of reported issues, including documentation of the status, investigation, finding and resolution of each issue. This information shall be reported to the Compliance Committee regularly.

Any determination that potential FWA related to the Plan's programs has occurred will be referred to the appropriate regulatory agency, as appropriate, for further investigation after the determination that a violation may have occurred. SCFHP will, as appropriate, provide information timely in response to follow-up requests for information.

B. Corrective Action Plans (CAPs)

Corrective action plans will be implemented whenever it is determined by the CCO and the Compliance Committee that any Personnel, FDRs or their employees have engaged in an activity that violated SCFHP policies and procedures, federal or state laws or regulations or CMS contractual or other requirements. These corrective action plans will be in writing and developed based on a root cause analysis conducted in response to any wrongful activity discovered by way of investigation resulting from any report, complaint, and/or internal or external audit or monitoring efforts, or as identified by CMS. Through the root cause analysis, SCFHP will undertake to determine what caused or allowed the non-compliance or FWA to occur so that an appropriate and effective remedy can be developed.

The goal of any CAP implemented is to remedy underlying issues and prevent future recurrence. Each CAP will be tailored to the particular misconduct identified and include specific time frames for completion. SCFHP will immediately cease any non-compliant practice upon knowledge or clear indication of a violation. When developing a corrective action plan to address non-compliance by an FDR, the elements of the corrective action plan, and the ramifications for non-compliance, will be included in a written CAP provided to the FDR. Corrective actions may include, for instance, disciplinary action against any Personnel; prompt identification and refund of any overpayment to the government or any enrollee; and/or suspension or termination of any FDR contract (or delegated functions thereunder).

CAPs will be monitored to ensure the required remediation has been carried out, and is sustained over time. All corrective action plans recommended, in progress, and implemented, along with results of ongoing monitoring will be documented and reported at least quarterly to the Compliance Committee and to the Board.

C. Government Investigations

SCFHP's policy is to be forthright and cooperative when dealing with government investigations, inquiries, or requests for information. Any Personnel or FDR made aware of a government investigation, inquiry or request for information is required to notify the CCO and/or Compliance Department immediately to ensure prompt response to the request(s).

Appendix A
Fraud, Waste and Abuse (FWA)
(Measures for Prevention, Detection and Correction)

SCFHP employs multiple measures to prevent, detect and correct potential instances of FWA. Many of these measures are outlined in the Compliance Program, including, for instance:

- Communicating standards of individual and organizational ethical and legal business practices in the,including compliance with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse;
- Educating Personnel and FDRs about FWA issues through appropriate training and the sharing of educational materials;
- Communicating to all (including FDRs and enrollees) the availability of an anonymous compliance hotline for potential FWA issue reporting and asking fraud related questions;
- Engaging in monitoring and auditing of Part C and Part D operations, based on risk analyses conducted that expressly consider FWA concerns;
- Engaging in timely and vigorous investigation of suspected FWA, in whatever manner reported to SCFHP;
- Responding to identified FWA, including as appropriate, by reporting to the MEDIC and/or returning identified overpayments and making adjustments to prescription drug event or other claims payment data.

SCFHP actively engages FDRs to assist in its FWA prevention, detection and correction efforts. Thus, for instance, FDRs perform compliance and FWA related activities on SCFHP's behalf, such as monitoring, auditing and training. SCFHP performs oversight of the FWA and compliance related activities of each FDR and has processes in place to revoke delegated functions in accordance with 42 C.F.R. § 42.422.504(i)(5) and42 C.F.R. § 423.505(i)(4) and its contractual rights if such functions are not being performed satisfactorily.

If identified instances of FWA are discovered, SCFHP, directly or through its FWA/SIU vendor, engages in vigorous investigation and will, as it determines appropriate, report to CMS, the MEDIC or other appropriate regulatory or law enforcement entities.

The purpose of this Appendix is to provide additional information concerning specific measures SCFHP will use to prevent, detect and correct FWA.

Targeted Efforts

A. Credentialing

SCFHP's credentialing program for contracted providers and pharmacies is comprehensive and includes elements that have both a direct and indirect effect on the quality, delivery, and outcome of health care provided to SCFHP’s members. SCFHP’s credentialing program is based on National Committee for Quality Assurance (NCQA) standards and in accordance with CMS requirements.

SCFHP has contracted with a PBM to provide pharmacy benefits to its members enrolled in the Plan. By contract, the PBM employs a similar, vigorous credentialing program for each pharmacy in

SCFHP's network, with each pharmacy needing to partake in the credentialing and re-credentialing process, performed at a minimum every three years, for participation, or continued participation, within the SCFHP's network.

B. Claims Adjudication

The Plan's claims are processed on a system using adjudication rules which employ FWA edits. Thus, for instance, such adjudication rules are designed to eliminate duplicate payments for services and make payment (or denial) of claims based on SCFHP eligibility rules, contracted provider pricing, referrals and authorizations and Correct Coding Initiative (CCI) edits. In addition, Local Coverage Determinations (LCDs) and national coverage determinations (NCDs) are also reviewed to ensure payment consistent with Medicare guidelines. Claims processes also ensure claims submitted, intentionally or unintentionally, by providers who have opted out of Medicare are not paid. Finally, certain check run controls are also in place to prevent inappropriate payments under Medicare or Medi-Cal.

Similarly, Part D has point of sale system edits that ensure appropriate authorizations are in place before dispensing and that prevent SCFHP from paying for prescriptions written by excluded prescribers.

C. Auditing and Data Analytics

SCFHP engages in auditing -- directly or through contracted entities -- pursuant to the terms of the annual compliance Work Plan. As part of its standing audit practice, SCFHP, by engagement of an external consultant and use of internal coding staff, performs Part C retrospective coding reviews annually. The reviewers substantiate the documentation of the Hierarchical Condition Categories (HCCs) supporting the Risk Adjustment Factors (RAF) scores submitted to CMS for member premium payment. SCFHP submits "additions" *and* "deletions" as appropriate dependent upon its ability to substantiate the HCCs within the audited documentation. In addition to ensuring accurate payment is received by the SCFHP ("adds"), and paid by CMS ("deletes"), these reviews can reveal potential fraudulent provider documentation practices and allow SCFHP to take corrective actions, as appropriate. It also allows SCFHP to identify providers who may need additional training regarding the appropriate provision of encounter data.

Where claims administration is delegated to an FDR, SCFHP audits the FDR annually for proof of data integrity, timeliness of claims payment, proper payment consistent with contractual and other requirements, and proper payment amounts.

Similarly, SCFHP has engaged its PBM to engage in analysis of pharmacy, prescribing provider, and beneficiary data to detect potentially defective claims. Such data analysis is a tool for identifying coverage and payment errors, and other indicators of potential FWA and non-compliance. To gather and analyze data to protect against FWA, on behalf of the SCFHP, the PBM, among other audits, performs retrospective (post-pay) audits. Standardized algorithms are applied to root out overpayments or erroneous payments to pharmacies. Through use of sophisticated modeling

techniques, auditors can identify patterns in the data that may indicate potential FWA that may not be readily apparent. Such data mining activities will focus on areas of concern identified by CMS in guidance and entities identified by the MEDIC, as well as known areas of potentially aberrant behavior or high incidence of fraud based on industry experience. SCFHP's PBM employs staff pharmacists, physicians and others (as appropriate) to engage in follow-up research and investigation of suspect claims.

Pharmacies within the SCFHP's network are also subject to desk top and/or onsite audit. Pharmacies can be chosen for a variety of reasons, such as aberrant claims patterns revealed through the modeling techniques noted above. Claim sample selection will focus on identifying claims and/or claims patterns that potentially deviate from the norm. SCFHP can designate particular pharmacies for in-depth audits, upon request.

If FWA is found through any of the auditing methodologies applied by the PBM, the SCFHP will receive a FWA alert and take appropriate follow-up action in a prompt manner.

In addition to PBM audits, SCFHP receives various reports daily, weekly and monthly from the PBM. The reports are reviewed promptly and on a routine basis by the SCFHP's Pharmacy Department. Review of these reports can reveal potential fraudulent activity requiring investigation and action. Examples of reports received and reviewed regularly include (but are not limited to): summaries of controlled substances claims per member; top 3% prescribers; prescriber dispensing patterns; and FWA reports, which include results of all claims adjusted or reversed during the quarter due to audit results.

Santa Clara Family Health Plan

Standards of Conduct

Approved by the Governing Board, ~~December 17, 2020~~TBD

40196

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Santa Clara County Health Authority dba Santa Clara Family Health Plan

Code of Ethics

Integrity is the cornerstone of Santa Clara Family Health Plan's (SCFHP) reputation and an important asset. We build and retain our integrity through the ethical behavior of every SCFHP employee and Governing Board member. To help strengthen the foundation, this code of ethics identifies and explains the key standards we strive to meet.

Personal and Professional Integrity

Each SCFHP employee and Governing Board member is expected to act in accordance with professional standards, as well as with honesty, integrity, openness, accountability, and a commitment to excellence. Each individual is expected to conduct SCFHP activities in accordance with this Standards of Conduct, exercising sound judgment to support SCFHP's mission and serving the best interests of SCFHP, its members and the community.

SCFHP promotes a working environment that values respect, fairness and integrity. We act in accordance with these values by treating our colleagues, members, and others with whom we interact with dignity, civility, and respect. Employees of SCFHP exercise responsibility appropriate to their position and delegated authorities. We strive for excellence in all of our activities and acknowledge that we are responsible to each other, to the health plan and it's Governing Board for our actions. We are each responsible for being aware of and complying with applicable professional standards that govern our conduct, including those that relate to our particular discipline.

Our conduct in the workplace

We recognize the diversity of fellow employees/co-workers, consultants, temps, job applicants, vendors, subcontractors, and other stakeholders. We refrain from harassment and discrimination based on gender, race, creed, color, national origin, and sexual orientation. We treat each other as we want to be treated – with fairness, honesty and respect.

Maintaining confidentiality and security

We honor the privacy of members' and employees/co-workers' personal information, whether medical or otherwise, just as we expect our privacy to be protected. We take appropriate precautions to protect the confidentiality and security of member, employees/co-workers and company information and transactions. We promise to protect confidential information, otherwise known as "intellectual property," that belongs to SCFHP. We refrain from divulging information that could be harmful to SCFHP or that could provide an advantage to our competitors.

Respecting company property and resources

We treat company property and resources respectfully while working at or serving SCFHP and after leaving. We protect and preserve company property and refrain from using it for personal gain. We understand that company property includes, but is not limited to, SCFHP's intellectual property, physical property and electronic communications systems.

Avoiding conflict of interest

SCFHP encourages employee participation in non-profit activities. However, representing oneself as an employee of SCFHP through associations or activities that might conflict or appear to conflict with SCFHP's interests is prohibited. We avoid doing business with competitors or other organizations that might conflict with the values at SCFHP. We do not accept material gifts from contractors or customers, or give gifts to them if doing so might compromise, or give the appearance of compromising, our business decisions. We do not take advantage of our association with SCFHP for personal gain.

Addressing health care resources

We strive to provide health care services, prescription drug coverage, products, and supports that are appropriate, efficient and cost effective. We apply proven evidence-based principles as we balance the needs of the many with the needs of the individual. We commit to working with providers and using our resources to continuously improve the health of our members and the community.

Obeying the law

We always uphold the law while working at or serving SCFHP. We commit to obeying all federal, state and local regulations with regard to our health plan and all our business units. We do not tolerate the use and/or abuse of illegal substances, discrimination, harassment, fraud, embezzlement or any other illegal activities.

Introduction

At Santa Clara Family Health Plan (SCFHP), business conduct is as important as business performance. Our behavior – both as individual employees (coworkers/employees, temporary employees, consultants, and contractors) and Governing Board members, and collectively as an organization – affects our success, shapes our reputation, and communicates our shared commitment to ethics, integrity and honesty.

Our Compliance Program guides us in making business decisions in alignment with the Plan's mission, vision, and values. One of the program's integral components is defining our expectations of each employee's personal conduct and workplace behavior. To communicate these expectations, we have developed this Standards of Conduct document.

This booklet is a quick reference guide on the standards of conduct that you must uphold as an SCFHP employee, Governing Board member or agent. It first introduces you to SCFHP's Code of Ethics, which includes:

1. Conduct in the workplace
2. Maintaining confidentiality and security
3. Respecting company property
4. Avoiding conflicts of interest
5. Addressing health care resources
6. Obeying the law.

These elements, which we refer to as our business conduct guidelines, define our standards of workplace behavior.

The information in this booklet focuses primarily on the code and guidelines. To expand your knowledge and understanding of expected behavior, we encourage you to review the Plan's policies and procedures. For more detailed information on how to comply with SCFHP's requirements for workplace conduct, refer to company-level and department-level policies and procedures and/or talk to your supervisor or Human Resources representative.

Our reputation for integrity is an invaluable long-term advantage. Fostering an ethical work environment that enhances SCFHP's reputation should be your call to action – your personal pledge to maintain the highest ethical standards as an SCFHP employee.

Our conduct in the workplace

"We recognize the diversity of fellow employees/co-workers, consultants, temps, job applicants, vendors, subcontractors, and other stakeholders. We refrain from gender or racial bias, creed, color, national origin, sexual or other discrimination or harassment. We treat each other as we want to be treated – with fairness, honesty and respect."

Equal employment

SCFHP believes in hiring, promoting and compensating employees without regard to race, color, national origin, age, gender, religious preference, marital status, sexual orientation, handicap or disability or any other characteristic protected by law. We are an equal opportunity employer committed to employment practices that comply with all laws, regulations and polices related to non- discrimination.

Freedom from harassment

SCFHP prohibits unlawful discrimination against any employee, applicant, individual providing services in the workplace pursuant to a contract, unpaid intern, and volunteer based on their actual or perceived race, color, religious creed, color, religion, sex, military and veteran status, civil air patrol status, marital status, registered domestic partner status, age (40 and over), national origin or ancestry, pregnancy (including childbirth and related medical conditions, and including medical conditions related to lactation) physical or mental disability, medical condition, genetic information, sexual orientation, gender, gender identity and expression (including transgender individuals who are transitioning, have transitioned, or are perceived to be transitioning to the gender with which they identify), military and veteran status or any other consideration protected by federal, state or local laws. An applicant's or employee's immigration status will not be considered for any employment purpose except as necessary to comply with federal, state or local laws. For purposes of this policy, discrimination on the basis of "national origin" also includes discrimination against an individual because that person holds or presents the California driver's license issued to those who cannot document their lawful presence in the United States. Our commitment to equal employment opportunity applies to all persons involved in our operations and prohibits unlawful discrimination and harassment by any employee (including supervisors and co-workers), agent, client, member, or vendor.

Because harassment means different things to different people, we must refrain from any behavior that can be construed as offensive or inappropriate. Examples of inappropriate and offensive behavior include degrading jokes, intimidation, slurs, and verbal or physical conduct of a sexual nature, and harassment, including unwelcome sexual advances and requests for sexual favors. If an employee feels that he or she has been harassed he or she should immediately report the harassment to his or her supervisor, the supervisor's supervisor, compliance or human resources. Reports will be promptly investigated, and employees found to be engaging in this behavior will be disciplined, up to and including termination of employment.

Freedom from Retaliation

SCFHP prohibits retaliation against any employee, individual providing services in the workplace pursuant to a contract, volunteer or other person who, in good faith, reports perceived harassment, ethical violations, noncompliance, or Fraud, Waste or Abuse.

Safe environment

At SCFHP, we are each responsible for creating a safe working environment. All employees are expected to work safely, utilizing available materials and devices. Employees are expected to report any of the following potential or actual problems to supervisors:

- Injuries or other illnesses;
- Hazards such as facilities and equipment malfunctions or dangers;
- Security violations or criminal activity on company premises; and
- Actual or threatened acts of violence or intimidation.

Violence or criminal activity should be reported to police and building security immediately, regardless of the availability of a supervisor

Maintaining confidentiality and security

"We honor the privacy of members' and employees'/co-workers' or employees'/co-workers' personal information, whether medical or otherwise, just as we expect our privacy to be protected. We take appropriate precautions to protect the confidentiality and security of member, employees/co-workers and company information and transactions. We promise to protect trade secrets and confidential information, otherwise known as "intellectual property," that belongs to SCFHP. We refrain from divulging information that could be harmful to SCFHP or that could provide an advantage to our competitors."

Confidentiality and security

To protect SCFHP and our members and employees, we are committed to preserving the privacy, confidentiality and security of information, except where we are permitted or required to share certain information in accordance with the Brown Act or other legal or regulatory requirements. The following information is always confidential, and may never be shared outside the Plan, and in connection with a legitimate business purpose:

- Members' protected health information, including diagnoses and treatments, personal data, billing and contact information; and
- Employee information, including personnel files, evaluations, disciplinary matters and psychological assessments.

When using or sharing such information, you must secure all data (electronic or otherwise) and follow all applicable laws and company policies. Failure to maintain confidentiality and appropriate security of information could subject an employee personally and/or SCFHP to civil and/or criminal penalties, regulatory sanctions and lawsuits, and undermine the trust our members and the community place in us.

Respecting company property and resources

"We treat company property and resources the same while working at SCFHP and after leaving. We protect and preserve company property and refrain from using it for personal gain. We understand that company property includes, but is not limited to, SCFHP's intellectual property, physical property and electronic communications systems."

Use of resources

SCFHP's facilities, equipment, technology and resources are for business purposes – to help employees do their work. Employees must use SCFHP's company property in a professional, productive, and lawful manner. Employees must act responsibly, reasonably and maturely, and use good judgment regarding all company-provided communications and computing devices, including, but not limited to:

- The Internet;
- All forms of printed and electronic media;
- Copying devices (scanners and copy machines);
- Telephones (including cell phones);
- Portable devices (iPads);
- Desktop and laptop computers; and
- Remote access hardware and software devices.

Employees must not use the computer to transmit, store or download material that includes, but is not limited to, harassing, threatening, maliciously false or obscene information. The computer should also not be used for any unauthorized activities.

Internal Controls

SCFHP has established control standards and procedures to ensure that company property and equipment is protected and properly used. Control standards are also in place to ensure that financial records and reports are accurate and reliable. All employees of SCFHP share the responsibility for maintaining and complying with required internal controls.

SCFHP takes all necessary steps to keep our Information Systems secure and inaccessible to outside interference and attack. Employees receive guidance to help protect the integrity of the system and the data stored therein.

Travel and entertainment

Travel and entertainment expenses should be consistent with the employees' duties and SCFHP's needs and resources. Employees are expected to exercise reasonable judgment in the use of SCFHP's funds. Employees must comply with SCFHP guidelines relating to all purchasing procedures, payment limits and travel and entertainment expense.

Avoiding conflicts of interest

"SCFHP encourages employee participation in non-profit activities. Representing oneself as an employee of SCFHP through associations or activities that might conflict or appear to conflict with SCFHP's interests is prohibited. We avoid doing business with competitors or other organizations that might conflict with the values at SCFHP. We do not accept gifts of any material value from contractors or members, or give gifts to them. We do not take advantage of our association with SCFHP for personal gain."

Activities and relationships beyond SCFHP

As SCFHP employees, and Governing Board members and committee members, we must make certain – that our outside activities do not in any way conflict with, appear to conflict with, or pose a hazard to SCFHP. To ensure that SCFHP leadership is apprised of any activities that may create an actual or apparent conflict, it is SCFHP's policy that employees, Governing Board members and committee members must advise the CEO of any non-SCFHP activity, associations or investment that might influence the individual's business decisions or ability to carry out his or her duties objectively.

Entertainment, gifts and gratuities

~~SCFHP understands that entertaining – including meals, social events or training and educational activities – is an overall accepted practice of many businesses, but at SCFHP it is not.~~ As a government contracted entity, we may not accept gifts or gratuities of any material value. If ~~such~~ gifts or gratuities of a $50 or greater value are received, they may be donated to charities, made available to all employees, or returned to the sender with acknowledgement of their support and return of the item(s).

Refrain from giving or accepting gifts to or from vendors, customers and other business associates. It is the employee's responsibility to report or seek counsel should the employee receive or give gifts.

Procuring services from vendors and suppliers

As an SCFHP employee, you must procure services or products consistent with applicable legal and regulatory requirements and SCFHP policies and procedures. Employees must offer fair and equal opportunity to vendors and suppliers seeking to do business with SCFHP, and employees must negotiate and buy products and services without prejudice or favoritism. At SCFHP employees should not procure services for personal gain or to enhance personal relationships.

Fundraising and solicitation activities

To avoid conflicts of interest and to ensure that required business activities are performed in an effective and efficient manner, distributing leaflets, flyers, or other forms of printed or written materials during work time is prohibited. Notwithstanding this prohibition, the Union shall have the right to post notices of activities and matters of Union concern on the designated bulletin board.

For further direction as to the requirements for fundraising and solicitation activities please refer to the employee handbook or talk with a Human Resources representative.

Participation on Governing Boards/Board of Trustees

Upon request, an employee shall disclose services as a member of the Governing Board/Board of Trustees of any organization. A director, officer, or other employee must notify the CEO prior to beginning service as a member of the Governing Board of any organization whose interests may conflict with those of SCFHP. SCFHP reserves the right to prohibit such membership where there might be a conflict or appearance of conflict. The CEO will consult with the Compliance Committee and/or legal counsel to determine if participation may conflict with the interests of SCFHP.

Addressing health care resources

"We strive to provide members with health care services and products that are appropriate, efficient and cost effective. We commit to working with providers and using our resources wisely to continuously improve the health of our members."

Use of health care resources and quality improvement

SCFHP continually looks for ways to improve health outcomes for our members while effectively managing our resources. Our methods include making evidence-based decisions, fairly administering benefits to members and educating members and providers. Our goal is to assure that members receive the right care at the right time in the right place.

We promote continuous quality improvement and are committed to complying with state and federal regulations regarding health care.

Fraud, waste, and abuse

SCFHP is committed to ensuring that our employees, plan members, providers, suppliers, vendors, and anyone else doing business with or associated with SCFHP complies with federal and state anti- fraud and abuse laws. The following are some examples of prohibited activities:

- Direct, indirect or disguised payments in exchange for the referral of potential members;
- Submitting false, fraudulent reports to any government entity to substantiate a request for payment to SCFHP, including stating that services were provided that were not rendered, reports that characterize the service differently than the service actually rendered, or other submissions of information or data that does not otherwise comply with applicable program or contractual requirements;
- Submission by providers of claims for payment by SCFHP for services that were not rendered, or substandard care or care that did not meet generally recognized standards of practice; and
- False representations by potential members in order to gain or retain participation in a SCFHP program or to obtain payment for any service.

Obeying the law

"We always uphold the law while working at SCFHP. We commit to obeying all federal, state and local regulations with regard to our health plans and all our business units. We do not condone the use of illegal substances, the abuse of legal substances, fraud, embezzlement or any other illegal activities."

Regulatory obligations

As a consumer health service organization and a government contracted entity, SCFHP is heavily regulated by federal, state and local agencies. Some of our regulated business practices include:

- Ensuring that medical services and business practices meet quality assurance standards and protect member rights and confidentiality;
- Managing provider networks and health care delivery systems to make certain they meet contractual requirements and are accessible to our members;
- Monitoring the appropriate utilization of health care resources and ensuring that the most cost effective, medically necessary, covered services are not inappropriately denied;
- Providing for expeditious handling of members' complaints and appeals;
- Processing claims accurately and promptly;
- Conducting sales and marketing activities ethically and within established regulations and guidelines;
- Ensuring accurate and timely administration of membership accounting, including enrollment, disenrollment, member status and other requirements;
- Promoting a work environment for employees that is safe, ethical and founded on principles of equal employment and non-discrimination; and
- Ensuring the accuracy of SCFHP's financial statements and business activities in general.

External audits and reviews

Frequently we will have outside parties on site to perform financial and regulatory audits and reviews of our financial statements, operations and business practices. These outside parties include independent auditors and federal and state government regulators and inspectors. It is SCFHP's policy to fully cooperate with these auditors and provide them with all necessary information.

Prior to and during these audits or inspections, you must:

- Never conceal, destroy or alter any documents;
- Never give any false or misleading statements to inspectors;
- Never provide inaccurate information; and
- Never obstruct, mislead or delay communication of information or records about a possible violation of law.

Illegal activities

SCFHP and our employees must not engage, directly or indirectly, in any corrupt business practices or other illegal activities, including, among other things, fraud, embezzlement, kickback arrangements or drug use.

Fraud includes such things as falsifying documents or misappropriating company assets. Health care fraud occurs when someone uses false pretenses, representations, promises or other means to defraud or otherwise obtain money, service or property from any health care benefit program.

Embezzlement involves the attempt to take, for personal use, money or property, which has been entrusted to you by others without their knowledge or permission.

A kickback arrangement involves accepting or offering bribes or payoffs intended to induce, influence or reward actions of any person or entity in a position to benefit SCFHP. Such persons or entities include customers, contractors, vendors and government personnel.

Financial Reporting

All financial reports, accounting records, research reports, expense accounts, time sheets and other documents accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is contrary to the policy of SCFHP and may be in violation of applicable laws. SCFHP abides by all relevant tax laws and files reports in a manner consistent with applicable laws and regulations.

Political and lobbying activities
Officers, directors, and general employees are restricted from engaging in activities that may jeopardize the tax exempt status of SCFHP, including participation in various lobbying or political activities.

Individuals shall not make agreements to contribute monies, property, or services of any officer or employee at SCFHP's expense to any political candidate, party, organization, committee or individual in violation of any law. Officers, directors, and employees are not restricted from personally participating in and contributing to political organizations or campaigns, but must not do so under the SCFHP name or use SCFHP funds.

SCFHP has many contacts and dealings with governmental bodies and officials. Such contacts and transactions are expected to be conducted in an honest and ethical manner. Any attempt to influence decision-making processes of governmental bodies or officials by an improper offer of any benefit is prohibited. Any requests or demands by any governmental representative for a payment or other improper favor should be reported immediately through http://icat/Pages/Default.aspx or directly to your manager or the Compliance Officer or any member of the Compliance Committee.

Sales, marketing and advertising standards
We are committed to growing our membership through a well-trained, highly professional staff. All SCFHP member outreach representatives are committed to fair, forthright and legally compliant and marketing practices. We adhere to any state regulations that require sales representatives to be licensed.

We do not engage in corrupt marketing practices, including misrepresentation of our covered services or "redlining," which refers to the practice of avoiding sales in specific geographic areas or neighborhoods.

When advertising our products and services, we present only truthful, non-deceptive information. In many cases, advertising and marketing materials require approval from regulatory agencies prior to distribution. When required, SCFHP submits materials to agencies and ensures their full compliance with applicable regulations.

Copyright laws
SCFHP complies with state, federal and foreign laws pertaining to copyright protection. Our compliance includes, but is not limited to, laws that prohibit duplication of print materials, licensed computer software and other copyright-protected works.

We expect compliance with all copyright protections, including refraining from using company property to display, copy, play, store, transfer, transmit, download music or other sound recording (including CDs and MP3 or similar file formats), copyrighted pictures or images, motion pictures, clips (including AVI, Mpeg, DVDs or other similar formats), or other non-business-related materials (e.g., games, screensavers).

Medi-Cal and Cal MediConnect Benefit Plans

SCFHP employees are required to follow the legal and regulatory requirements pertaining to our relationship as a government contracted entity servicing Medi-Cal and Cal MediConnect benefits. The requirements for these programs are established in the DHCS, DMHC and CMS regulations and manuals.

As a government contracted entity, SCFHP is obligated to abide by federal, state and local laws pertaining to that relationship. Penalties for breaking government contract laws and regulations can be severe and negatively impact SCFHP, its business, and reputation.

Excluded parties

SCFHP takes steps to ensure that it does not engage in relationships with or make any payments to individuals or entities that are debarred, suspended, or otherwise excluded from participating in state or federally funded programs. This applies to the Governing Board or any committee, employees, contractors, consultants, providers, delegated entities, and vendors.

Document Retention

SCFHP maintains a record retention process that supports the requirements of federal law, regulations, and policies and procedures. Should SCFHP or anyone associated with SCFHP be involved in any litigation activities, SCFHP will not alter, destroy or throw away information that may be related to the dispute. All employees are required to abide by this requirement.

Government requests or requests for information

SCFHP employees should notify their supervisor and the Compliance Officer (or any member of the Compliance Committee) if they are approached by an agent or official of the state or federal government, and asked to provide information, records, documents or answer questions if the request is not related to a routine report or workforce activity, or was not scheduled in advance.

Should you receive subpoena, court order, notification of legal action (or threat thereof), or become aware of fraud and abuse investigations, or requests for information from third parties, you are requested to forward such communication to the compliance department for handling and response.

Responsibilities & consequences

SCFHP's guidelines and policies cannot address every potential situation or issue that employees may encounter. Employees must have a thorough understanding of SCFHP's code of ethics, guidelines and policies and procedures so he or she can effectively evaluate the specific situations.

Employee responsibilities

SCFHP provides employees with training so they are knowledgeable about our ethics and compliance initiatives. In return, we rely on the employee to help ensure that those initiatives remain a priority. We expect the employee to uphold all of the standards outlined in these guidelines and to report known or suspected violations of those standards.

Reporting suspected violations

Take responsibility for safeguarding SCFHP's integrity. If you observe potential violations of law or the company code of ethics, report them. Failure to do so could pose a risk to SCFHP or, in the case of illegal activities or regulatory violations, a risk to you, your co-workers or SCFHP's members.

Resolution and non-retaliation

Once a problem or suspected violation has been reported, SCFHP will take appropriate action to review the reported matter. We will not retaliate against you for reporting ethics or compliance violations in good faith. Anyone who engages in retaliatory activity is subject to disciplinary action, up to and including termination.

Consequences of violations

SCFHP will be thorough in our review of possible ethics or compliance violations. Employees may be subject to appropriate disciplinary action, up to and including termination, for engaging in activities such as, but not limited to:

- Authorizing or participating in actions that violate SCFHP guidelines, policies and procedure;
- Failure to report a possible violation of SCFHP guidelines, policies and procedures;
- Refusing to cooperate with a compliance investigation;
- Disclosing confidential information to any unauthorized person, company, organization or government agency about an inquiry without authorization;
- Retaliating against someone for reporting misconduct or violations; or
- Filing intentional false reports of misconduct or violations.

The degree of disciplinary action will be determined by the nature and surrounding circumstances of the violation.

Where to find answers to your questions and report issues

Ethics and compliance resources

Standards of Conduct are meant to provide an overview of SCFHP's policies on ethics, compliance and conduct-related issues. This publication is a living document and is subject to change as we refine our policies and procedures, and as government agencies and regulators modify their rules.

If you need more information or if you have an ethics or compliance-related question, the best thing to do is to talk with your supervisor or Human Resource Representative. Employees may also contact the Compliance Department directly. These individuals are the best sources for helping you understand the laws, regulations and practices that affect your work.

In addition, we encourage you to explore the following resources:

SCFHP's employee handbook

The handbook covers various topics, including employment, benefits, performance reviews, wage and salary information, and employee relations subjects such as dress code, workplace conduct, counseling, and health and safety issues. The employee handbook also directs you to the appropriate policies and procedures for each topic.

SCFHP's Intranet

This site contains extensive information on company policies, procedures and standards that affect your work.

Where to report issues

If you have an ethics or compliance question or concern, you have the following options:

- Talk with your supervisor. S/He is familiar with you and the issues in your workplace.
- Contact your Human Resource representative.
- Send a report using the Compliance Reporting Form.
- Contact the Compliance Officer.
- Call the anonymous and confidential Compliance Hotline

SCFHP's policy is to preserve the confidentiality of individuals who communicate suspected violations who are questioned in an investigation, subject to limits imposed by law. To the extent possible, all reported issues are treated as confidential and no attempt is made to identify the submitter from which the information was received.

POLICY

Policy Title:	**Corrective Actions**	**Policy No.:**	CP.07 v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish the standards that Santa Clara Family Health Plan (SCFHP) utilizes to correct actual or potential non-compliance, fraud, waste and abuse (FWA) and/or unethical conduct, and to promote a culture of compliance and continuous improvement.

II. Policy

SCFHP issues corrective actions to internal business units, individuals, First Tier, Downstream and Related Entities (FDRs), and/or delegated entities as appropriate, upon the identification of non-compliance, unethical behavior or FWA to correct and prevent the issue(s) from recurring.

III. Responsibilities

A. Compliant activities and ethical behavior is the responsibility of all SCFHP employees, temporary staff, volunteers, interns, consultants and Governing Body members (Employees), FDRs, and delegated entities. Accordingly, the following are responsible for issuing, investigating, supporting and/or demonstrating remediation of corrective actions associated with potential non-compliance, unethical behavior or FWA:

1. SCFHP managers and directors may issue corrective actions for their staff to resolve issues identified during regular monitoring;
2. SCFHP's compliance department may issue corrective actions for internal business units, individuals and/or FDRs/delegated entities to resolve issues identified during regular monitoring, auditing or associated with regulatory reporting requirements that have not been met;
3. The Compliance Committee may recommend the issuance of corrective actions based on their review of potential issues presented for their guidance and input;

4. The Governing Body may request corrective actions based on the organization's overall financial or operational performance;
5. SCFHP's Human Resources may issue performance improvement plans (PIPs), a form of corrective action, when it identifies systemic performance or behavioral issues demonstrated by employees; and
6. FDRs/delegated entities may issue corrective actions to its staff and/or downstream entities that support SCFHP's government-funded health care programs.

B. All SCFHP Employees and FDRs/delegated entities are responsible for participation in, and remediation of, any regulatory corrective actions issued by regulatory agencies to SCFHP.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(G)
42 C.F.R. § 423.504(b)(4)(vi)(G)
Medicare Managed Care Manual, Chapter 21, Section 50.7.2
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.7.2

V. Approval/Revision History

First Level Approval	Second Level Approval
Anna Vuong Manager, Medi-Cal Compliance Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee	Approved/2/28/19	Ratify/3/28/19
v2	Revised	Compliance Committee	Approved 11/19/2020	Ratify 12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Compliance Training**	**Policy No.:**	CP.10 v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to ensure all Santa Clara Family Health Plan (SCFHP) employees, temporary staff, volunteers, consultants, and board members ("Employees"), First-tier, Downstream and Related entities (FDRs), and delegated entities receive appropriate training and comply with all state, federal and SCFHP compliance requirements and policies.

II. Policy

SCFHP ensures that all Employees, FDRs, and delegated entities receive general compliance training that includes SCFHP's Standards of Conduct and compliance policies and procedures, and FWA training upon hire, appointment or contract, upon any updates in regulatory requirements, and annually thereafter (within the 12-month period from the prior training cycle).

III. Responsibilities

A. General compliance and FWA training is a cross-departmental activity and managed by the following Business Units:
   1. Human Resources, in collaboration with the Compliance Department, is responsible for conducting new hire orientation training that includes general compliance and FWA training within 90 days of hire for all Employees, upon updates to regulatory requirements, and annually thereafter.
   2. Provider Network Management is responsible for communicating the requirements for SCFHP's contracted provider network to provide new hire and annual general compliance training to its staff.
   3. The Compliance Department is responsible for communicating to SCFHP's FDRs and delegated entities the requirements for providing general compliance and FWA training to all FDR staff within 90 days of hire, upon updates to regulatory requirements, and annually thereafter.

POLICY

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(C)
42 C.F.R. § 423.504(b)(4)(vi)(C)
Medicare Managed Care Manual, Chapter 21, Section 50.3.1
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.3.1

V. Approval/Revision History

First Level Approval	Second Level Approval
Anna Vuong Manager, Medi-Cal Compliance	Tyler Haskell Interim Compliance Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee	Approved/2/28/19	Ratify/3/28/19
v2	Revised	Compliance Committee	Approved 11/19/2020	Ratify 12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Annual Compliance Program Effectiveness Audit**	**Policy No.:**	CP.12 v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish the standards that Santa Clara Family Health Plan (SCFHP) utilizes to implement, monitor, measure and promote an effective compliance program that detects, corrects and prevents non-compliance and fraud, waste and abuse.

II. Policy

SCFHP performs an annual, comprehensive compliance program audit or assessment to measure the overall effectiveness of its compliance program.

III. Responsibilities

A. SCFHP's compliance department identifies qualified, independent individuals or entities that are subject matter experts in conducting annual compliance program audits or assessments.
B. The Compliance Committee will review and approve the Compliance Officer's candidates prior to the award of the contract.
C. SCFHP's Compliance Officer and Compliance Committee are responsible for reviewing the compliance program audit or assessment report and making recommendations for corrective actions, where appropriate.
D. The Compliance Department conducts regular monitoring of compliance program operational activities through the use of established dashboard metrics.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(F)
42 C.F.R. § 423.504(b)(4)(vi)(F)
Medicare Managed Care Manual, Chapter 21, Section 50.6.7
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.6.7

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Anna Vuong Manager, Medi-Cal Compliance Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance	Approved / 2/28/19	Ratify / 3/28/19
v2	Revised	Compliance	Approved 11/19/2020	Ratify 12/17/2020
V2	Reviewed	Compliance		

POLICY

Policy Title:	**Standards of Conduct**	**Policy No.:**	CP.15 v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to state Santa Clara Family Health Plan (SCFHP)'s overarching principles and values by which SCFHP operates and define the underlying framework for its compliance policies and procedures.

II. Policy

SCFHP has formal Standards of Conduct describing the expectations that apply to all employees, temporary employees, volunteers, interns, consultants and Governing Body members (Employees), First Tier, Downstream and Related entities (FDRs), and delegated entities in conducting themselves in an ethical manner.

III. Responsibilities

A. SCFHP's Compliance Officer is responsible for:
   1. Updating the Standards of Conduct to incorporate changes in applicable laws, regulations, and other program requirements; and
   2. Obtaining approval from the Compliance Committee of the Board whenever updates are made to the Standards of Conduct.

B. SCFHP's Human Resources is responsible for ensuring that the Standards of Conduct and the underlying compliance policies and procedures are distributed to all Employees upon hire and annually thereafter.

C. SCFHP's Compliance Department is responsible for ensuring all FDRs and delegated entities have access to SCFHP's Standards of Conduct.

D. The Compliance Committee of the Board is responsible for review and approval of updates made to the Standards of Conduct.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(A)

POLICY

42 C.F.R. § 423.504(b)(4)(vi)(A)
Medicare Managed Care Manual, Chapter 21, Section 50.1.1
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.1.1

V. Approval/Revision History

First Level Approval	Second Level Approval
Anna Vuong Manager, Medi-Cal Compliance Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee	Approved/2/28/19	Ratify/3/28/19
v2	Revised	Compliance Committee	Approved 11/19/2020	Ratify 12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Risk Assessments**	**Policy No.:**	CP.17 v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish Santa Clara Family Health Plan (SCFHP)'s commitment to identifying, prioritizing, and assigning accountability for managing existing or potential threats related to noncompliance or ethical misconduct that could lead to fines or penalties, reputational damage, or the inability to continue operations in its government-funded health care programs.

II. Policy

SCFHP employs a standardized and consistent methodology for assessing its internal operational risks, contractual and regulatory risks, as well as the risks associated with delegated activities performed by it First Tier, Downstream and Related Entities (FDRs) and delegated entities that are designed to prioritize monitoring and auditing activities according to specified risk categorizations.

III. Responsibilities

A. SCFHP's Compliance Officer is responsible for the:
   1. Development and maintenance of SCFHP's risk assessment system;
   2. Annual implementation of the risk assessment process;
   3. Annual effectiveness reviews of the risk assessment system;
   4. Education of all stakeholders on the results and implications of the annual risk assessment; and
   5. Development of an annual monitoring and auditing work plan derived from the results of the annual risk assessment.

B. SCFHP's Compliance Department is responsible for establishing monitoring and auditing schedules based on the risk prioritization established by the risk assessment process.

C. SCFHP's Compliance Department is responsible for educating FDRs and delegated entities on SCFHP's risk assessment policy and procedure.

D. The Compliance Committee of the Board is responsible for assisting with the implementation and oversight of the risk assessment process, including approval of the annual monitoring and auditing work plan that is derived from the annual risk assessment process.
E. The Governing Body is responsible for reviewing and approving the risk assessment process.

IV. References

42 C.F.R. §§ 422.503(b)(4)(vi)(B) and (F)
42 C.F.R. §§ 423.504(b)(4)(vi)(B) and (F)
Medicare Managed Care Manual, Chapter 21, §§ 50.2.2, 50.2.3, 50.6.2
Medicare Prescription Drug Benefit Manual, Chapter 9, §§ 50.2.2, 50.2.3, 50.6.2

V. Approval/Revision History

First Level Approval	Second Level Approval
Mai Phuong-Nguyen Oversight Program Manager Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Compliance Committee	Approved/2/28/19	Ratify/3/28/19
v2	Revised	Compliance Committee	Approved 11/19/2020	Ratify 12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Communication Between SCFHP and FDR/Delegated Entities**	**Policy No.:**	DE.04 v2
Replaces Policy Title (if applicable):	Delegated Entity Communication Process	**Replaces Policy No. (if applicable):**	DE004, DE204
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish the Santa Clara Family Health Plan (SCFHP) requirements regarding communication between SCFHP and its First Tier, Downstream and Related Entities (FDRs)/delegated entities.

II. Policy

SCFHP uses a variety of methods to communicate with FDRs/delegated entities in order to ensure compliance with applicable federal, state, and SCFHP contractual requirements.

A. SCFHP communication methods with the FDR/delegated entity include electronic, telephonic, external, and in-person.

B. SCFHP's formal communications with the FDR/delegated entity are documented. Formal Communications are defined as:
   1. Audit Notices
   2. All Plan Letters
   3. Regulatory Requirements
   4. Corrective Action Plans

C. SCFHP initially and annually thereafter, reviews the communication processes, methods, and contact information between SCFHP and FDR/delegated entity.

III. Responsibilities

The Compliance Department is responsible for carrying out the terms of this policy.

A. The Compliance Department is responsible for the:
   1. Communication methodology established between SCFHP and the FDR/delegated entity.
   2. Oversight of the communication process between SCFHP and the FDR/delegated entity.

IV. References

DHCS: SCFHP Contract with DHCS Exhibit A, Attachment 4
CMS: Three-Way contract between SCFHP, DHCS, CMS
NCQA: NCQA Health Plan Standards, 2020

V. Approval/Revision History

First Level Approval	Second Level Approval
Daniel Quan Director, Compliance Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Delegation Oversight Committee	4/28/2016	n/a
v2	Revised	Compliance Committee	11/19/2020	12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Joint Operations Committee Meetings Between SCFHP and FDRs/Delegated Entities**	**Policy No.:**	DE.05 v2
Replaces Policy Title (if applicable):	Delegation Oversight Joint Operations Committee Meeting	**Replaces Policy No. (if applicable):**	DE005 DE205
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish the Santa Clara Family Health Plan (SCFHP) requirements to conduct and participate in Joint Operations Committee (JOC) meetings between SCFHP and its First Tier, Downstream and Related Entities (FDRs)/delegated entities.

II. Policy

SCFHP establishes, conducts, and participates in JOC meetings with FDRs/delegated entities. The JOC meetings occur on at least an annual basis with each FDR/delegated entity. JOC meetings may be held in person, via webinar, or telephonic. A standard agenda will be established with specific needs of the FDR/delegated entity and SCFHP. FDRs/delegated entities and key SCFHP participants have the opportunity to submit agenda topics prior to each JOC meeting. Ad hoc meetings may be scheduled at the request of the FDR/delegated entity or by SCFHP.

III. Responsibilities

The Compliance Department and Provider Network Management are responsible for carrying out the terms of this policy.

A. The Provider Network Management Department is responsible for:
   1. Managing all JOC meetings for FDRs/delegated entities that have network providers

B. The Compliance Department is responsible for:
   1. Managing all JOC meetings for FDRs/delegated entities that do not have network providers

C. Managing the JOC meetings includes:
   1. Scheduling JOC meetings
   2. Participating in the JOC meetings
   3. Documenting the JOC meeting in the standardized meeting minute format
   4. Distributing all related documents to the JOC participants
   5. Escalating JOC activities if necessary to the Oversight Workgroup or Compliance Committee

6. Relaying applicable information from the Compliance Committee or regulators to the FDR/delegated entity through the JOC.

D. Business Units representing areas of delegation are responsible for staffing and/or participating in the JOC, providing meeting materials when applicable, and addressing issues involving the FDR/delegated entity.

E. Quality Improvement Department is responsible for:
   1. Reporting JOC activities to the Quality Improvement Committee (QIC).
   2. Relaying applicable information from the QIC to the FDR/delegated entity through the JOC.

IV. References

DHCS: SCFHP Contract with DHCS Exhibit A, Attachment 4
CMS: Three-Way contract between SCFHP, DHCS, CMS
NCQA: NCQA Health Plan Standards, 2020

V. Approval/Revision History

First Level Approval	Second Level Approval
Daniel Quan Director, Compliance	Tyler Haskell Interim Compliance Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Delegation Oversight Committee	4/28/2016	n/a
v2	Revised	Compliance Committee	11/19/2020	12/17/2020
V2	Reviewed	Compliance Committee		

POLICY

Policy Title:	**FDR/Delegated Entity Reporting**	**Policy No.:**	DE.12 v2
Replaces Policy Title (if applicable):	Delegated Entity Reporting Process	**Replaces Policy No. (if applicable):**	DE012, DE212
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

The purpose of this policy is to establish the Santa Clara Family Health Plan (SCFHP) requirements to accept, process, and monitor reporting from First Tier, Downstream and Related Entities (FDRs)/delegated entities.

II. Policy

SCFHP accepts and processes reports from FDRs/delegated entities following the timeframes established by state and federal regulations, and identified in the delegate's contract and delegation agreement.

Reporting by FDRs/delegated entities includes both regular ongoing reporting defined by the delegation agreement as well as any reporting required defined by a corrective action plan, as applicable.

III. Responsibilities

The Compliance Department is responsible for carrying out the terms of this policy.

A. The Compliance Department is responsible for:
   1. Notifying the FDR/delegated entity of the SCFHP reporting requirements
   2. Monitoring the FDRs/delegated entity's report submissions to SCFHP
   3. Communicating non-compliance to the FDR/delegated entity
   4. Issuing a corrective action plan when applicable
   5. Reporting non-compliance to the Oversight Workgroup and Compliance Committee if necessary

B. Business units are responsible for:

   1. Receiving and processing applicable reporting from the FDR/delegated entity
   2. Reporting non-compliance to the Compliance Department

C. The Quality Department is responsible for reporting non-compliance to the Quality Improvement Committee.

POLICY

IV. References

DHCS: SCFHP Contract with DHCS Exhibit A, Attachment 4
CMS: Three-Way contract between SCFHP, DHCS, CMS
NCQA: NCQA Health Plan Standards, 2020

V. Approval/Revision History

First Level Approval	Second Level Approval
Daniel Quan Director, Compliance Date	Tyler Haskell Interim Compliance Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Delegation Oversight Committee	4/28/2016	n/a
v2	Revised	Compliance Committee	11/19/2020	12/17/2020
V3	Reviewed	Compliance Committee		

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, October 12, 2021, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Open) – Draft

Members Present	Specialty
Ria Paul, MD, Chair	Emergency Medicine
Ali Alkoraishi, MD	Adult & Child Psychiatry
Nayyara Dawood, MD	Pediatrics
Jennifer Foreman, MD	Pediatrics
Jimmy Lin, MD	Internist
Laurie Nakahira, D.O., Chief Medical Officer	
Christine Tomcala, Chief Executive Officer	

Members Absent
N/A

Staff Present
Janet Gambatese, Director, Provider Network Operations
Chelsea Byom, Director, Marketing and Communications
Tyler Haskell, Interim Compliance Officer
Lan Tran, Quality Improvement Nurse
Natalie McKelvey, Manager, Behavioral Health
Neha Patel, Manager, Clinical Quality & Safety
Mauro Oliveira, Manager, Grievance and Appeals
Gaya Amirthavasar, Process Improvement Project Manager, QI
Byron Lu, Process Improvement Project Manager, QI
Karen Fadley, Provider Database Analyst
Victor Hernandez, Quality Assurance Process Manager, Grievance & Appeals
Tiffany Franke, Behavioral Health Case Manager
Nancy Aguirre, Administrative Assistant

1. **Roll Call**

   Ria Paul, MD, Chair, called the meeting to order at 6:04 pm. Roll call was taken and quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   Minutes of the August 10, 2021 Quality Improvement Committee (QIC) meeting were reviewed when a quorum was established.

   It was moved, seconded and the minutes of the 08/10/2021 QIC meeting were **unanimously approved.**

   Motion: Dr. Alkoraishi
   Second: Dr. Nakahira
   Ayes: Dr. Paul, Ms. Tomcala
   Absent: Dr. Dawood, Dr. Foreman, Dr. Lin

Nayyara Dawood joined at 6:08PM.

4. **Adjourn into Closed Session**
   Pursuant to Welfare and Institutions Code Section 14087.36 (w)

   Adjourned to closed session at 6:08pm.

5. **Reconvene Open Session**

   Reconvened open session at 6:18pm

6. **CEO Update**

   Christine Tomcala, Chief Executive Officer, reported the current Plan membership is approximately 287,500 members. Of which, approximately 10,368 are Cal MediConnect (CMC) members and 277,100 are Medi-Cal (MC) members.

   Ms. Tomcala announced the HEDIS performance for MC moved up in ranking. In 2020, SCFHP ranked 12th out of 56 health plans. This year, SCFHP ranked 10th out of 56 health plans. This is an achievement considering the circumstances.

Jennifer Foreman joined at 6:20PM.

7. **Annual Assessment of Physician Directory Accuracy Report 2021**

   Karen Fadley, Provider Database Analyst, presented the Annual Assessment of Physician Directory Accuracy Report 2021.

   Ms. Fadley noted during 2021, the following measures were monitored for aspects of physician directory accuracy: 1) Accuracy of office locations, 2) Accuracy of phone numbers, 3) Accuracy of hospital affiliations, 4) Accuracy of accepting new patients, and 5) Awareness of physician office staff of physician's participation in the organization's network.

   Each measure's quantitative and qualitative analysis were reviewed, in addition to their barriers and opportunities for improvement. The following three interventions were selected: 1) Continue to communicate timeliness of provider changes at quarterly joint operation committees; 2) Ensure that provider relations staff has on-going communications to discuss data changes with MD and their office staff; and 3) Quarterly validation of the provider data through calls to provider office in validation of their submitted data reporting.

   It was moved, seconded and the Annual Assessment of Physician Directory Accuracy Report 2021 was **unanimously approved.**

   Motion: Ms. Tomcala
   Second: Dr. Nakahira
   Ayes: Dr. Alkoraishi, Dr. Dawood, Foreman, Dr. Paul
   Absent: Dr. Lin

8. **Physician and Hospital Directories Usability Testing Report**

   Chelsea Byom, Director, Marketing and Communications, presented the Physician and Hospital Directories Usability Testing Report. The methodology, survey questions and factors, and the results were reviewed.

   Ms. Byom noted the survey indicated difficulties in searching for Skilled Nursing Facilities (SNF). Overall, all participants found their experience using the provider search satisfactory.

   Dr. Paul asked if a corrective action plan or strategy is in place to improve the difficulties in searching for SNFs. Ms. Byom explained the Plan will follow up with the vendor to determine how the product can be modified to improve upon difficulties in searching for SNFs.

   It was moved, seconded and the Physician and Hospital Directories Usability Testing Report was **unanimously approved.**

Motion: Ms. Tomcala
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Foreman, Dr. Nakahira Dr. Paul
Absent: Dr. Lin

9. Annual CMC Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Tiffany Franke-Brauer, Manager, Behavioral Health Case Manager, presented the Annual CMC Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis. The analysis reviewed data for comparison between CY2018, CY2019, and CY2020. In 2020 this analysis was presented at the December QIC. The full 14 months was utilized as the staff were overextended due to COVID-19 pandemic. In 2021, the report review cycle was moved back to achieve the traditional annual review cycle in October.

All six (6) factors, including their goals and results, were reviewed. Ms. Franke-Brauer pointed out a data discrepancy identified in 2019. Based on this discrepancy, the data was reviewed for a more accurate comparison and trending. Results do not show any conflictions in data tending.

Ms. Franke-Brauer shared the Plan's opportunities for improvement and interventions selected. For factor 4, management of treatment access and follow-up for Members with coexisting medical and behavioral disorders – Management of Treatment of Members with Schizophrenia and Diabetes Mellitus Type II, the intervention would focus on notifying the current PCP Providers to Promote overall Health of Members and encourage outreach to Member to assist Member to have follow up appointment for A1c testing for members with Severe Mental Illness (SMI) & Cardiovascular Disease (CVD), the intervention would focus on notifying the member's cardiologist about the importance of completing LDL-c testing for members with SMI and CVD and that one was not completed in the previous year.

SCFHP plans to improve timing of data collection and implementation of interventions to improve upon intervention effectiveness and goal achievement.

It was moved, seconded and the Annual CMC Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Paul, Ms. Tomcala
Absent: Dr. Dawood

10. Assessment of CMC Member Understanding of Policies & Procedures: Call Code Analysis

Ms. Byom presented the Assessment of CMC Member Understanding of Policies & Procedures: Call Code Analysis. The purpose of this assessment is to ensure CMC members' understand the policies and procedures of the Plan. All call notes (made by CMC members within 90 days of their enrollment in the Plan) are assessed to identify top themes. Ms. Byom reviewed the themes identified and opportunities for improvement.

Ms. Byom noted there were two process improvements made to address the top themes. A printed hardcopy of the Health Risk Assessment (HRA) has been added to all new CMC member welcome packets, as well as an instruction sheet to the Authorized Representative Form (ARF).

It was moved, seconded, and the Assessment of CMC Member Understanding of Policies & Procedures: Call Code Analysis was **unanimously approved.**

Motion: Ms. Tomcala
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul
Absent: Dr. Lin

Jimmy Lin joined at 7:08PM.

11. Member Experience Analysis

Victor Hernandez, Quality Assurance Process Manager, Grievance and Appeals (G&A), and Natalie McKelvey, Manager, Behavioral Health (BH), presented the Member Experience Analysis.

Mr. Hernandez explained the methodology used in categorizing the G&As, in addition to splitting them between BH and non-BH categories. Grievance rates and goals were reviewed and compared for CY2019 and CY2020.

Mr. Hernandez reviewed the G&A (non-BH) highlights and noted the interventions in place.

Ms. McKelvey reviewed the completion rate for the BH Member Experience Survey, as well as the response rate and the participant demographics. Also reviewed were opportunities for improvement. Interventions will include increasing the provider network and educating members and providers through events, newsletters, and tips sheets.

Last year this analysis was presented at December QIC. In 2021, a business decision was made to move this analysis to the October QIC to allow for actions to be implemented prior to the December NCQA submission.

It was moved, seconded, and the Member Experience Analysis was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

12. Annual CMC Continuity and Coordination of Medical Care Analysis (2021)

Lan Tran, Quality Improvement Nurse, presented the Annual CMC Continuity and Coordination of Medical Care Analysis (2021). Annually, SCFHP reviews four (4) measures associated with Member Movement between Practitioners and Member Movement between Settings to assess the continuity and coordination of care. For all measures, the measurement year 2020 rate is compared with our baseline data from measurement year 2018 and measurement year 2019.

Ms. Tran reviewed the goals for each measures, results, barrier analysis, opportunities for improvement, and interventions. For Measure 1, Transition of Care – Medication reconciliation Post Discharge, the following intervention was selected: Provider Network Operations (PNO) to work with QI to build a check-box for medication reconciliation template for 10 Provider sites with paper charting to decrease the administrative burden of medication reconciliation. For Measure 2, Comprehensive Diabetes Care (CDC) Eye Exam Rate, the intervention selected to develop health education materials to promote importance of diabetic care. For Measure 3, PCP follow up after 30 days of Discharge Rate, the intervention selected included working with IT to build an IT report that automates the PCP admission notification reporting process.

In 2020 this analysis was presented at the December QIC. The full 14 months was utilized as the staff were overextended due to COVID-19 pandemic. In 2021, the report review cycle was moved back to achieve the traditional annual review cycle in October.

It was moved, seconded, and the Annual CMC Continuity and Coordination of Medical Care Analysis (2021) was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Paul, Ms. Tomcala

13. Grievance and Appeals Report Q2 2021

Mr. Hernandez presented the G&A Report Q2 2021. Mr. Hernandez reviewed the Q2 2021 top 3 MC Grievance Categories and the top 3 MC Grievance Subcategories. Also reviewed were the MC Appeals by Case Type, Disposition, Overturn Rationale, and Uphold Rationale.

In addition, the Top 3 CMC Grievance Categories and the top 3 CMC Grievance Subcategories were reviewed, as well as the CMC Appeals by Case Type, Disposition, Overturn Rationale, and Uphold Rationale.

Dr. Lin asked for an explanation of what an overturn for post-services appeals means. Mr. Hernandez clarified that an overturn means the denied claimed was overturned, and therefore, paid.

It was moved, seconded, and the G&A Report Q2 2021 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

14. Compliance Report

Tyler Haskell, Interim Compliance Officer, reviewed the Compliance Report. Mr. Haskell noted the Plan submitted corrective action plans and supporting documentation to the Department of Health Care Services (DHCS) for each of the three (3) findings from the MC Managed Care Audit conducted in March, 2021.

Mr. Haskell reviewed the final audit report received from the Department of Managed Health Care (DMHC), regarding the DMHC MC Managed Care Audit conducted in March 2021.

Mr. Haskell noted the Compliance Department recently disclosed to CMS an issue the Plan discovered that was preventing providers from receiving information about transitions of care, interdisciplinary care team (ICT) meetings, and individual care plans (ICP).

Mr. Haskell reported the Plan has been selected by CMS's external quality review organization to participate in the 2021 Performance Measure Validation Audit. All requested documents have been submitted in advance of a scheduled review session on August 19, 2021. A draft report is anticipated in early December.

15. Pharmacy and Therapeutics (P&T) Committee Meeting Minutes

Dr. Lin reviewed the draft P&T minutes for the 09/16/2021 meeting.

It was moved, seconded, and the draft minutes of the 09/16/2021 P&T meeting were **unanimously approved.**

Motion: Dr. Alkoraishi
Second: Dr. Nakahira
Ayes: Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Paul, Ms. Tomcala

16. Credentialing Committee Report

Laurie Nakahira, D.O., Chief Medical Officer, reviewed the 08/04/2021 Credentialing Committee Report.

It was moved, seconded, and the 08/04/2021 Credentialing Committee Report was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Foreman
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Dr. Paul, Ms. Tomcala

17. Ad Hoc QIC Meeting

Dr. Laurie announced the upcoming Ad Hoc QIC meeting will be on 11/16/2021, from 6:00 – 7:00PM.

18. Adjournment

The next regular QIC meeting will be held on December 7, 2021. The meeting was adjourned at 7:56PM.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan Assessment of Physician Directory Accuracy: 2021 Analysis

Cal-MediConnect – 2021

Prepared by:
Karen Fadley, Manager, Provider Data, Credentialing, and Reporting

For review and approval by the Quality Improvement Committee

October 2021

Overview

Santa Clara Family Health Plan (SCFHP) aims to provide its members and prospective members with the most accurate and up-to-date information possible in our physician directories. Provider directories function as a vehicle for our members to connect with our providers and access the healthcare delivery system. By performing routine outreach to our providers to keep their information up to date, we maintain our dedication to our members and their health. SCFHP monitors activities directed at improving the accuracy of the physician directory, as necessary, to improve the outcomes of the monitored activities.

Annually, SCFHP, reviews data associated with physician directory accuracy. Through analysis, SCFHP Plan identifies opportunities for improvement. During 2021, the following measures were monitored for aspects of physician directory accuracy.

Measure 1: Accuracy of office locations

Measure 2: Accuracy of phone numbers

Measure 3: Accuracy of hospital affiliations

Measure 4: Accuracy of accepting new patients

Measure 5: Awareness of physician office staff of physician's participation in the organization's network

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve physician directory accuracy. The quantitative analysis process includes a review of results and compares those results against an established performance goal. In future measurement years, trends will be assessed. The qualitative analysis process utilizes the data to identify potential root cause and barriers applicable to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause. SCFHP will track and trend each measure over a 3-year period, beginning with Baseline/Measurement Year 1:

1. Baseline/Measurement 2021
    a. Quantitative analysis
    b. Qualitative analysis to include barriers, opportunities and recommended interventions to meet performance goals in measurement year 3.
    c. Implementation of interventions for measurement year 3.

I. Methodology

SCFHP measures the rate of physician directory accuracy through a provider outreach campaign to confirm provider directory accuracy. The data informatics team pulls the latest data used to produce the provider directory. From the data extract, a statistically significant sample is randomly selected. The following parameters were used to calculate the sample size:

Parameter	Value
Margin of Error	10%
Confidence Level	90%
Population Size	451
Recommended Sample Size	60

Two provider data staff members made calls during September using the Provider Directory Attestation form attached in Exhibit A. An analyst performed a randomized selection of PCP and SCP office and provided the listing to the Manager, Provider Database and Reporting, grouping the list by location so the caller could make one call to each office. For practitioners with multiple offices, each location was called. When there were multi-specialty offices, each practitioner was counted as one. Staff were instructed to talk to the office manager, who would have the most accurate information on whether the practitioner was taking new patients and which products were accepted by the office for payment. Based on the response from the provider's office, the provider data staff member records whether the information in the directory is accurate. If the information is not accurate, the representative records the accurate information into a spreadsheet to be updated into the provider database and subsequently updated into the directory.

Measure 1: Accuracy of office locations

Numerator: Number of respondents with correct address listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of office locations listed in the directory

Measure 2: Accuracy of phone numbers

Numerator: Number of respondents with correct phone numbers listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of phone numbers listed in the directory

Measure 3: Accuracy of Hospital Affiliations

Numerator: Number of respondents with correct hospital affiliation listed in the directory
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of hospital affiliations listed in the directory

Measure 4: Accuracy of Accepting New Patients

Numerator: Number of respondents with correct 'Accepting New Patients' designation
Denominator: Total number of physician offices which responded
Goal: 100% accuracy of 'Accepting New Patients' designation in the directory

Measure 5: Awareness of physician office staff of physician's participation in the organization's network

Numerator: Number of respondents with awareness of participation in organization's network
Denominator: Total number of physician offices which responded
Goal: 100% awareness of physician office staff participating in the organization's network

II. Analysis

a. Results

Table #1. Measures 1-5 – Provider Directory Accuracy

	Accuracy of Office Locations	Accuracy of Phone Numbers	Accuracy of Hospital Affiliations	Accuracy of Accepting New Patients	Awareness of Office Staff of Physicians Participation in the Organization's Network
Number of Respondents with Accurate Entries	48	50	43	50	49
Total Physician Responses	52	52	52	52	52
Accuracy Percentage (%)	92%	96%	83%	96%	96%
2020 Accuracy Percentage (%)	98%	97%	100%	97%	100%
Goal	100%	100%	100%	100%	100%
Goal Met (Y/N)	N	N	N	N	N

b. Quantitative analysis

The performance goal set in Measurement Year 3 (MY3), 2021 of 100% was not met. The rate of accuracy of office locations was 98% in 2019, and 98% in 2020. It decreased by 6% to 92% in 2021. It is 8 percentage points below the performance goal. The rate of accuracy of phone

numbers was 98% in 2019, 97% in 2020 and went down to 96% in 2021, which is four percentage points below the performance goal.
The rate of accuracy of hospital affiliations was 80% in 2019, 100% in 2020 and went down to 83% in 2021, which is 17% below this performance goal. The accuracy of accepting new patients was, at 98% for 2019, 97% for 2020 and 96% 2021, the accuracy is 96%, which is -1% change, which is four percentage points below the performance goal. The accuracy level for participation in the organization's network was 94% for 2019, 100% for 2020 and 96% for 2021, which is four percent below the performance goal.

c. Qualitative analysis

In an effort to meet the performance goal for 2022, a barrier analysis was completed to identify opportunities and interventions to improve the rate of all accuracy measures. We focused on the two lowest performing measures, where there was the most opportunity for improvement.

2022 Barrier and Opportunity Analysis Table 2.0 (this goes to QIC every other year)

Barrier	Opportunity	Intervention	Selected for 2022?	Date Initiated
Delays in receiving changes from providers through their delegates	Reminders to delegates.	Continue to communicate timeliness of provider changes at quarterly joint operation committees.	Y	Ongoing
Rapidly changing provider data due to frequent staff changes	Inform/ educate providers of importance of submitting timely information	Ensure that provider relations staff has on-going communications to discuss data changes with MD and their office staff.	Y	Ongoing

Barrier	Opportunity	Intervention	Selected for 2022?	Date Initiated
SCFHP Provider Data report Data Validation Quality Checks	Create Quarterly Quality Checks on Provider Data Directory Validation	Quarterly validate the provider data through calls to provider office in validation of their submitted data reporting.	Y	Ongoing

III. Reporting

Committee Approval Table 3.0

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Exhibit A

SAMPLE PROVIDER ATTESTATION FORM

Provider Directory Attestation
Date: xx/xx/xxxx

Santa Clara Family Health Plan (SCFHP) is required to validate provider demographics on a quarterly basis in accordance with all our regulatory requirements. **Each practice location will receive a separate attestation form specific to the location**. **Please review and fax the completed attestation to 1-408-874-1433 before xx/xx/xxxx.** If there are any changes to your information, please document the updates in the "Changes needed" column, then sign and date at the bottom. If there are no changes, check the "No change" box for each item.

	Please complete "Changes needed" column if information is missing.	**No change**	**Changes needed**
Legal name & title: (As listed on license)		☐	
Other name(s): (Recognized by patients)		☐	

Practitioner NPI #:		☐	
Practitioner gender:		☐	
Practitioner ethnicity:		☐	
Languages spoken by practitioner:		☐	
CA State license # and expiration date:		☐	
DEA # / DEA expiration date:		☐	
Practitioner type:		☐	
Declared specialty	**Taxonomy**	**No change**	**Changes needed**
		☐	
		☐	

Board certification specialty	**Board certification**	**Certification date**	**Certification exp. date**	**Status**	**Changes needed**

	Please complete "Changes needed" column if information is missing.	**No change**	**Changes needed**
Practitioner hospital admitting privileges & effective date:		☐	
Medical group name/practice name:		☐	
Practice location address:		☐	
Practice city, state, and ZIP:		☐	
Practice phone:		☐	
After hours phone number:		☐	
Practice fax:		☐	
Practice fax for authorizations:		☐	
Hours at this location:		☐	
Name and NPI of supervising physician: (If NP, PA, or CNP)		☐	
Website URL:		☐	
	Please complete "Changes needed" column if information is missing.	**No change**	**Changes needed**
Organizational/billing NPI:		☐	
Tax ID # (used for billing):		☐	
Languages spoken by staff:		☐	
Proximity to public transport:		☐	☐ <1 block ☐ <2 blocks ☐ <5 blocks ☐< 1 mile
Accepting new patients?		☐	
Age limits (youngest/oldest):		☐	
Gender limits:		☐	☐ F only ☐ M only ☐ None

Provider email address: A provider's office email address shall be displayed only with the written permission of the provider, and only if the provider has affirmatively verified that the email address is intended for patient communication, and is regularly monitored and maintained in a manner consistent with state and federal health privacy laws.

Email for patient communication:		☐	
Email for SCFHP communication:		☐	
Cultural competency training completed? (Date & training name)		☐	
Participate in telehealth?		☐	☐ Telehealth only ☐ None ☐ In-person & telehealth
Full-time equivalent (FTE): (Total # of hours per week)		☐	

Completed trainings	**No change**	**Completed trainings**	**No change**

Substance abuse:		☐	HIV/AIDS		☐
Trauma-informed:		☐	Serious mental illness		☐
Physical disabilities:		☐	Homelessness		☐
Chronic illness:		☐	Deafness or hard of hearing		☐
QASP level:		QASP level: ☐ Paraprofessional ☐ Professional ☐ Provider			☐
Other (specify):					

Malpractice carrier:	**Insurance type:**	**Policy #:**	**Changes needed**
			☐ Malpractice ☐ General liability
Policy claim amount: **Aggregate amount:**	**Policy effective date:**	**Policy expiration date:**	**Changes needed**
			☐ 1M/3M ☐ 2M/4M ☐ 5M/5M ☐ 10M/10M ☐ Other _____

Please use the space below to provide additional information regarding this practitioner:

Attestation completed by:

Print name: _____ Print title: _____

Signature: _____ Date: _____

Office use only:

40429

Santa Clara Family Health Plan™

Provider Search Survey

September 2021

Introduction

NET 5 Element I: Usability Testing

- Marketing conducts a survey, at least every three years, to evaluate its web-based physician and hospital directories for understandability and usefulness to members and prospective members.
- The results are used to make modifications to our web-based provider search to enhance member experience.

Santa Clara Family Health Plan™

Methodology

Participant Selection

- Survey participants are selected from departments that frequently use the provider search to assist members in finding a provider: Enrollment & Eligibility, Medicare Outreach, and Community Resource Center.
- Selection also took the most common languages into consideration based on our population health needs assessment; participants could either read, write or speak in the following languages:

Language	Percentage of Cal MediConnect Membership	Number of Staff Who Received Survey
English	40.88%	16
Spanish	18.18%	7
Vietnamese	15.42%	5
Chinese	13.19%	2

Survey

- The survey is created using questions from the NCQA standard.
- Staff are given two weeks to complete the survey.
- Each question is reviewed by counts and percentages.
- Qualitative responses are reviewed for further context when applicable.

Survey Questions

Factor	Questions
1. Reading level.	• How easy was it to understand the search results? • How easy was it to understand the search instructions?
2. Intuitive content organization.	• What do you think about the look and feel of the Provider Search? • How satisfied are you with the organization of the Provider Search?
3. Ease of navigation.	• How satisfied are you with your experience navigating through the Provider Search? • Did you find the information you were looking for? • Did you find the search tool options useful? • Did you run into any roadblocks while navigating the Provider Search?
4. Directories in additional languages, if applicable to the membership.	• How easy was it to locate and/or request the directory in another language?
Overall	• How was your overall experience with the Provider Search? • Do you have any other comments about how we can improve the Provider Search?

Santa Clara Family Health Plan™

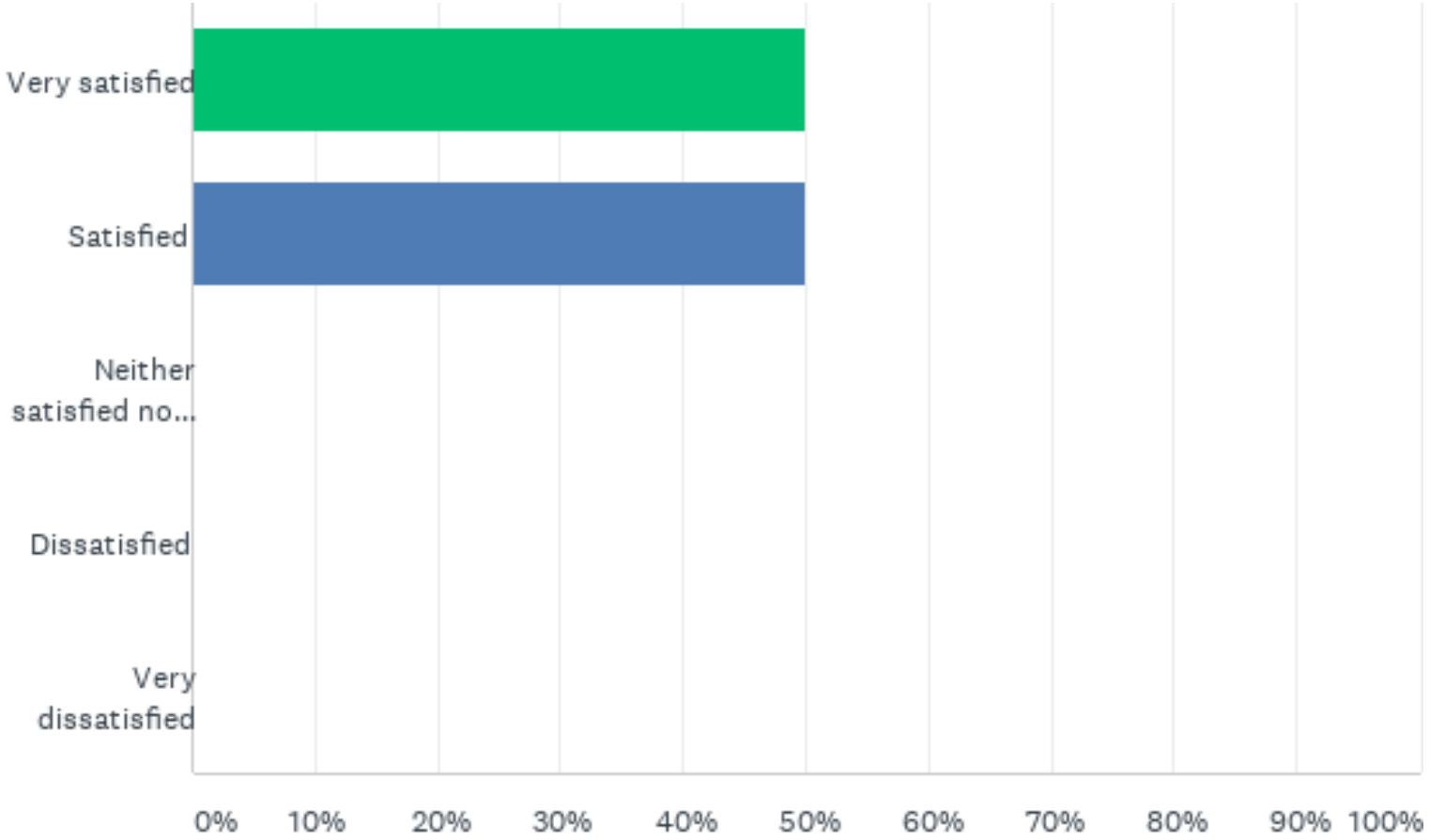
Results

Survey Completion

- The survey was sent out to 16 staff members who were not involved in the development of the directory.
- A total of 8 staff (50%) completed the survey.

Q1: How satisfied are you with your experience navigating through the Provider Search?

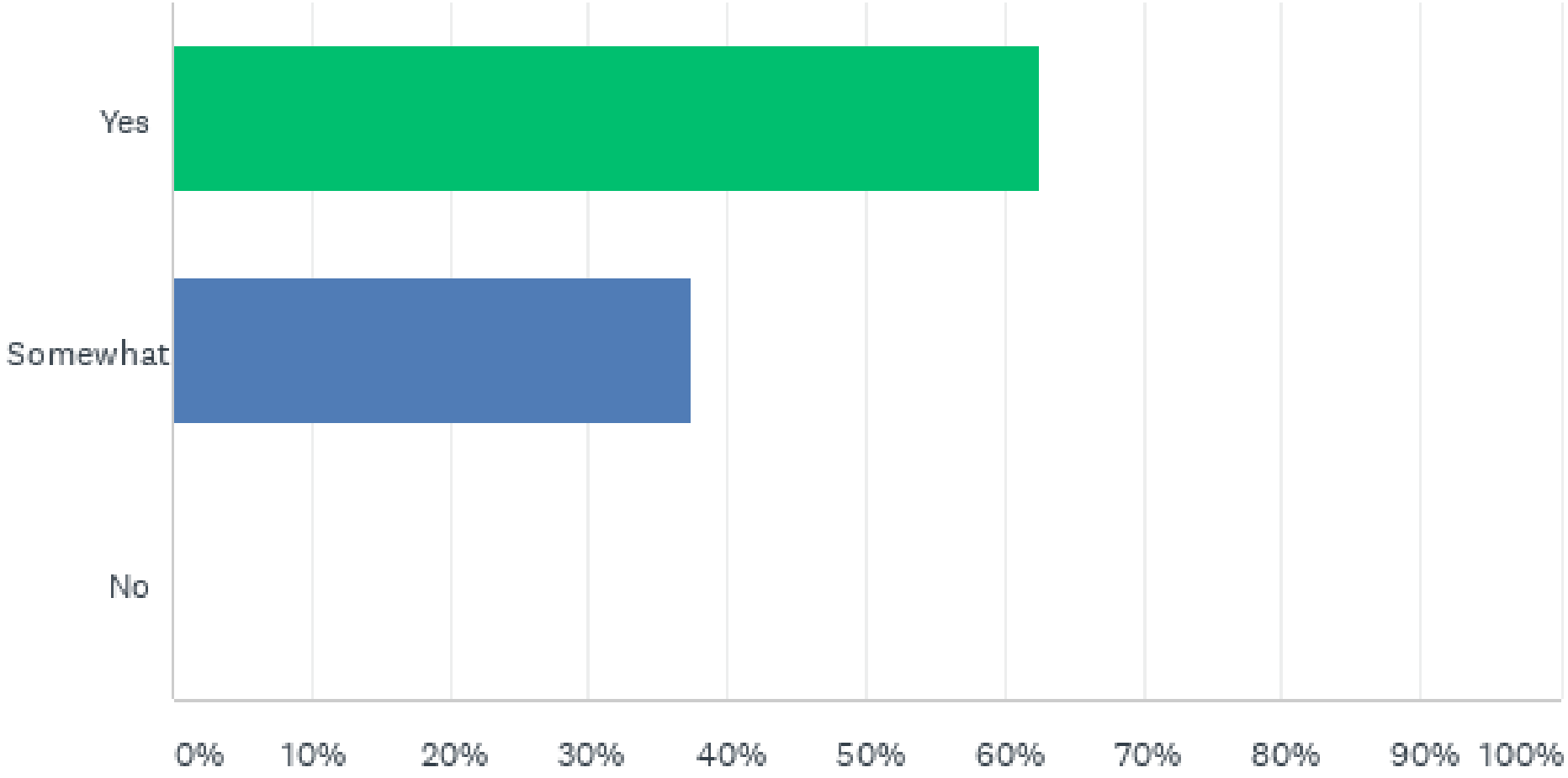
- Answered: 8 Skipped: 0



Q1: How satisfied are you with your experience navigating through the Provider Search?

ANSWER CHOICES	RESPONSES	
Very satisfied	50.00%	4
Satisfied	50.00%	4
Neither satisfied nor dissatisfied	0.00%	0
Dissatisfied	0.00%	0
Very dissatisfied	0.00%	0
TOTAL		8

Q2: Did you find the information you were looking for?

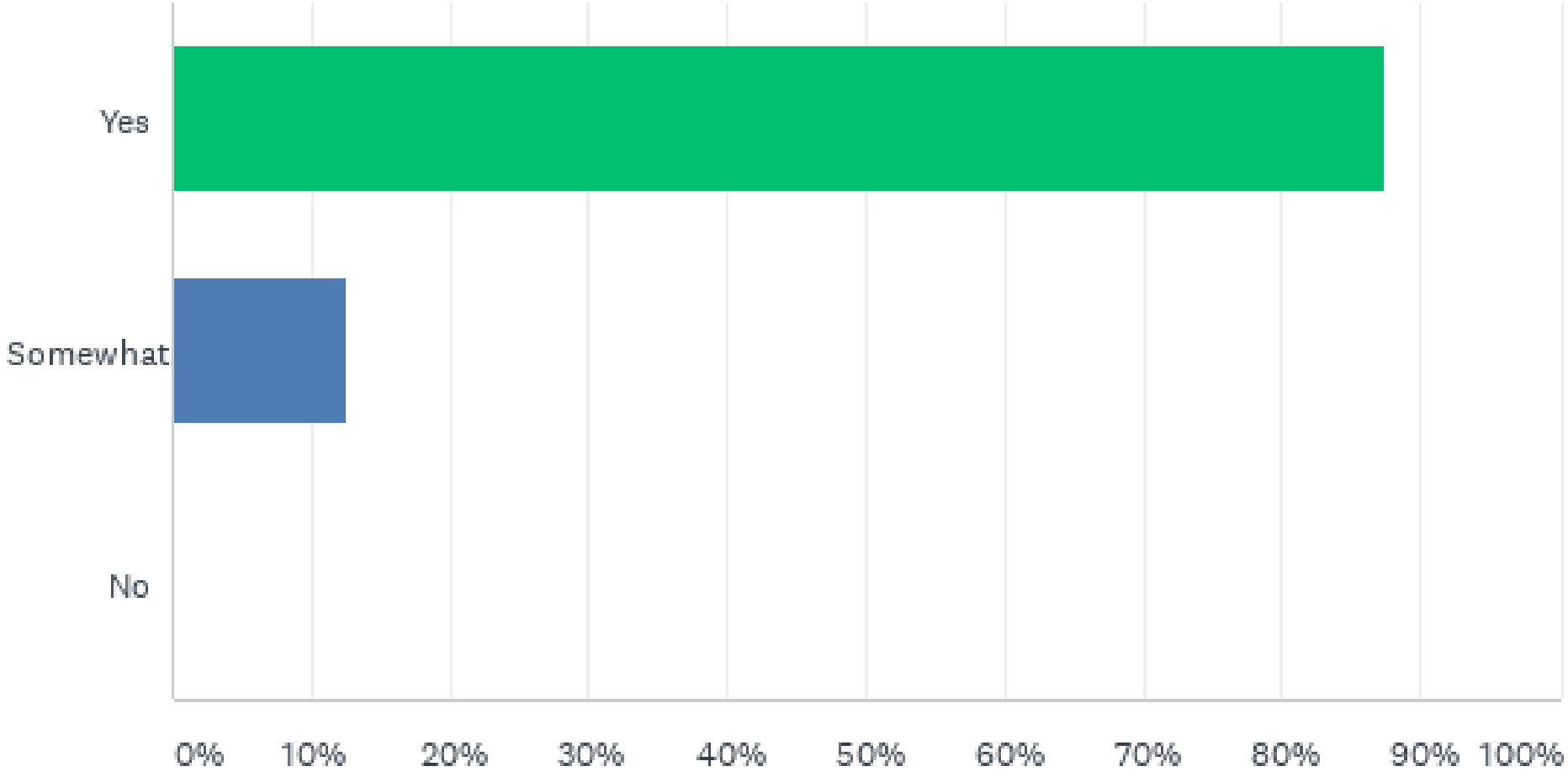


Q2: Did you find the information you were looking for?

ANSWER CHOICES	RESPONSES	
Yes	62.50%	5
Somewhat	37.50%	3
No	0.00%	0
TOTAL		8

#	IF SOMEWHAT OR NO, PLEASE EXPLAIN.
1	Could not find list of skilled nursing facilities

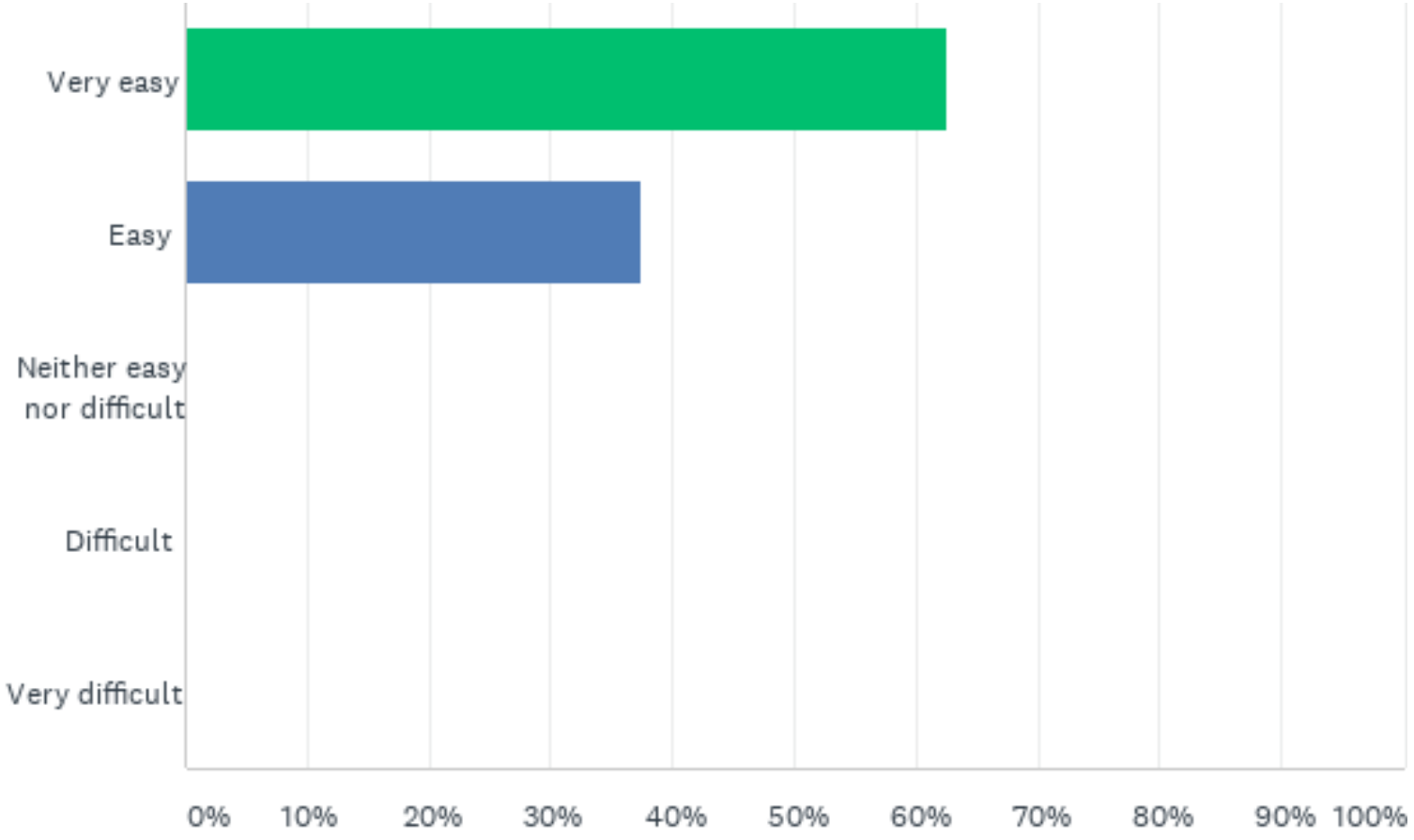
Q3: Did you find the search tool options useful?



Q3: Did you find the search tool options useful?

ANSWER CHOICES	RESPONSES	
Yes	87.50%	7
Somewhat	12.50%	1
No	0.00%	0
TOTAL		8

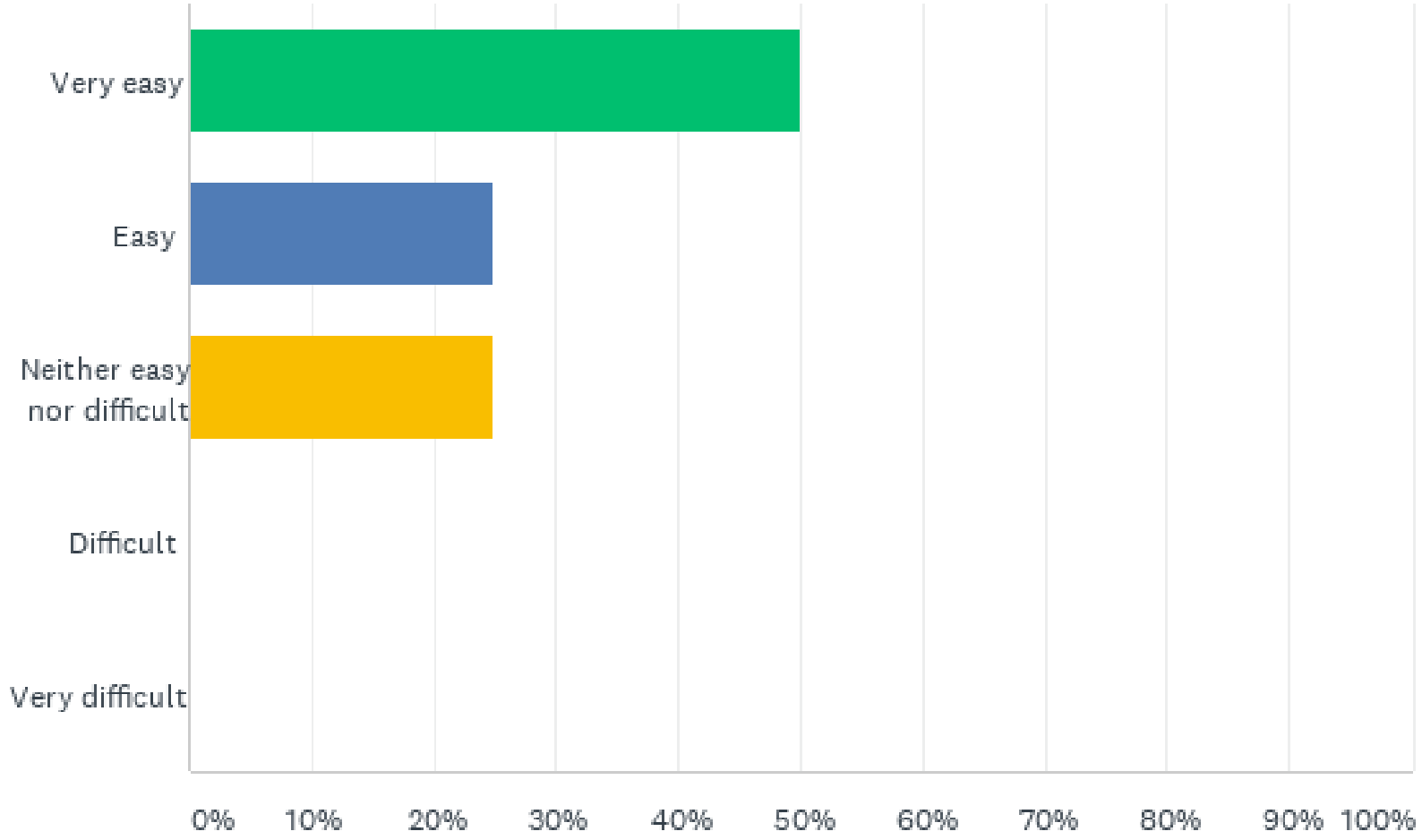
Q4: How easy was it to understand the search results?



Q4: How easy was it to understand the search results?

ANSWER CHOICES	RESPONSES	
Very easy	62.50%	5
Easy	37.50%	3
Neither easy nor difficult	0.00%	0
Difficult	0.00%	0
Very difficult	0.00%	0
TOTAL		8

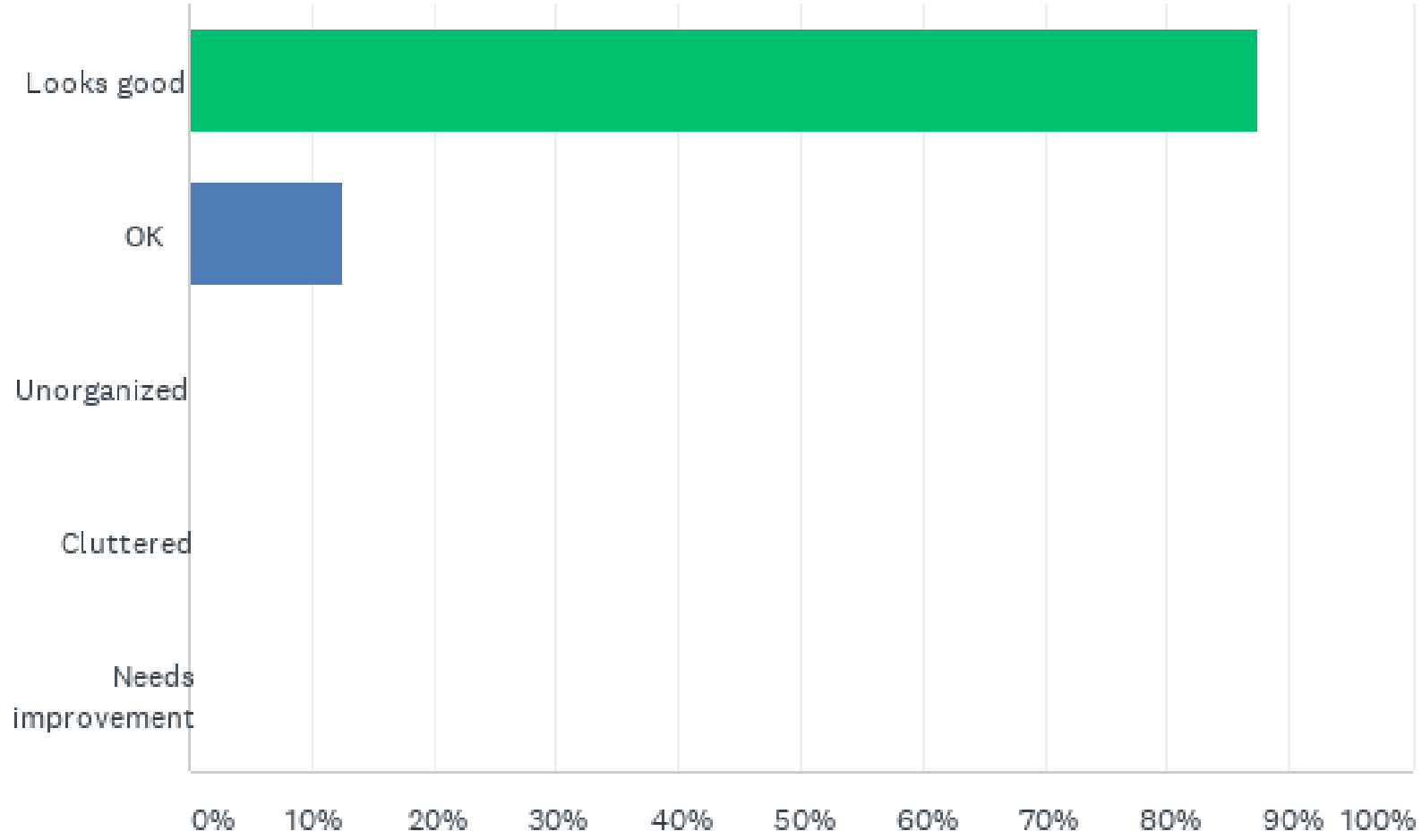
Q5: How easy was it to understand the search instructions?



Q5: How easy was it to understand the search instructions?

ANSWER CHOICES	RESPONSES	
Very easy	50.00%	4
Easy	25.00%	2
Neither easy nor difficult	25.00%	2
Difficult	0.00%	0
Very difficult	0.00%	0
TOTAL		8

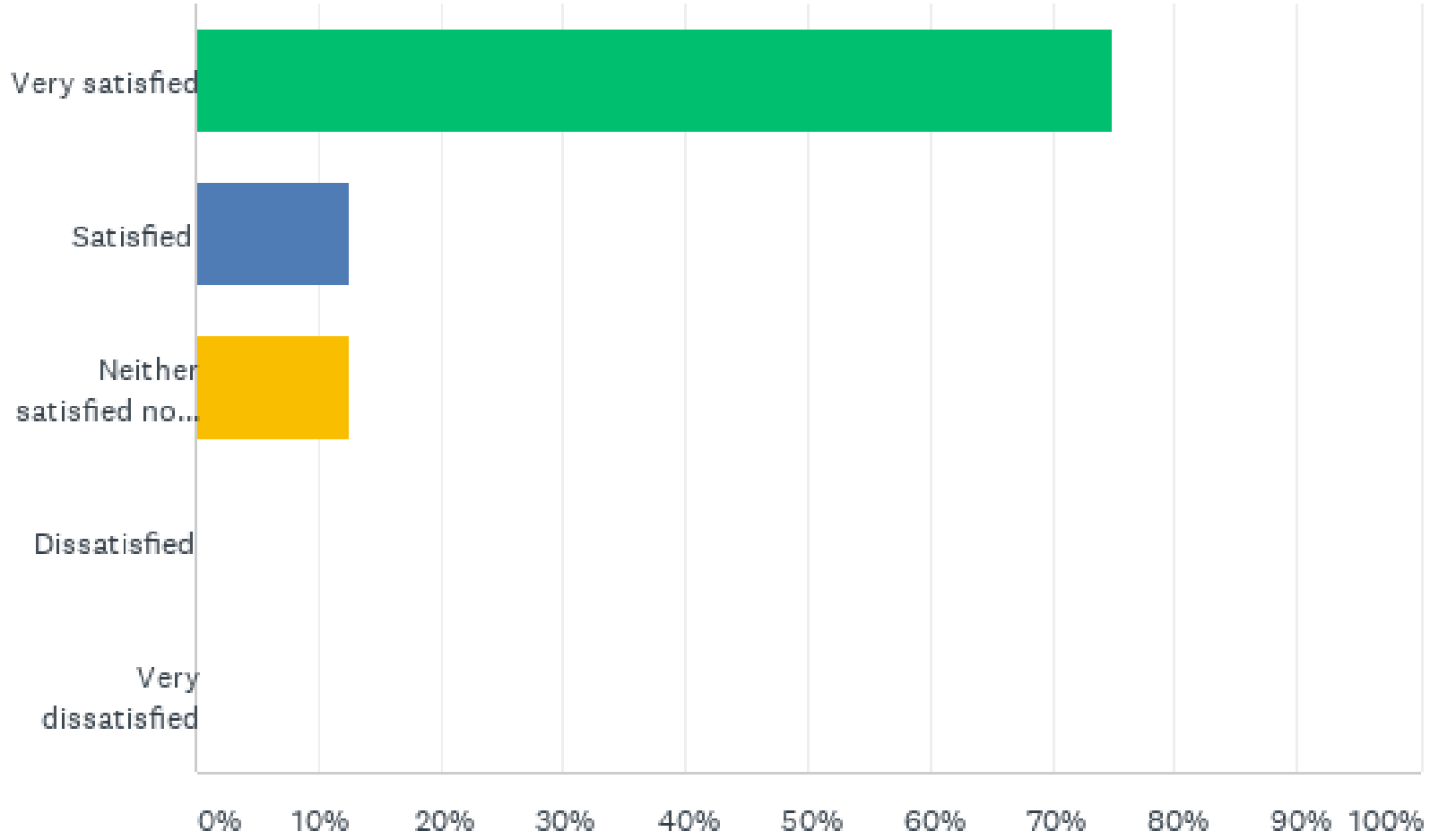
Q6: What do you think about the look and feel of the Provider Search?



Q6: What do you think about the look and feel of the Provider Search?

ANSWER CHOICES	RESPONSES	
Looks good	87.50%	7
OK	12.50%	1
Unorganized	0.00%	0
Cluttered	0.00%	0
Needs improvement	0.00%	0
Total Respondents: 8		

Q7: How satisfied are you with the organization of the Provider Search?

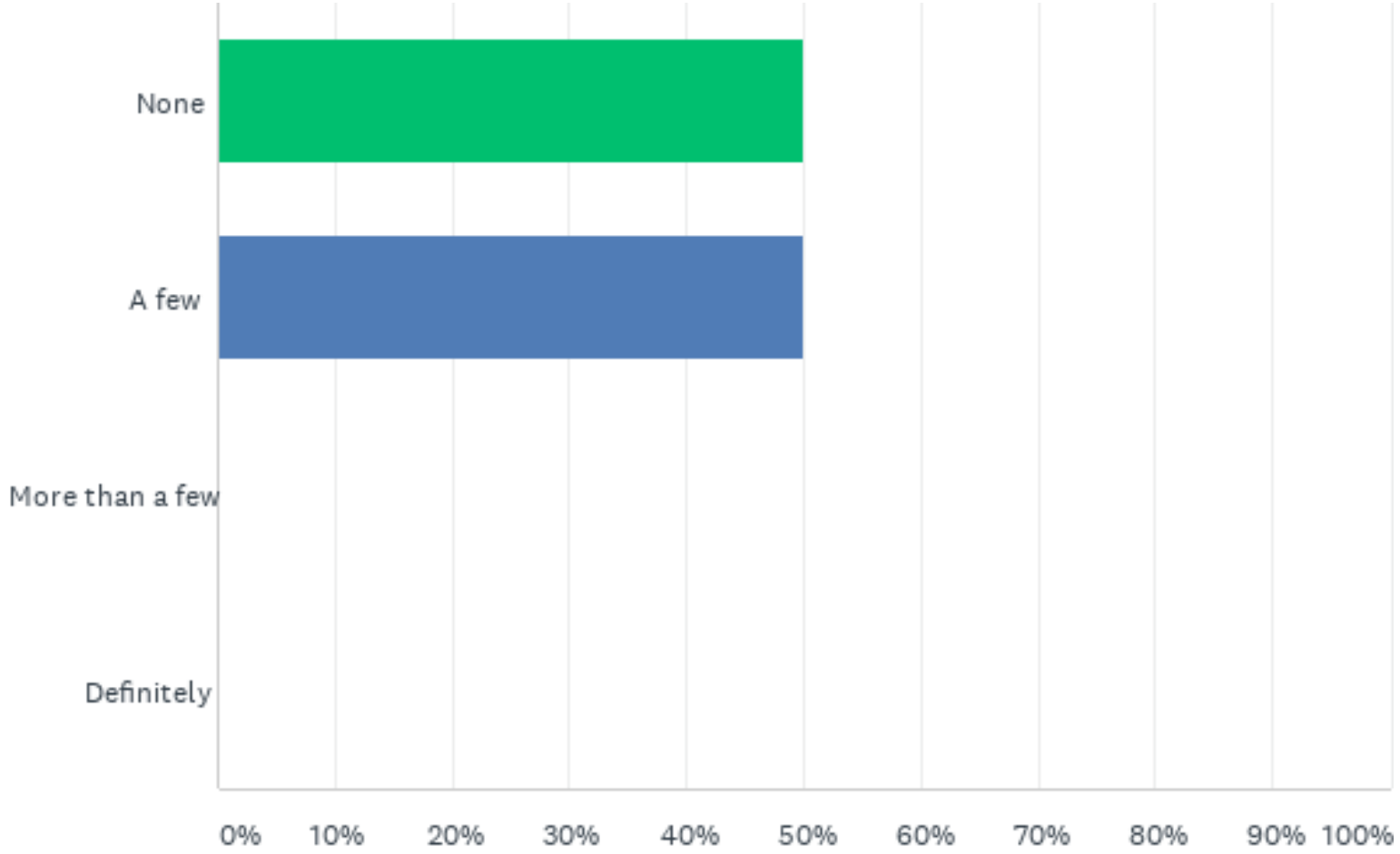


Q7: How satisfied are you with the organization of the Provider Search?

ANSWER CHOICES	RESPONSES	
Very satisfied	75.00%	6
Satisfied	12.50%	1
Neither satisfied nor dissatisfied	12.50%	1
Dissatisfied	0.00%	0
Very dissatisfied	0.00%	0
TOTAL		8

#	PLEASE EXPLAIN YOUR CHOICE.
1	Quick look up table to assist members, or members can find it useful.

Q8: Did you run into any roadblocks while navigating the Provider search?

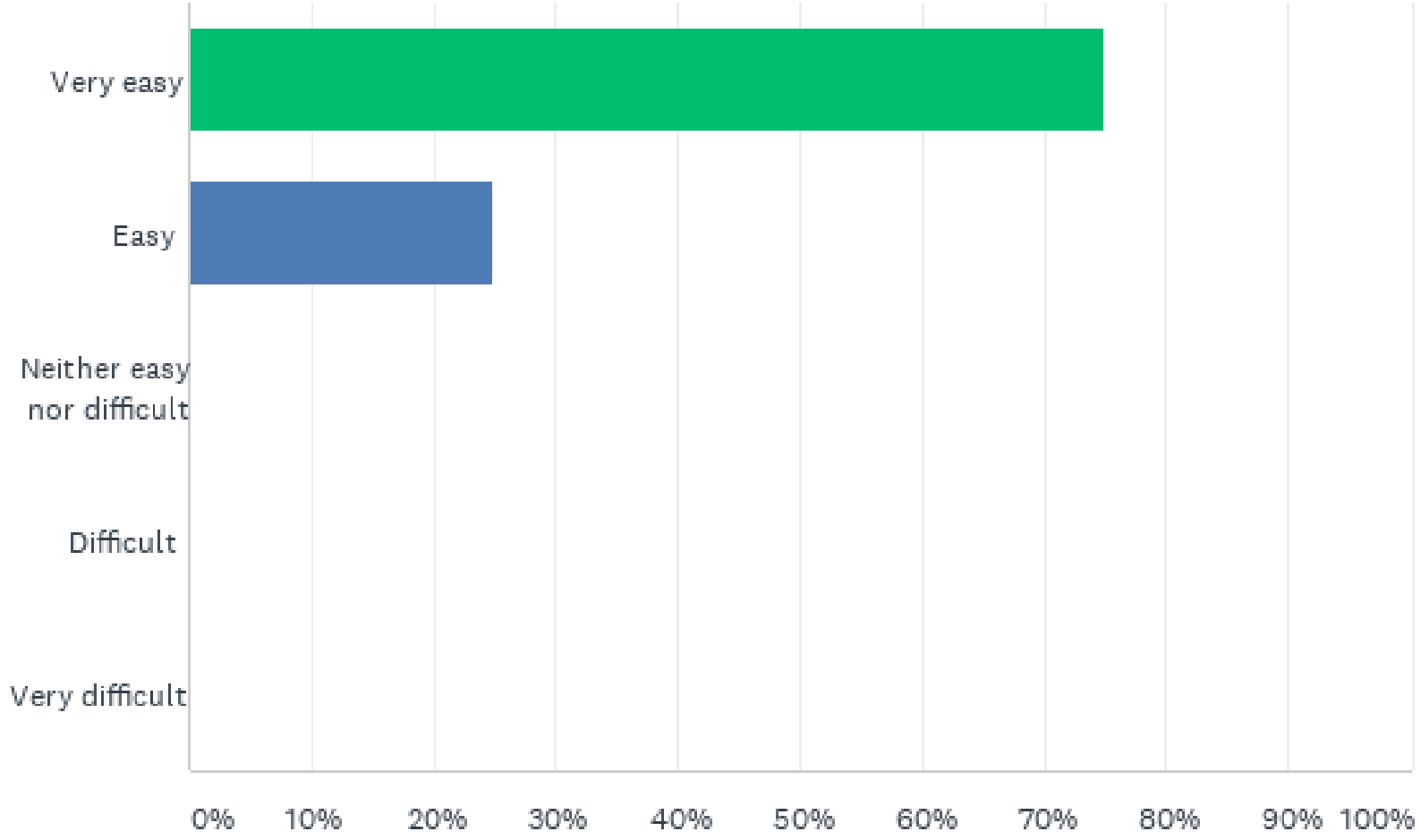


Q8: Did you run into any roadblocks while navigating the Provider search?

ANSWER CHOICES	RESPONSES	
None	50.00%	4
A few	50.00%	4
More than a few	0.00%	0
Definitely	0.00%	0
TOTAL		8

#	PLEASE EXPLAIN.
1	hard to find Skilled Nursing Facilities
2	Email instructions made me think to explore information as on record e.g. pertaining to PCP. Not explained to find Facility it is separate query (which I already knew).
3	searching for specialist. some are similar and they do not pop up

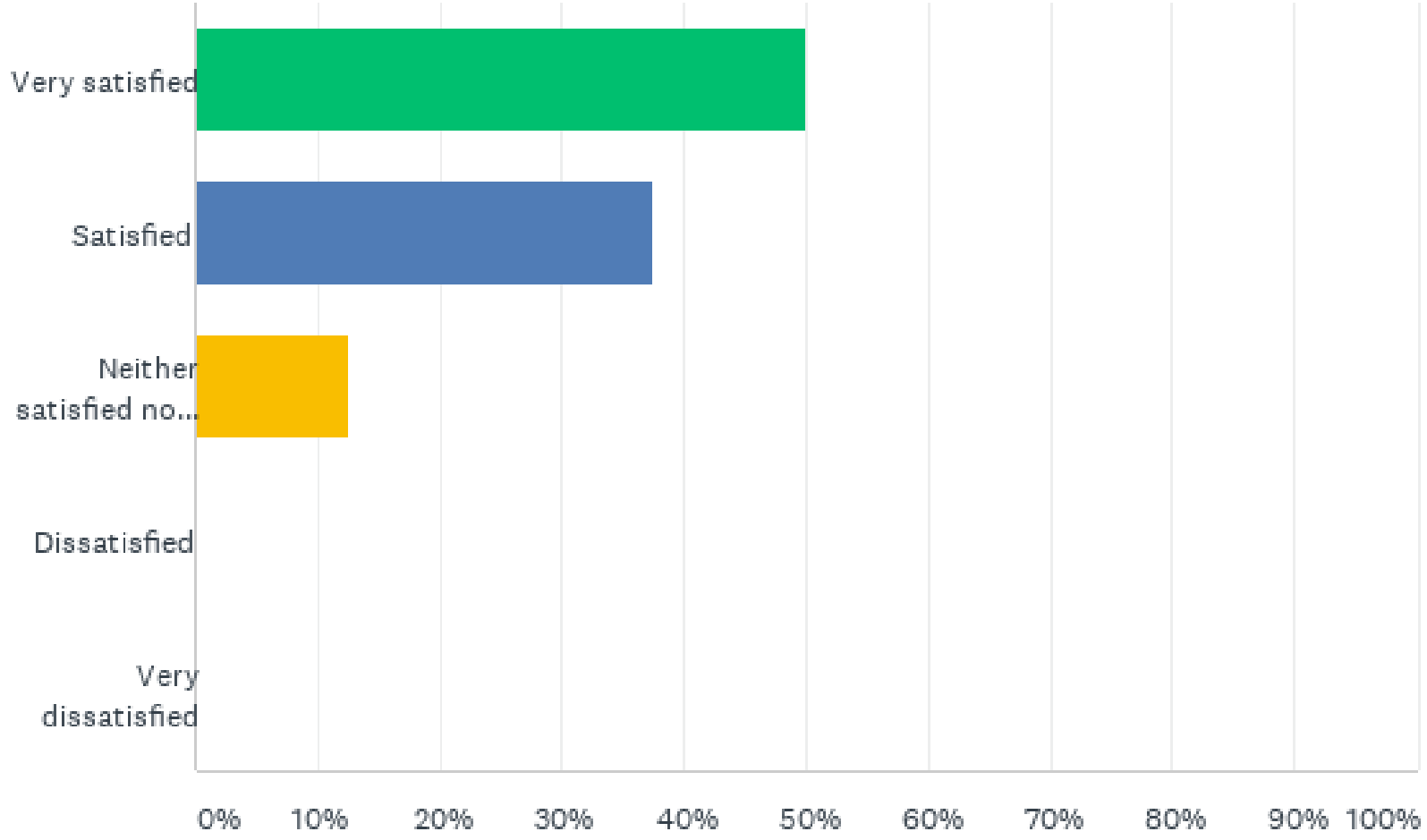
Q9: How easy was it to locate and/or request the directory in another language?



Q9: How easy was it to locate and/or request the directory in another language?

ANSWER CHOICES	RESPONSES	
Very easy	75.00%	6
Easy	25.00%	2
Neither easy nor difficult	0.00%	0
Difficult	0.00%	0
Very difficult	0.00%	0
TOTAL		8

Q10: How was your overall experience with the Provider Search?



Q10: How was your overall experience with the Provider Search?

ANSWER CHOICES	RESPONSES	
Very satisfied	50.00%	4
Satisfied	37.50%	3
Neither satisfied nor dissatisfied	12.50%	1
Dissatisfied	0.00%	0
Very dissatisfied	0.00%	0
TOTAL		8

#	PLEASE EXPLAIN.
1	Very good tool to search for providers and Facilities at finger tips

Q11: Do you have any other comments about how we can improve the Provider Search?

#	RESPONSES
1	it works really well. It has many fields to narrow the search.
2	for member a video in how to use "Find Doctor" would be helpful

Findings

Factor	Findings
1. Reading level.	More than half felt that the overall reading level was easy to understand, for both the search instructions and the search results.
2. Intuitive content organization.	Over 87% were satisfied with the organization and look/feel of the Provider Search, feeling the content organization was well laid out.
3. Ease of navigation.	Although 87.5% of participants found the search tool options to be useful, the ease of navigation could be improved, as 50% ran into roadblocks finding the information they were looking for, specifically a list of Skilled Nursing Facilities.
4. Directories in additional languages, if applicable to the membership.	All participants found it easy or very easy to locate and/or request a Provider Directory in another language.

Opportunities for Improvement

Barrier: Difficulty searching for Skilled Nursing Facilities

- Make the “Provider” and “Facility” tabs more visible and understandable
- Create a “How to” introduction video for Provider Search

Conclusion

The provider search function was useful in finding and understanding physician and facility information. However, there is room for improving the navigation. In the survey results, it was noted that there were difficulties searching for Skilled Nursing Facilities. Overall, all participants found their experience using our provider search satisfactory.

Santa Clara Family Health Plan™

NCQA – Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Calendar Year 2020 Review

Overview

Overview of SCFHP's analysis of the continuity and coordination between medical and behavioral healthcare - National Committee for Quality Assurance (NCQA)

- Review of Factors:
  1. Exchange of information between behavioral and medical care
  2. Diagnosis, treatment and referral of behavioral disorders commonly seen in primary care
  3. Appropriate use of psychotropic medications
  4. Management of co-existing medical and behavioral disorders (Intervention completed)
  5. Prevention programs for behavioral health
  6. Special needs of members with severe and persistent mental illness (Intervention completed)

The analysis reviewed data for comparison between CY 2018, CY 2019 and CY 2020.

Factor 1 – Exchange of Information

SCFHP collects data on the exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

*Methodology changed in CY 2019 from Medical Record Review to Primary Care Physician (PCP) Questionnaire to enable us to obtain information directly from providers.

Population: CMC Members connected to both outpatient Behavioral Health (BH) services as well as established PCP as evidenced by claims [denominator] whose PCPs received medication lists/updates at least annually and after BH updates [numerator].

- Goal: 80% of the total number of samples meet the timeliness standard.
- CY2018 (baseline) & CY 2019 (comparison year 1) & CY 2020 (comparison year 2) we did not meet our goal.

Barriers and intervention suggestions for improvement reviewed in a workgroup session June 2021; this factor was not chosen for implementation of interventions for this report cycle.

Factor 1 – Exchange of Information

CY 2018 (Medical Record Review):	CY 2019 (PCP Questionnaire):	CY 2020 (PCP Questionnaire):
• Only EMR records to review (n = 21).	• Response rate of 13/60 questionnaires, or 22%	• Response rate of 6/60, or 10%. • Decrease in response rate by 12 percentage points.
• Sample size: 60 Members	• Sample size: 60 Members	• Sample size: 60 Members
• Only EMR passed for timeliness; a passive pass as access was acknowledged but no verification of communication, medication review, etc.	• One PCP agreed that information was received timely & One PCP acknowledged access to EMR system (counted as a pass for timeliness) • 2 /13 = 15%	• Two PCPs stated that information pertaining to Member medications was obtained at PCP request by the Member; no PCP reported direct BH Provider communication pertaining to medication (one PCP directly requested). • 0 / 6 = 0%
• Did not meet goal as 21/60 or 35% passed for timeliness.	• Did not meet goal as 2/13 or 15% passed for timeliness.	• Did not meet goal as 0/6 or 0% passed for timeliness.

Factor 2 – Appropriate diagnosis, treatment, & referral of behavioral disorders commonly seen in primary care

The SCFHP looks at the results of the HEDIS measure Antidepressant Medication Management (AMM) to monitor that members with a behavioral health diagnosis of depression are being appropriately treated.

Population: For each measure, the total number of Members taking medication for the specified period of time (numerator) is compared to the total number of Members prescribed antidepressant medication (denominator).

The two measures include the Acute Effective Treatment Phase (consistent compliance for 12 weeks) as well as the Continuation Treatment Phase (consistent compliance for 6 months)

- Goal: 75th Percentile HEDIS for both AMM measures in Metric Year measured.
- MY 2018 (baseline): 75th percentile Continuation Phase & 50th percentile Acute Phase.
- MY 2019 (comparison year): 50th percentile Continuation Phase & 25th percentile Acute Phase.
- MY 2020 (comparison year): 50th percentile Continuation Phase & 50th percentile Acute Phase
- We did not meet our goal.

Factor 2 – Appropriate diagnosis, treatment, & referral of behavioral disorders commonly seen in primary care

HEDIS AMM Measure	2018	2019	2020
Effective/Acute Phase of Treatment	73.73% Goal: 75.39% (missed goal for 75th percentile by 1.66 percentage points)	71.78% Goal: 77.52% (missed goal for 75th percentile by 5.74 percentage points)	75.00% Goal: 77.52% (missed goal for 75th percentile by 2.52 percentage points)
Continuation of Treatment	61.86% Goal: 60.32% (goal met)	57.92% Goal:61.58% (not met) (missed goal for 75th percentile by 3.66)	61.57% Goal: 61.58% (missed goal for 75th percentile by 0.01 percentage points)

Factor 3 – Appropriate Use of Psychotropic Medications

The SCFHP collects data on Behavioral Health and Primary Care Practitioner adherence to prescribing guidelines concerning antidepressant medication prescriptions.

CMC M2M Members prescribed antidepressant medications for mental health (denominator) and determine if the prescription was written for the Member by their PCP (numerator) or Psychiatrist (numerator).

- **Goal (part I):** 50% of antidepressant medications for this population to be prescribed by PCPs and 50% of antidepressant medications to be prescribed by Psychiatrists.
- Data discrepancy noted: CY 2018 data and CY 2019 were gathered for trending comparison in 2019; Continuing into CY 2020 We met our goal. *This is part one of goals for this factor.

	Total # Scripts (denominator)	Psychiatrist Scripts	PCP Scripts	Not-Included * (unidentifiable providers)
CY 2018	N = 944	278/944 = **29%**	633/944 = **67%**	33/944 = 4%
CY 2019	N = 924	250/924 = **27%**	628/924 = **68%**	46/924 = 5%
CY 2020	N = 930	285/930 = **30.1%**	580/930 = **62.4%**	65/930 = 7.5%

Factor 3 – Appropriate Use of Psychotropic Medications

We plan to continue to monitor this measure to maintain a 50-50 split in prescriptions and chose to modify this goal to continue PCP education.
As there are research studies as well as American Psychological Association support to include talk therapy along with prescribing of antidepressants, current rates of talk therapy were reviewed and included in our secondary goal for this factor beginning in CY 2019 report.

Goal (part II): 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year. This was measured by comparing the total number of Members receiving antidepressant medications for M2M conditions through PCPs (denominator) over those currently engaged in talk therapy as identified by CPT & HCPC talk therapy codes (numerator).

We did not meet our part II Goal for this factor; it was not chosen for interventions this report cycle.

	Total # Scripts (denominator)	Psychiatrist Scripts + Member is Receiving Talk Therapy	PCP Scripts + Member is Receiving Talk Therapy
CY 2019	250 = Psychiatry 628 = PCP	(99/250) = 40%	(178/628) = 28%
CY 2020	285 = Psychiatry 580 = PCP	(75/285) = 26.3% (-13.7 percentage points)	(101/580) = 17.1% (-10.9 percentage points)

Factor 5 – Secondary preventative behavioral healthcare program implementation

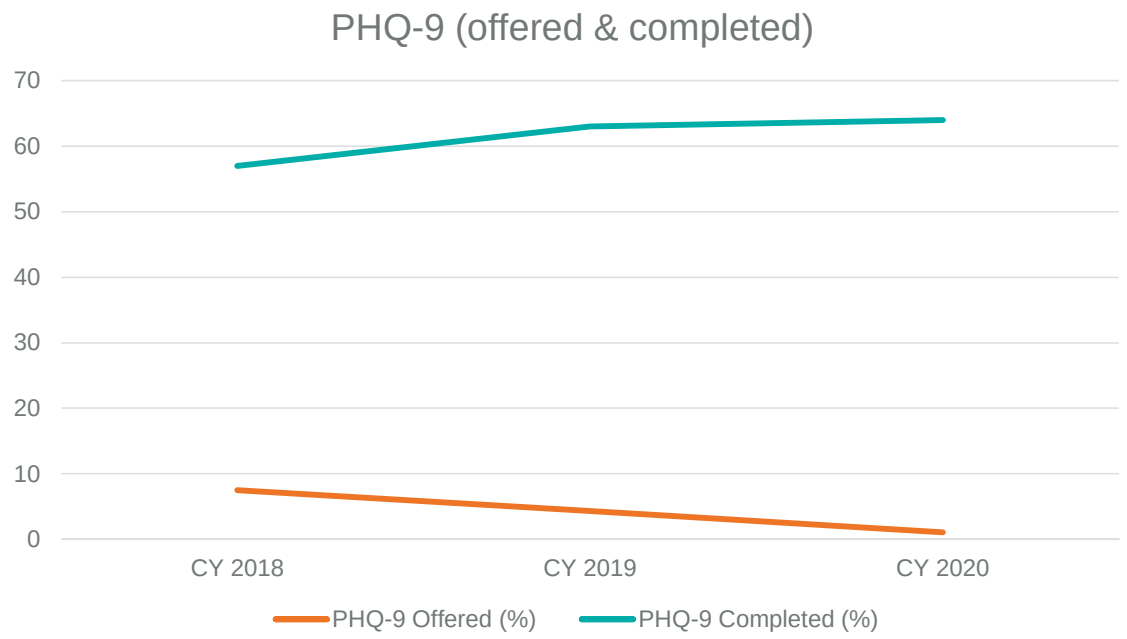
The SCFHP collects data on Members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions. These Members are identified through use of the Health Risk Assessment (HRA).

Population: All CMC Members who indicate depressive symptoms within their HRA [denominator] are offered Patient Health Questionnaire – 9 (PHQ-9) for review of need and support. The Member desire to complete or decline the PHQ-9 is noted for additional information to review for this population.

Goal = 80-100 % CMC Members with HRA indicators of depression have been offered to complete the PHQ-9, as captured within a PHQ-9 Assessment within the Health Plans case management software program.

- Our overall goal is supplemented with data to determine participation of Members who have been offered a PHQ-9 assessment (denominator) and the level of participation as declined or completed (numerator).

Factor 5 – Secondary preventative behavioral healthcare program implementation



While not an official intervention, quarterly internal trainings have been ongoing in CY 2020 to help increase the number of PHQ-9 assessments offered to Members who meet criteria to address outreach efforts.

Of the total Members eligible within this program to be offered to complete a PHQ-9 for assessment and follow up recommendations, only 1.1% had a PHQ-9 assessment offered to them; this shows a decrease from CY 2019 in outreach by 3.2%.

However, in our comparison year CY 2019 of those offered the PHQ-9 63% completed the assessment while in CY 2020 of those offered the PHQ-9 64% completed the assessment; despite lower outreach in CY 2019 Member participation continues to increase (increased by 1%).

Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders (Interventions Completed & Effectiveness)

The Santa Clara Family Health Plan collects data on CMC Members identified as having dual diagnoses of Schizophrenia (diagnosis code F29) as well as Diabetes Mellitus II (DMII).

% of Members with both Diabetes Mellitus Type II and Schizophrenia who had a Primary Care/Internal Medicine visit within CY 2020 (numerator) / total number of members diagnosed with both Diabetes Mellitus Type II and Schizophrenia (denominator).

Goal = 75% of CMC members identified with diagnoses of Schizophrenia & Diabetes Mellitus Type II to have attended at least one annual Primary Care Visit for ongoing physical health monitoring.

CY 2018 = did not meet our goal by 13.3 percentage points
CY 2019 = did not meet our goal by 12 percentage points.
CY 2020 = did not meet our goal by 14 percentage points.

	CY 2018 Data	CY 2019 Data	CY 2020 Data
Total Members with diagnoses Schizophrenia & Diabetes Mellitus II (Total N)	94	97	92
Those who met with PCP for follow up:	58	61	56
Those who did not meet with PCP for follow up:	36	36	36
Percentage who completed PCP follow up:	(58 / 94) = 61.7%	(61 / 97) = 63% (+ 1.3%)	(56 / 92) = 61% (- 2%)

Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders (Interventions Completed & Effectiveness)

Barrier	Opportunity	Intervention	Selected	Date Initiated
Many Members diagnosed with SPMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	Information to Member and Providers to educate on need for DM2 follow up and potential medication influence on blood sugar (medical discussion)	Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have follow up A1c testing completed	Y	12/2019
Members of this subpopulation may not prioritize health care/annual PCP visits. (Deficit of Knowledge)	Provide outreach and education to remind all Members of the importance of Health Care provider follow up appointments	3 outgoing calls to connect with Member and remind to: Schedule PCP Annual Wellness exam + Have A1c blood testing completed	Y	11/5/2020-11/16/2020
Members of this subpopulation may not remember health care/annual PCP visits. (Deficit of Knowledge)	Information to Providers to educate on need for DM2 follow up and potential medication influence on blood sugar and reminder of Standards of Care to review.	Letter to current PCP Providers to Promote overall Health of Members – encourage outreach to Member to assist Member to have follow up appointment for A1c testing completed and medication review	Y	10/2021

Our data in review of CY 2020 shows a decrease in PCP appointment attendance by 2%,
The first intervention involving letters to providers was indicated to be beneficial (1.3% increase) versus our second intervention of calls to Members (2% decrease). The third intervention implemented brought Standards of Care and encouragement for outreach to Members for specific A1c testing. SCFHP plans to improve timing of data collection and implementation of interventions in 2021 to continue to improve upon intervention effectiveness and goal achievement.

Factor 6 – Special needs of members with severe and persistent mental illness (Interventions Completed & Effectiveness)

The Santa Clara Family Health Plan (SCFHP) collects data based originally on the parameters of the HEDIS measure Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC); to increase number of Members addressed, increased the Severe Mental Illness diagnoses in our data pull.

SCFHP has expanded the HEDIS measure to include other Severe and Persistent Mental Illness (SMI) diagnoses, including:

- Schizophrenia
- Schizoaffective Disorders
- Bipolar Disorders
- Unspecified Psychosis

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia: Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

After modifying the parameter, our population for this measure increased from single digit to double digit numbers.

Population: For measurement, all CMC Members diagnosed with both SPMI diagnoses & Cardiovascular Disease (denominator) & are reviewed through claims data to verify that they have been seen by their PCP for LDL-C blood work follow up (numerator).

Factor 6 – Special needs of members with severe and persistent mental illness (Interventions Completed & Effectiveness)

Goal: 75% of Total Members with SPMI & Cardiovascular Disease diagnoses will have completed LDL-C blood work testing for follow up treatment care with their providers.

SCFHP did not meet the set goal in CY 2020 by 56.5 percentage points.

There was a decrease in Members who had completed LDL-C testing in CY 2020 by 0.5%.

TABLE. Comparison CY 2018, CY 2019, and CY 2020: Dually Diagnosed Members (SMI + Cardiovascular Disease) follow up testing

	Total SMI + CD Members	Members who COMPLETED LCL-C testing	Members who DID NOT COMPLETE LCL-C testing
CY 2018	31	6 / 31 = **19%**	25 / 31 = **81%**
CY 2019	42	8 / 42 = **19%**	34 / 42 = **81%**
CY 2020	27	5 / 27 = **18.5%**	22 / 27 = **81.5%**

Factor 6 – Special needs of members with severe and persistent mental illness

Barrier	Opportunity	Intervention	Selected	Date Initiated
Lack of support – Member may have forgotten to follow up and complete necessary follow up for medical condition of CHF by completing LDL-C testing	Notify Members of identified need for LDL-C testing (3 outbound calls to Members)	Notify Members of identified need for LDL-C testing (3 outbound calls to Members) & offer assistance in obtaining PCP apt if desired.	Y	10/2019
Many Members diagnosed with SMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have medical follow up completed	Fax letter to providers (BH & PCP) for medical follow up need (LDL-C lab order)	Y	11/2020
Providers are prescribing medications without adhering to Standards of Practice; Member must be seen every 6-12 months for assessment	Provider Education & Reminder of Standards of Care for those with Cardiovascular Disease	Letter created and sent to Cardiologists of Members identified without follow up to encourage appointments and remind them of Standards of Care Practices	Y	10/2021

Workgroup to review Barriers and Discuss Interventions was conducted 10/2019, 10/2020, and 6/2021 respectively. This factor was chosen for intervention implementation at baseline year CY 2018 for ongoing trending.

Review of CY 2020 data shows a slight decrease of 0.5% in response to our second intervention completed in 2020 for this factor. There was no difference in data between CY 2018 & CY 2019 (18% completed and met with PCP)

SCFHP plans to improve timing of data collection and implementation of interventions in 2020 to improve upon intervention effectiveness and goal achievement.

Santa Clara Family Health Plan™

Questions?

Contact Tiffany Franke-Brauer, Behavioral Health Case Manager Lead at tfranke@scfhp.com or Gaya Amirthavasar, Process Improvement Project Manager at GAmirthavasar@scfhp.com

Summary Handout:
NCQA QI 4 – Continuity and Coordination Between Medical Care and Behavioral Healthcare

Factor	Metric	Result/Trend	Goal Met?
1. Exchange of Information	80% of the questionnaires to PCPs reported that information was shared to meet the timeliness standard	2018 – 35% (21/60 responses) 2019 – 15% (2/13 responses) 2020 – 0% (0/6 responses)	No
2. Appropriate Diagnosis, treatment, referral of behavioral disorders commonly seen in primary care	Medication adherence of adults (aged 18 – 64 years old) prescribed antidepressant medication during two different effective phase treatments: - the Acute Phase (or first 12 weeks) of medication adherence, and - the Continuation Phase (or 6 continuous months) of medication adherence	2018 – Acute goal missed by 1.66 percentage points; Continuous goal met 2019 - Acute goal missed by 5.74 percentage points; Continuous goal missed by 3.66 percentage points 2020 - Acute goal missed by 2.52 percentage points; Continuous goal missed by 0.01 percentage points	No
3. Appropriate use of psychotropic medications	Metric 1: 50% split between Psychiatrists and PCPs prescribing antidepressant medications to our Mild-to-Moderate Behavioral Health Members Metric 2: 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year	Metric 1: 2018 – 29%/67%* 2019 – 27%/68% 2020 – 30.1%/62.4% Metric 2: 2019 – 28% 2020 – 17.1%	Metric 1: Yes Metric 2: No
4. Management of treatment access and follow up for members with coexisting medical and behavioral disorders	75% of members with diagnoses Schizophrenia & Diabetes Mellitus II who completed PCP follow up	2018 – 61.7% 2019 – 63% 2020 – 61%	No
5. Primary or secondary preventative behavioral healthcare program implementation	80-100% of HRA identified Members with self-identified indicators of depression to have been offered the PHQ-9 for assessment.	Offered PHQ-9: 2018 – 328/4376 = 7.5% 2019 – 122/2831 = 4.3% 2020 – 72/6779 = 1.1% Completed PHQ-9: 2018 – 57% 2019 – 63% 2020 – 64%	No
6. Special needs of members with sever and persistent mental illness	75% of our total subpopulation members to have completed follow up testing as ordered by PCP (LDL-C test)	2018 – 24% 2019 – 19% 2020 – 18.5%	No

Santa Clara Family Health Plan (SCFHP)

Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

(CY2020 – Second Comparison Year Report, CY 2019 – First Comparison Year, CY 2018 [Baseline Year] Analysis)

Quality Improvement Committee: October 6, 2021

Introduction

The Santa Clara Family Health Plan (SCFHP) collaborates with providers from multiple areas of specialty to assist with care coordination between medical and behavioral health providers. Each year, data is collected and analyzed to help identify opportunities in which Members and Providers can best be supported to meet Member healthcare needs.

SCFHP has set performance goals for each measure within the annual year. Data is collected and analyzed for comparison and review. The quantitative data is analyzed and trended year by year to determine how the results are comparing against the performance goal. The qualitative analysis involves a review of the trended data and analysis for any barriers as related to the performance goal. An annual Barrier Analysis is completed with internal and external participants invited for their opinions and expertise. Each measure is tracked annually over a three-year period. This report speaks to SCFHP second year of comparison (CY 2020) with trending compared between CY 2019 first year comparison and CY 2018 baseline data analysis.

There are six areas measured for continuity and collaboration between medical and behavioral healthcare:

	Specific Areas Monitored	**Specific Measure**
1.	Exchange of Information	Medical Record / Primary Care Provider Questionnaire.
2.	Diagnosis, treatment and referral of behavioral disorders	HEDIS AMM - Antidepressant Medication Management
3.	Appropriate use of psychotropic medications	Antidepressant Medication Prescriptions and Adjunct Therapy
4.	Management of coexisting medical and behavioral conditions	Schizophrenia and Diabetes Mellitus Type 2 care – A1c Testing
5.	Prevention programs for behavioral healthcare	PHQ-9: Secondary Preventative Program
6.	Severe and persistent mental illness	SMI & Cardiovascular Disease care – LDL-c testing

Factor 1: Exchange of Information – Medical Record Review of Behavioral Health and Primary Care Practitioners (PCPs)

SCFHP collected data on exchange of information between Behavioral Health (BH) Specialists and relevant medical delivery systems by initially conducting an annual medical record review. A focus on communication from BH Specialists to PCPs was decided as every Member is assigned a PCP and the PCP remains the main Member health provider.

The medical record review proved ineffectual in our baseline year in obtaining sufficient information from the behavioral health providers. The Health Plan explored options and decided to create a Primary Care Provider (PCP) Questionnaire; this allows SCFHP to obtain the same information as collected during the file review to allow for comparison trending and analysis. Methodology changes have been reviewed below and was continued for this report for CY 2020.

Methodology

SCFHP pulled all claims for any Cal MediConnect (CMC) member that had at least one visit with a PCP or Internal Medicine Specialist AND a Behavioral Health (BH) Practitioner visit in an outpatient setting within the calendar year 2020. To qualify for this data pull, the member had to have an established PCP relationship identifiable from our claims system database. This requirement remained consistent for our baseline (CY 2018) and first comparison (CY 2019) reports. Claims used for Member identification for CY 2020 report were reviewed (1/1/2020-12/31/2020), collected during the month of February 2021.

In place of a medical record review, SCFHP sent a Primary Care Physician Questionnaire which addresses information received from a Member's Behavioral Health Clinic. As stated previously, this change was prompted by a desire to obtain information from more practitioners and to address the difficulty SCFHP was experiencing in obtaining information from our partners in County Mental Health due in part to their electronic record system change. We acknowledge that they are in the process of transitioning to a new electronic system that is separate from the current medical documentation system in place in county, and despite best coordination efforts they were unable to provide us with any data for this year. The medical record review process had been a difficult process for CY 2018 (baseline year):

- Information was obtained for CY 2018 largely through review of who possessed access to electronic medical records.
- For CY 2019 we were able to reach out to the PCPs directly for their experience in reviewing information from Behavioral Health Care Practitioners through a PCP Questionnaire.
- For CY 2020 we continued the PCP Questionnaires for data collection.

From this data set, we identified a total of 341 unique members. We calculated a statistically valid sample by using a 90% confidence interval and a margin of error of 10. The total random sample size equaled 57 members. To remain consistent with previous years (sample size = 60) we randomly selected 60 members using a blind draw process.

Questionnaires were securely faxed on 4/5/2021 (verified as sent) to PCPs with a return response fax request of 5/5/2021. All Members were assigned a random identification number. No late faxes were received.

Questions asked within the Questionnaire speak to:

- If Behavioral Health Care Agency provided overall medication list to PCP
- If Behavioral Health Care Agency provided medication list changes to PCP
- Was PCP informed of any recent hospitalizations of Member / medication changes thereafter?
- Was information provided timely?
- Was information provided sufficient?
- Did patient discuss Behavioral Health Medications currently prescribed with PCP?
- Has PCP ever directly requested a list of medications prescribed by Behavioral Health Provider directly? (And if so, did they receive this list?)

For timeliness, SCFHP kept our definition the same for CY 2020 as well as for our first year report (CY 2019) as well as our baseline report (CY 2018); *Timeliness* has been defined for this standard as sharing of pertinent, medically relevant information, including medications, at minimum once per year or after an event (such as hospitalization of Member). Timeliness was rated based on PCP responses regarding the sharing of information, with sufficient sharing of information as a pass.

A copy of the questionnaire has been included in this report for review as an addendum. The factor of timeliness has been defined as a BH Provider communicated member BH medications to the PCP within the Calendar Year of 2020, including updates as appropriate, and this would indicate a pass.

Numerator: All PCPs who reported that they received Behavioral Health medication lists for their Members timely from the BH Practitioner in 2020

Denominator: All Member's PCPs with a Behavioral Health (BH) outpatient claim and Primary Care Physician (PCP) claim in 2020 who responded to the survey;

Goal: 80% of the total number of samples meet the timeliness standard of sharing behavioral health information (with a focus on medications for pharmacological review) to Primary Care Providers.

- Of note: this goal remained the same for our CY 2018 (Medical Record Review methodology) as well as for CY 2019 (PCP Questionnaire). This is also in line with our Provider Network Management PCP satisfaction survey goal.

Quantitative Analysis

SCFHP conducts an annual review for timeliness of behavioral health practitioner communication and care coordination with PCPs for medication review and safe treatment practices. More information communicated and care coordinated leads to better healthcare outcomes overall for the Health Plan Members. A goal of 80% for timeliness standard of sharing behavioral health information (with a focus on medications for pharmacological review) to PCPs

was established prior to our baseline year. An NCQA Workgroup was established to review Barriers and Root Cause annually; Below CY 2020 data results are listed as well as a comparison between our baseline CY 2018 and our first year comparison CY 2019.

Overall, our response rate from providers for CY 2020 results in 6 out of 60 surveys returned, or a return rate of 10%.

When asked if PCPs received information from the BH Providers timely, 0 providers of the total 6 who responded indicated they received the medication information timely (0 / 6 = 0% total). While Members were noted by two PCPs as able to share their mental health medication lists with their PCP, the communications did not some directly from the Behavioral Health Provider. We did not meet our timeliness goal of 80%.

Comparison Table:

CY 2018 (Medical Record Review):	**CY 2019 (PCP Questionnaire):**	**CY 2020 (PCP Questionnaire):**
Only EMR records to review (n = 21).	Response rate of 13/60 questionnaires, or 22%	Response rate of 6/60, or 10%. Decrease in response rate by 12 percentage points.
Sample size: 60 Members	Sample size: 60 Members	Sample size: 60 Members
Only EMR passed for timeliness; a passive pass as access was acknowledged but no verification of communication, medication review, etc.	One PCP agreed that information was received timely & One PCP acknowledged access to EMR system (counted as a pass for timeliness) 2 /13 = 15%	Two PCPs stated that information pertaining to Member medications was obtained at PCP request by the Member; no PCP reported direct BH Provider communication pertaining to medication (one PCP directly requested). 0 / 6 = 0%
Did not meet goal as 21/60 or 35% passed for timeliness.	Did not meet goal as 2/13 or 15% passed for timeliness.	Did not meet goal as 0/6 or 0% passed for timeliness.

Reviewing data for CY 2020, of the SCFHP unique sample of 60 Members a total of 60 faxes to Member specific PCPs were sent. 6 of 60 PCPs responded to the questionnaire (6/60 = 10% response rate).

The current information shows that 0 out of 6 PCP responses show that Members meet our timeliness standard, with a Pass rate of 0% and a Do Not Pass rate of 100%.

We did not meet our goal that 80% of the total number of samples meet the timeliness standards. In comparison to our previous year, we showed a 15% drop in meeting our

timeliness goal when compared to CY 2019. This is a marginal improvement from a 20% drop noted between CY 2018 & CY 2019.

In changing our methodology SCFHP has more direct access to what BH information PCPs are receiving in a timely manner by accessing their direct responses; therefore we may have more opportunities to identify barriers, and actions to improve our results.

Qualitative analysis

Barriers identified within questionnaires by PCPs were reviewed first prior to open discussion during the Barrier/Root Cause Analysis Workgroup. PCPs noted:

- "We assume behavioral health is updating the active med list."
- "List was received by the patient."
- "Unable to see psych notes in EMR (electronic medical record system)."
- "No letter or communication of behavioral health. Same Provider never received anything."
- "Electronic health record which is accessible would be helpful."
- "Never received any communications with ALL behavioral providers."

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

Taking PCP barriers into consideration, additional barriers were identified during the workgroup:

- Through the county, Behavioral Health has a new EMR system (Avatar) not connected to the medical county system nor hospital systems (EPIC).
- lack of education concerning HIPAA requirements and the ability to be able to communicate relevant information to appropriate providers,
- and overall access to the medication information at hand,
- compliance issues regarding simply sending the information to PCPs (42 CFR),
- Member inability to recall their BH clinic or Provider they are currently seeing.

Encouraging Providers as well as Members to be involved in their own healthcare appeared as a common thread; one of the most common suggestions was education: for providers, and for Members. SCFHP did not choose to address these barriers in 2020.

Barrier and Opportunity Analysis Table (Factor 1):

Barrier	Opportunity	Intervention	Selected	Date Initiated
HIPPA/Privacy Information (Deficit of Knowledge) – difficult for PCPs and Psychiatrists to cross-communicate regarding medical and Behavioral Health diagnoses & medications.	Educate members on the importance of signing a release to allow sharing of medical record information between member providers. Educate providers on how to access ROI and review consent for BH information with Member.	Article within SCFHP Newsletter stating importance and benefits of signing a release to allow sharing of medical record information between member providers Could provide county BH ROI to PCPs to allow for their own use with their patients/our Members.	N	n/a
Access to Medically Relevant information (PCP and Psychiatrist)	Increase communication paths between PCPs and Psychiatrist in order to support relevant exchange of member information (e.g. medications)	Include Member lab results and medications filled through the SCFHP Physician Portal.	N	n/a
Knowledge of Current Providers of Member	Increase awareness of current BH Provider and PCP to each party (ROI needed by Member to share information)	Complete ROI with Member and share BH Provider/agency and PCP Provider/agency with each party.	N	n/a
Members do not bring their medication lists to PCP appointments	Encourage members to go to their Pharmacy and request a Medication List to bring with them to PCP appointment	Contact members through mailing or phone calls to remind them to complete in CY.	N	n/a

Factor 2: Diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care (AMM HEDIS measure)

Depression is a common behavioral health diagnosis that is treated by the PCP. SCFHP looks at the results of the HEDIS measure Antidepressant Medication Management (AMM) to monitor that members with depression who are prescribed medication are continuing treatment.

Methodology

SCFHP utilized the AMM HEDIS measurement to monitor the adherence of members to their antidepressant medications. SCFHP partners with a HEDIS vendor to run our HEDIS measures each year. The rates are pulled using the HEDIS technical specifications (footnote)[i]. For our baseline data we reviewed HEDIS rates for AMM in 2020 the rates measure the following:

> The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.
>
> 1. *Effective Acute Phase Treatment*. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
> 2. *Effective Continuation Phase Treatment*. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

For each measure, the total number of Members taking medication for the specified period of time (numerator) is compared to the total number of Members prescribed antidepressant medication (denominator).

HEDIS data was obtained through our contracted vendor in July 2021 for CY 2020 report.

Goal: The HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures.

Indicator	MY 2020 Rate	5th	10th	25th	50th	75th	90th	95th
Acute Phase	75.00	59.76	62.39	67.27	72.22	77.52	83.14	85.29
Continuation Phase	61.57	42.98	44.88	50.54	56.6	61.58	67.03	71.79

Quantitative Analysis

The chart above shows that for both the Acute and Continuation Phases of treatment, SCFHP HEDIS scores for 2020 fall within the 50th percentile. We did not meet our goal to have each phase within the 75th percentile.

The denominator for each phase includes the percentage that falls within the 75th percentile, while the numerator stems from the year's HEDIS report numbers for each factor (acute or continuation). Trending between years can be seen in the chart below (Data results).

Data Results:

HEDIS AMM Measure	2018	2019	2020
Effective/Acute Phase of Treatment	**73.73%** **Goal: 75.39%** (missed goal for 75th percentile by 1.66 percentage points)	**71.78%** **Goal: 77.52%** (missed goal for 75th percentile by 5.74 percentage points)	**75.00%** **Goal: 77.52%** (missed goal for 75th percentile by 2.52 percentage points)
Continuation of Treatment	**61.86%** **Goal: 60.32%** (goal met)	**57.92%** **Goal:61.58% (not met)** (missed goal for 75th percentile by 3.66)	**61.57%** **Goal: 61.58%** (missed goal for 75th percentile by 0.01 percentage points)

In 2020, SCFHP scored in the 50th HEDIS percentile for the AMM Effective Acute Phase Rate and scored in the 50th HEDIS percentile for AMM Effective Continuation Phase Rate. The goal was to achieve 75th percentile for both rates.

The Health Plan was 2.52 percentage points from the 75th percentile of the effective acute phase. For the continuation phase, the Health Plan was 0.01 percentage points behind the 75th percentile for the continuation phase.

When trending results across 2018, 2019 & 2020, comparing our results we can see that both in the Acute & Continuation Phases all rates showed an increase when compared with 2019 and still behind the initial results of 2018 (where continuation phase HEDIS results were met). There is a negligible increase to the eligible population for this measure.

Qualitative analysis

The qualitative analysis shows regardless of previous findings for 2018 & 2019 reporting, members taking an antidepressant medication during the first 12 weeks/84 days are more adherent than members taking a medication consistently for 6 months/180 days.

At this time the 2020 HEDIS data shows that the reverse is true; 2020 members taking an antidepressant medication during the first 12 weeks/84 days are less adherent than members taking a medication consistently for 6 months/180 days.

Comparing across 2018, 2019 & 2020, SCFHP members continue to struggle to initiate and continue depression medication less frequently than other CMC health plans based on comparison with other HEDIS percentile measurements.

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

Barriers identified include:

- deficit in knowledge of Members in the need to continue antidepressant medications to allow effect prior to stopping medication,
- influence of side effects in Member discontinuation of medication,
- ability to obtain 90 days of medication after prescribing provider is confident that over previous 3 months Member has been refilling the medication/taking it consistently (for continuation phase of treatment)
- lack of Member support in ongoing medication compliance and prioritization of importance of medications.

While no specific interventions were chosen to act upon this year for CY 2021, there were additional efforts within the organization to address general mental health including an additional article within the SCFHP mailed Newsletter for Members indicating Mental Health as the key to wellbeing and promoting discussion with PCPs and appropriate providers (this was particularly important due to the COVID pandemic and resulting isolation/difficulty accessing services as have previously).

Barrier and Opportunity Analysis Table (Factor 2):

Barrier	Opportunity	Intervention	Selected	Date Initiated
Member knowledge about need for antidepressant medication adherence when beginning a new medication – takes time to take effect & need to continue to take for ongoing effect to last	Member Education regarding antidepressant medication information	Provider letter requesting Provider review antidepressant medication with Member when Member attends appointment (Medication compliance conversation request) ; may include Info Card to provide to Providers to give to the Members	N	n/a
Lack of support – lack of a Care Coordinator/Case Manager to assist in health promotion and member tracking	Identify and promote social support in prioritizing and assisting with health care goals (member may be more likely to follow up with ongoing support)	Offer Member a Personal Services Coordinator/Case Manager or coordinate with existing supports to track medications (refills, med management) and appointments (help create a system for tracking with health as priority)	N	n/a
Member Forgetfulness to refill medications	Identify through MedImpact those in need of refills – connect and offer assist in obtaining necessary medication	Connecting with Members on a determined, regular basis (every month?) to provide reminder to refill antidepressant medication and/or assist in obtaining refills	N	n/a

Factor 3: Appropriate Use of Psychotropic Medications - Primary Care Practitioners (PCPs) and Antidepressant Medication Prescriptions

SCFHP collects data on BH and PCP adherence to prescribing guidelines concerning antidepressant medication prescriptions. Santa Clara County behavioral health members are able to access appropriate antidepressant medications through two avenues – Behavioral Health/Psychiatrist prescription (as connected through the local county mental health system), or access through Primary Care/Internal Medicine Doctor prescription. Due to a high demand for antidepressant medications and an acknowledged limited number of psychiatrists available to members throughout the county, the Health Plan identified 2 primary issues:

1. Many PCPs are uncomfortable in prescribing antidepressants and thus a need for increase in education surrounding dosage/subpopulation considerations is vital to increase Member access to care;
2. Collaboration between PCPs and non-physician BH practitioners could increase the effectiveness of depression management and provide greater access for our members.

In order to ensure that psychotropic medications are prescribed accurately, a PCP must have a level of comfort in knowing which antidepressants to prescribe, how the medication may interact with current medications the Member is taking, side effects, etc.

Our first objective and goal was to verify that Members had access to prescribers when needed, as both PCPs and Psychiatrist have the education to make decisions pertaining to prescribing psychotropic medication. We chose to focus on PCP education and prescribing of antidepressant medication to be able to determine where any additional education or gaps in knowledge may be with providers.

With more PCPs available within the county, and with each Member assigned to a PCP, this education is important in allowing more Members with depression access to appropriate antidepressant medication treatment. The process for member to connect to Psychiatry services begins with the County System and involves a process of referrals prior to meeting with a clinic Psychiatrist. This could delay or discourage members from seeking treatment.

This metric indicates PCP prescribing comfort for members who require antidepressant medications as well as Provider preparedness to prescribe appropriately as set by FDA (Food & Drug Administration); while prescribing of such medications falls within the scope of PCP practice, SCFHP acknowledges that appropriate prescribing of psychotropic medications falls within different PCP comfort levels – the Health Plan has begun to outline as well as implement means to improve PCP awareness of anti-depressant guidelines and comfort level in prescribing antidepressant medications.

A data discrepancy was identified in 2019. Based on this discrepancy SCFHP decided to rerun the 2018 data for more accurate comparison and trending. The discrepancy was corrected and did not affect 2020 data used in this report.

Methodology

SCFHP uses HEDIS NCD (National Coverage Determination) antidepressant medication codes for identification of Members receiving these prescriptions through the Health Plan's Pharmacy Benefit Management system (MedImpact).

Of these identified Members, SCFHP reviews the total antidepressant medication scripts and uses county behavioral health determination of Mild to Moderate (M2M) Affective Mood Disorder ICD-10 codes connected to each Member as based on level of functioning to determine the mild to moderate population for this study. Our total population includes:

1. the number of Cal MediConnect Members with a Mild-to-Moderate ICD 10 diagnostic code[ii]
2. who also have filled an antidepressant medication prescription within the past year

The antidepressant medication had to have been prescribed by the member's PCP/Internal Medicine Doctor or a Psychiatrist for the purpose of mental health treatment to qualify for this metric.

For this measure, we are measuring the CMC M2M Members prescribed antidepressant medications for mental health (denominator) and determining if the prescription was written for the Member by their PCP (numerator) or Psychiatrist (numerator). Claims and MedImpact (medication software) data reviewed 1/1/2020 through 12/31/2020. Data was collected for CY 2020 report during the month of February 2020.

Our goal was modified for CY 2020; in CY 2019 we met our goal.

Goal:

1. To *continue* to have at least 50% of antidepressant medication prescriptions to be provided by Primary Care Practitioners;
2. 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year.

This will be measured by comparing the total number of Members receiving antidepressant medications for M2M conditions through PCPs (denominator) over those currently engaged in talk therapy as identified by CPT & HCPC talk therapy codes (numerator).

Quantitative Analysis

Our ultimate goal was for a 50% split between PCPs and Psychiatrists prescribing antidepressant medications to our Mild-to-Moderate Behavioral Health Members.

Trending data collected for CY 2018, 2019 & 2020:

- PCPs are prescribing over 50% of psychotropic medications overall to our M2M population
- Psychiatrists are prescribing roughly 30% of psychotropic medications overall to our M2M population.

Calendar Year	Total # Scripts (denominator)	Psychiatrist Scripts	PCP Scripts	Not-Included * (unidentifiable providers)
CY 2018	N = 944	278/944 = **29%**	633/944 = **67%**	33/944 = **4%**
CY 2019	N = 924	250/924 = **27%**	628/924 = **68%**	46/924 = **5%**
CY 2020	N = 930	285/930 = **30.1%** (Increase 3.1%)	580/930 = **62.4%** (Decrease 5.6%)	65/930 = **7.5%** (Increase 2.5%)

We continue to meet our Goal (part 1) of 50-50 split in prescribers of antidepressant medication (PCP versus Psychiatrist).

Results (Prescriptions written):

PCPs prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant) = (580 / 930 = 62.4%)

Psychiatrists prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of Psych antidepressant prescriptions / total number of prescriptions for antidepressant) = (285 / 930 = 30.1%)

We met our goal of 50-50 split in antidepressant prescriptions between PCPs and Psychiatrists. This shows that Member's in need of depression medication have access and that PCPs are showing through scripts willingness to prescribe.

Data appears strikingly similar across three measures years of CY 2018, CY 2019, & CY 2020 for medications prescribed.

Additional information was analyzed for the second portion of our goal. The use of talk therapy was reviewed for members being prescribed antidepressant medication by the PCP. Specifically, the goal

is to have 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP have at least one counseling session in the current year.

The data for counseling (talk therapy) when prescribed an antidepressant showed:

- 178 of total Members receive antidepressant prescriptions from PCPs (178/628) are connected to talk therapy (28%) (CY2019)
- 99 of total Members receive antidepressant prescriptions from Psychiatrists (99/250) are connected to talk therapy (40%) (CY 2019)
- 101 of total Members receive antidepressant prescriptions from PCPs (101/580) are connected to talk therapy (17.1%) (CY2020)
- 99 of total Members receive antidepressant prescriptions from Psychiatrists (75/285) are connected to talk therapy (26.3%) (CY 2020)

Calendar Year	Total # Scripts (denominator)	Psychiatrist Scripts + Member is Receiving Talk Therapy	PCP Scripts + Member is Receiving Talk Therapy
CY 2019	250 = Psychiatry 628 = PCP	(99/250) = **40%**	(178/628) = **28%**
CY 2020	285 = Psychiatry 580 = PCP	(75/285) = **26.3%** **(-13.7 percentage points)**	(101/580) = **17.1%** **(-10.9 percentage points)**

CPT and HCPC codes were used to identify amongst out M2M population who is receiving talk therapy. This is a benefit covered by SCFHP and information through use of codes was obtained through claims data.

Education to PCPs has been effective both historically (e.g. Anti-depressant PCP Dinner 3/2018) and ongoing (e.g. Newsletter articles pertaining to antidepressant medications to improve the comfort level of PCPs in prescribing antidepressant medications. Education on the importance of mental health treatment and increase in providers contracted and available. [2019 & 2020]).

The noted decrease in any Member receiving talk therapy, regardless if prescribed psychotropic medications through PCP or Psychiatrist, has been noted.

While we continue to meet our prescribing goal of 50-50 split between PCPs and Psychiatrists, we did not meet our talk therapy goal of 40% of members with Mild-to-Moderate (M2M)

depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year.

We missed out goal by 13.7 percentage points.

Qualitative Analysis

The quantitative analysis shows currently of our identified population, PCPs are prescribing 63% of the total antidepressants and Psychiatrists are prescribing 30%.

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

The data for counseling (talk therapy) when prescribed an antidepressant showed:

- CY 2019: 178 of total Members receive antidepressant prescriptions from PCPs (178/628) are connected to talk therapy (28%)

- CY 2020: 101 of total Members receive antidepressant prescriptions from PCPs (101/580) are connected to talk therapy (17.1%; decrease by 10.9 percentage points)

- CY 2019: 99 of total Members receive antidepressant prescriptions from Psychiatrists (99/250) are connected to talk therapy (40%)

- CY 2020: 75 of total Members receive antidepressant prescriptions from Psychiatrists (75/285) are connected to talk therapy (26.3%) (13.7%; decrease by 10.9 percentage points)

Calendar Year	Total # of Scripts (denominator)	Psychiatrist Scripts + Member is Receiving Talk Therapy	PCP Scripts + Member is Receiving Talk Therapy
2019	250 = Psychiatry 628 = PCP	(99/250)=**40%**	(178/628)=**28%**
2020	285 = Psychiatry 580 = PCP	(75/285)=**26.3%** **(-13.7 percentage points)**	(101/580)=**17.1%** **(-10.9 percentage points)**

CPT and HCPC codes were used to identify amongst out M2M population who is receiving talk therapy. This is a benefit covered by SCFHP and information through use of codes was obtained through claims data.

Education to PCPs has been effective both historically (e.g. Anti-depressant PCP Dinner 3/2018) and ongoing (e.g. Newsletter articles 2019 & 2020 pertaining to antidepressant medications to improve the comfort level of PCPs in prescribing antidepressant medications & education on the importance of mental health treatment and increase in providers contracted and available).

The disproportionate percentage of members who receive their antidepressant medication by the PCP without the benefit of counseling (talk therapy) indicated that there is an opportunity to improve the collaboration and appropriate treatment for members by education on the use of medication and counseling to promote better outcomes for members with M2M depression.

Goal:

1. to *continue* to have at least 50% of antidepressant medication prescriptions to be provided by Primary Care Practitioners;

2. 40% of members with Mild-to-Moderate (M2M) depression receiving anti-depressant medication through their PCP to have at least one counseling session in the current year. This will be measured by comparing the total number of Members receiving antidepressant medications for M2M conditions through PCPs (denominator) over those currently engaged in talk therapy as identified by CPT & HCPC talk therapy codes (numerator).

The American Psychological Association (APA) promoted talk therapy in conjunction with antidepressant medications; as taken from APA.org, "For the initial treatment of depression in adults, the guideline recommends either psychotherapy or second-generation antidepressants, which include selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). There was not enough evidence to recommend one psychotherapy treatment over another, but in general, there was support for behavioral therapy; cognitive therapy, CBT and mindfulness-based cognitive therapy; interpersonal psychotherapy; psychodynamic therapies; and supportive therapy."

The analysis identified a new addition to our maintenance goal and was reviewed for opportunities for improvement. SCFHP did not choose to address these barriers in 2020.

Barrier and Opportunity Analysis Table (Factor 3):

Barrier	Opportunity	Intervention	Selected	Date Initiated
PCPs lack knowledge and/or comfort level required to manage/prescribe their members' antidepressant medications	PCPs lack knowledge and/or comfort level required to manage/prescribe their members' antidepressant medications	1) Implement an access telephone line with Santa Clara County Behavioral Health Services Department to provide access to psychiatrist for telephonic medication consultation; 2) Ongoing education to Contracted PCPs on antidepressant medications, general prescribing guidelines and considerations (last session: 3/2018)	N	n/a
PCPs lack knowledge in how to refer to talk therapy services (2 routes: ACCESS line through County or directly through SCFHP)	PCPs lack knowledge and/or comfort in referring Members to therapists (through county or SCFP)	Educate PCPs on access to talk therapy providers and inform them of the referral process/access through county or SCFHP	N	n/a

Factor 4: Management of Treatment access and follow-up for Members with coexisting medical and behavioral disorders – Management of Treatment of Members with Schizophrenia and Diabetes Mellitus Type II

The Santa Clara Family Health Plan collects data on CMC Members identified as having dual diagnoses of Schizophrenia (diagnosis code F29) as well as Diabetes Mellitus II (DMII).

Members with Severe and Persistent Mental Illnesses (SPMI), such as Schizophrenia, often experience symptoms which promote an increase in disorganization and decrease in ability to process information, keep track of ongoing appointments and track ongoing progress of medical needs; connection to a single Primary Care Provider (also known as establishing care) is additionally beneficial to this population due to active symptoms potentially impairing the Members ability to accurately share pertinent medical information. SCFHP identifies this population as vulnerable to factors which may limit Member ability to follow up in an ongoing manner for medical care. CY 2020 data support an increased need for CMC Members diagnosed with both Schizophrenia and Diabetes Mellitus Type II (DM2) to be seen on an ongoing basis for follow up regarding medical care.

Methodology

SCFHP collects data annually on Cal MediConnect Members (CMC) with diagnoses of Schizophrenia as well as Diabetes Mellitus Type II and rates of Primary Care Practitioner/Internal medicine provider appointments as evidenced by Claims data. The Health Plan will determine the percentage of Members with both Diabetes Mellitus Type II and Schizophrenia who had a Primary Care/Internal Medicine visit within CY 2020 (numerator) compared to the total baseline number of members diagnosed with both Diabetes Mellitus Type II and Schizophrenia (denominator). This percentage is used to determine a deficit in acceptable Primary Care Practitioner annual exams to support need for ongoing analysis and monitoring. Data was collected for CY 2020 report, using claims (1/1/2020 through 12/31/2020), and data was collected in February 2020.

Goal: 75% of CMC members identified with diagnoses of Schizophrenia & Diabetes Mellitus Type II to have attended at least one annual Primary Care Visit for ongoing physical health monitoring.

Quantitative Analysis

Total number of Members with diagnoses of Schizophrenia and Diabetes Mellitus Type II were identified through claims data in CY 2020 (**N = 92**). Of these Members, 56 were identified as having had a Primary Care Practitioner (PCP) annual visit (56/92 = 61%) and 36 were identified as not having has a Primary Care Practitioner (PCP) visit (36/92 = 39%).

We did not meet our goal by 14 percentage points.

In the following chart we illustrate our trending of data for CY 2018 (baseline year), 2019 & 2020 and how the data compared:

	CY 2018 Data	CY 2019 Data	CY 2020 Data
Total Members with diagnoses Schizophrenia & Diabetes Mellitus II (Total N)	94	97	92
Those who met with PCP for follow up:	58	61	56
Those who did not meet with PCP for follow up:	36	36	36
Percentage who completed PCP follow up:	(58 / 94) = 61.7%	(61 / 97) = 63% (Increase 1.3%)	(56 / 92) = 61% (Decrease 2%)

SCFHP identifies that the number of CMC Members diagnosed with both Schizophrenia and Diabetes Mellitus Type II of whom saw Primary Care Practitioners within the CY 2018 compares similarly with CY 2019 data as well as with CY 2020 data as can be seen by the table above.

We have seen a decrease in PCP appointment attendance for this population for DMII treatment by 2%; this shows a gradual decline toward goal completion over the previous 3 years. Compared to our overall goal, we did not meet set goal by 14 percentage points.

There was no significant trend in data post-intervention for CY 2020. This may be due to the timing of the intervention which was completed late in the calendar year.

Year 1 (2018) intervention of letters to Providers as reminders for their members showed higher results than Year 2 (2019) intervention of calls to Members.

Qualitative Analysis

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

Barrier and Opportunity Analysis Table (Factor 4):

Barrier	Opportunity	Intervention	**Selected**	Date Initiated
Members of this subpopulation may not prioritize health care/annual PCP visits. (Deficit of Knowledge)	Provide outreach and education to remind all Members of the importance of Health Care provider follow up appointments	3 outgoing calls to connect with Member and remind to: Schedule PCP Annual Wellness exam + Have A1c blood testing completed	y	11/5/2020-11/16/2020
Members of this subpopulation may not remember health care/annual PCP visits. (Deficit of Knowledge)	Reminder to Providers to educate and follow up on treatment on need for DM2 A1c testing & follow up regarding medication influence on blood sugar (medical discussion)	Letter to current PCP Providers to Promote overall Health of Members – encourage outreach to Member to assist Member to have follow up appointment for A1c testing completed and medication review	Y	9/2021
Communication between PCP and Psychiatrists often limited due to consent forms and misunderstanding of HIPPA	Member education regarding benefits of permitting certain data to be shared across multiple providers	Article within SCFHP Newsletter stating importance and benefits of signing a release of information to allow sharing of medical record information between member providers	N	n/a
Many Members diagnosed with SPMI meet with BH	Information to Member and Providers to	Letter to BH and PCP Providers to Promote overall	Y	12/2019

Barrier	Opportunity	Intervention	**Selected**	Date Initiated
Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	educate on need for DM2 follow up and potential medication influence on blood sugar (medical discussion)	Health of Members – encourage Member to have follow up A1c testing completed		

The barrier analysis completed in the baseline year (CY 2018) identified that PCPs and Psychiatrists are in need of increase in communication methods – it was suggested within the BH Workgroup that many members with severe mental Illnesses such as Schizophrenia may neglect their own medical care as it is not a top priority for them; the Member may be disorganized or overwhelmed with current obligations and/or active symptoms (family, case management if connected to a mental health clinic, group attendance/addressing mental health symptoms, etc.).

In 2019 (CY 2018 intervention) to increase Provider awareness of Members who are remiss in completing health care treatment recommendations a letter was created and securely faxed (using Right Fax) to each Member's Behavioral Health Provider and established Primary Care Physician to promote outreach to Member for completing A1C testing for the monitoring of Diabetes Mellitus Type II.

The letter included information on the SCFHP benefit of case management and care coordination. The CMC Customer Service contact information was provided to promote member education and referral to case management for additional support in coordinating their medical and behavioral health care needs. This intervention was completed on 12/10/2019 and both BH and PCP providers were included. Due to the late completion of the intervention the full impact of the intervention is not reflected in the CY 2019 data. There was a slight percentage point increase this cannot be fully attributed to the intervention.

This is relevant as within our second intervention of Member outbound telephone calls, for CY 2019, was completed in 2020 as we have not yet achieved our goal. An intervention to increase Member support to complete A1c testing for DMII was implemented November 2020, and calls were used as a means of increasing Member awareness for need for follow up in diabetes care.

Three outbound calls were completed for the identified CMC Members who had not met with PCP CY 2019 to encourage them to connect with their PCP to complete A1c testing for DMII monitoring and treatment recommendations. Assistance in completing this task was offered to Members who were reachable via telephone calls. While no Members accepted the offer for

assistance to connecting with PCP, all were offered the number to Case Management for follow up assistance as needed.

36 Members were identified without follow up for DMII, and a total of 64 calls placed between 11/5/2020 & 11/16/2020. Of the 36 Members called:

- 11 Members were connected with, and either reported having upcoming appointments with PCP or were in placement in facilities such as short-term skilled nursing facilities (SNFs) where Social Workers and Nurses could verify Member was being monitored for DMII condition and A1c testing completed.
- 10 Members were unable to call due to termed eligibility status or they had passed away.
- 15 Members were unable to reach and thus a general request for PCP follow up was left on their voicemail, if available.

As in 2019 (CY 2018 intervention) Provider letters to increase awareness & recommendation for follow up showed an increase in PCP appointment attendance for this Member group up by 2 percentage points, and in 2020 (CY 2019 data) our Outbound Call interventions showed a decrease in 2 percentage points. It has been suggested as an intervention for this year that a PCP reminder letter be sent to current PCPs for follow up care and treatment to meet standards of care.

Intervention Script (DMII) – intervention CY 2019 data:

Script for the DMII & Schizophrenia calls
(*objective*: to connect with the Member and

- 1) remind Member to have A1c test completed and
- 2) to follow up with PCP regarding DMII and what Member can do to stay healthy and treatment compliant.

"Hello. My name is [NAME HERE] and I am calling from the Santa Clara Family Health Plan.
We are calling Members to provide reminders to follow up with their doctors for management of any current medical conditions.
I'd like to remind you to talk to your doctor about completing lab work for your condition of diabetes, specifically the A1c test. This will help your doctor to help guide your treatment for this condition."

Then: "Have you made an appointment to see your primary care doctor recently?" -- If no, "May I help you to schedule that appointment? We can assist with transportation through the Health Plan via a taxi cab as well."

Thank the Member for his or her time before ending the call.

Three calls out to Member - if no connect on final call, leave general voice message to "please follow up with your provider for all medical treatment and testing to keep yourself healthy in 2020."

For CY 2020, a PCP letter was created and securely faxed (using Right Fax) to each Member's current, established Primary Care Physician to promote outreach to Member for completing A1C testing for the monitoring of Diabetes Mellitus Type II treatment/medication review. You can find such letter included in documents submitted with this report.

For CY 2020, a PCP letter was created and securely faxed (using Right Fax) to each Member's current, established Primary Care Physician to promote outreach to Member for completing A1C testing for the monitoring of Diabetes Mellitus Type II. This showed positive results when a similar intervention (CY 2018 report) that involved reminder letters to Providers was reviewed and this intervention was approved through NCQA consultants as a measure that garnered an effect productive to meeting our overall 75% PCP appointment for A1c testing goal. This intervention was recommended for sending to current PCPs to assess for increase once outreach to members for A1c testing again. For this factors population:

- Total Members who did not follow up with PCP = 36.
- 31 Members of this subpopulation had letters sent to their current PCP for follow up requesting an appointment outreach for Member for A1c testing as well as medication reconciliation.

- 5 Members were no longer enrolled.

The efficacy of PCP involvement provided important during our first set of interventions and it was deemed appropriate to continue to send letters to current PCPs for ongoing standards of care of treatment and follow up testing to help direct appropriate care.

Factor 5: Secondary Preventative Behavioral Healthcare Program Implementation – PHQ-9

SCFHP collects data on members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions. Data pulled from the Health Plans annual Health Risk Assessment (HRA) identified Members who have self-reported a diagnosis of depression and/or depressive symptoms as present within the previous 3 months.

In an effort to acknowledge the high prevalence of depression amongst the overall population, the Health Plan collected data concerning levels of Member identified depression. The data indicates the need for a secondary behavioral health program to connect members, based on their current level of depression and need, to appropriate treatment and interventions. This data addresses the need for a secondary behavioral health program to connect members, as based on their currently identified level of depression and need, to appropriate interventions. It is based on this data collected that the Health Plan identified the need for PHQ-9 (Patient Health Questionnaire - 9) assessment completion and follow up care monitoring.

Need being addressed: With depression rates high and Members in need of treatment (medication as well as therapy), & related high health risk factors associated with severe depression, the PHQ-9 Program would address the following needs:

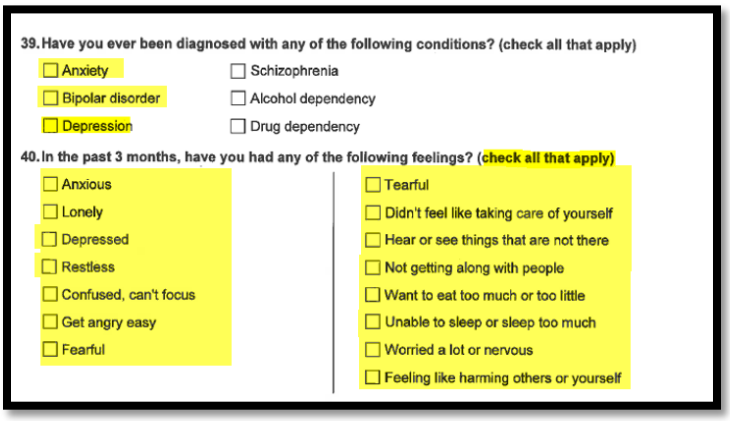
- Identify who is experiencing depressive symptoms via Health Risk Assessment responses,
- Use of a reliable, valid and empirically tested tool (PHQ-9) to identify severity of symptoms,
- Triage of resources and referrals to connect Member to supportive treatment, &
- Reassessment to verify intervention effectiveness and potential modifications/opportunities for improvement.

Methodology

The SCFHP collects data on CMC Members identified within the HRA, completed annually by Members, to identify the population of members currently self-indicating diagnoses and/or symptoms of depression. All Members who indicate depressive symptoms (denominator) are reviewed to ensure discussion of options available to them as the focus of the PHQ-9 program is to keep Members aware of therapy, medications and county case management options. The Member desire to complete or decline the PHQ-9 is noted for additional information to review for this population. SCFHP tracks if these CMC Members have been offered a PHQ-9 assessment based on recorded responses to the PHQ-9 assessment embedded in our case management software assessment (numerator) to analyze total outreach.

Our overall goal is supplemented with data to determine participation of Members who have been offered a PHQ-9 assessment (denominator) and the level of participation as declined or completed (numerator).

Health Risk Assessments completed January 1st, 2020 through December 31st, 2020 were reviewed for responses on HRA mental health questions (see image below). Depression indicators included symptoms associated with depression, and/or a marked diagnosis of Depression or Bipolar Disorder or Anxiety as self-identified and submitted on Health Risk Assessment (HRA) form.

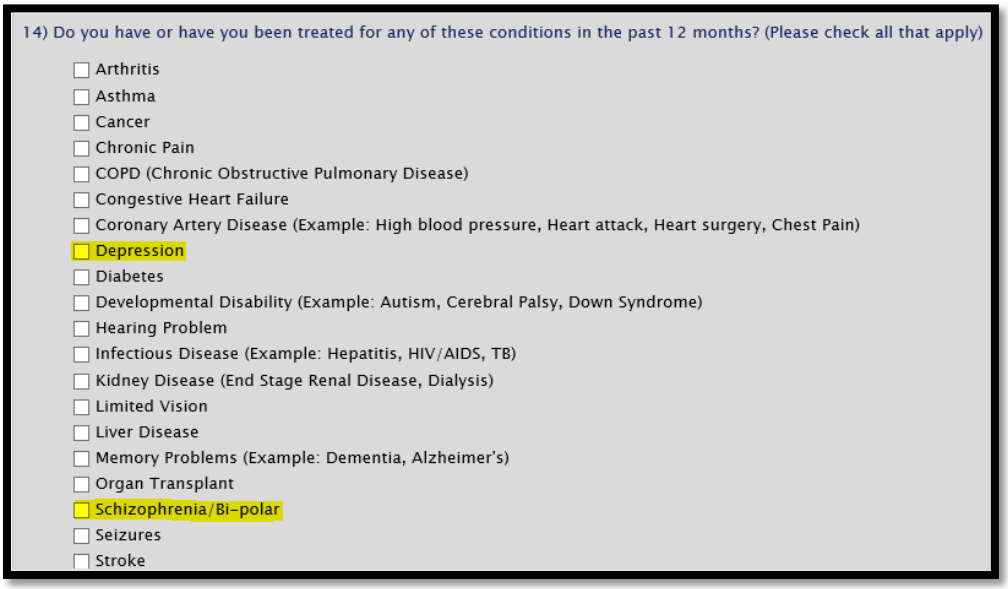


39. Have you ever been diagnosed with any of the following conditions? (check all that apply)

- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Alcohol dependency
- ☐ Drug dependency

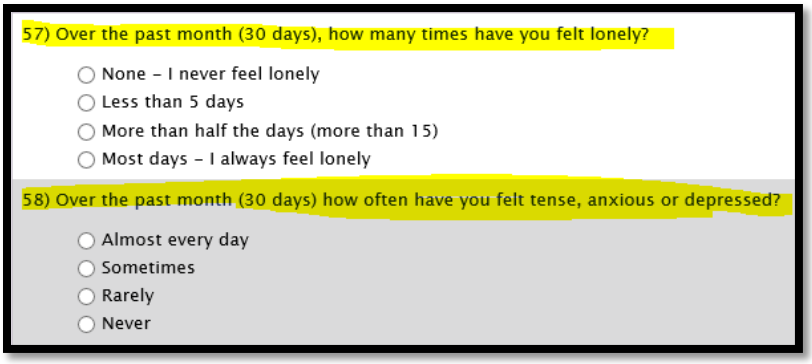
40. In the past 3 months, have you had any of the following feelings? (check all that apply)

- ☐ Anxious
- ☐ Lonely
- ☐ Depressed
- ☐ Restless
- ☐ Confused, can't focus
- ☐ Get angry easy
- ☐ Fearful
- ☐ Tearful
- ☐ Didn't feel like taking care of yourself
- ☐ Hear or see things that are not there
- ☐ Not getting along with people
- ☐ Want to eat too much or too little
- ☐ Unable to sleep or sleep too much
- ☐ Worried a lot or nervous
- ☐ Feeling like harming others or yourself



14) Do you have or have you been treated for any of these conditions in the past 12 months? (Please check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Pain
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Example: High blood pressure, Heart attack, Heart surgery, Chest Pain)
- ☐ Depression
- ☐ Diabetes
- ☐ Developmental Disability (Example: Autism, Cerebral Palsy, Down Syndrome)
- ☐ Hearing Problem
- ☐ Infectious Disease (Example: Hepatitis, HIV/AIDS, TB)
- ☐ Kidney Disease (End Stage Renal Disease, Dialysis)
- ☐ Limited Vision
- ☐ Liver Disease
- ☐ Memory Problems (Example: Dementia, Alzheimer's)
- ☐ Organ Transplant
- ☐ Schizophrenia/Bi-polar
- ☐ Seizures
- ☐ Stroke



It should be noted that as of March 2020, the Health Risk Assessment questions have changed. The Health Plan will modify methodology to capture the same indicators of depression as noted in the new HRA. The CY 2021 report reflects accuracy of data captured as outlined above; the HRA changed but the indicators of depression diagnosis, loneliness or depression expressed directly on document, etc) remained the same.

Goal = 80-100% of CMC Members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment and offered assistance if desired.

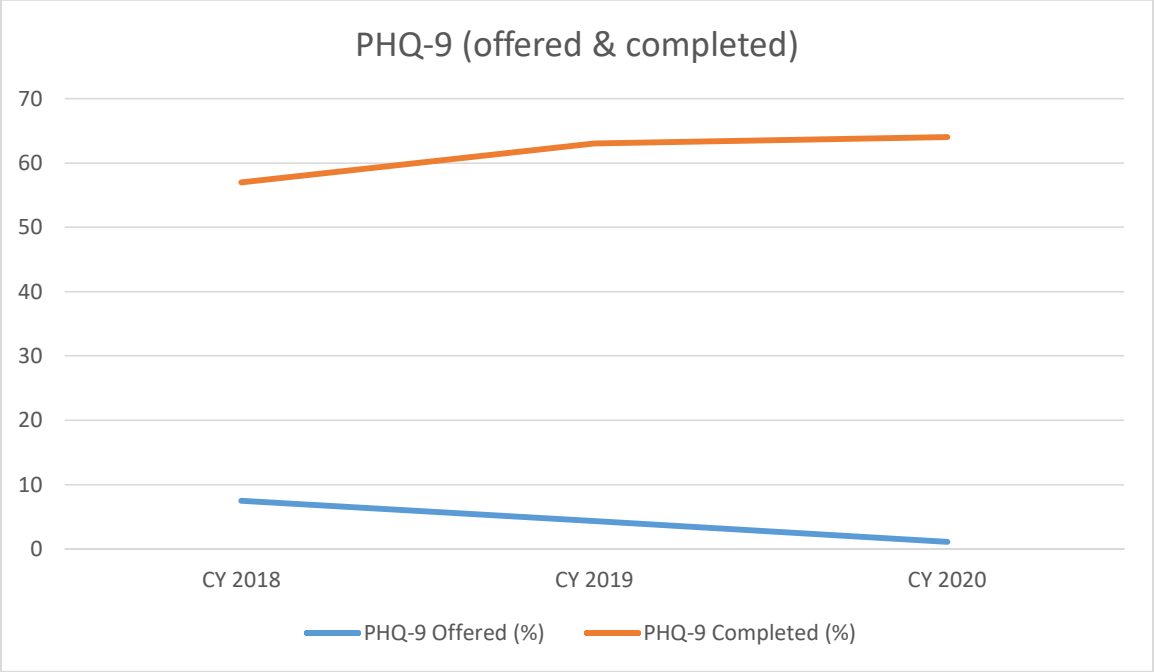
Quantitative Analysis

Within our specified timeframe of CY 2020 data:

- 6779 Unique Members had identified symptoms and/or a diagnosis of Depression on their Health Risk Assessment.
- Of the 6779 Members, 118 Members were outreached. Of the 118, 72 had agreed to complete a PHQ-9 assessment & 46 Members declined to complete.
- PHQ-9 offer rate for the overall population = 1.1% (72/6779)
- Of Members offered, the PHQ-9 completion rate = 64%.

We did not meet our overall goal of 80-100% of Members indicating depressive symptoms to have had a PHQ-9 offered.

The graph below shows PHQ-9 completion rates for CY 2018 (baseline) and CY 2019 (comparison year 1) and CY 2020 (comparison year 2).



Of the total Members eligible within this program to be offered to complete a PHQ-9 for assessment and follow up recommendations, only 1.1% had a PHQ-9 assessment offered to them; this shows a decrease from CY 2019 in outreach by 3.2%.

However, in our comparison year CY 2019 of those offered the PHQ-9 63% completed the assessment while in CY 2020 of those offered the PHQ-9 64% completed the assessment; despite lower outreach in CY 2019 Member participation continued to increase (increased by 1%).

Qualitative Analysis

As there was an increase in participation this calendar year (CY 2020) of 1% of members offered the PHQ-9 are showing a desire to complete this assessment and review with PCP or BH provider more often than previously. This assessment measure is useful in guiding interventions and thus *supports* the need for a PHQ-9 Program as well as an increase in outreach efforts – assessment scores may be used to help guide treatment and resources to those most in need. This is particularly important considering the increase in isolation and lack of resources available during the COVID pandemic 3/2020-2021 ongoing.

In terms of outreach we did not meet our goal of 80-100% completion rate, yet Member completion rates of those offered the assessment continued to increase and did so by 1%.

Barriers for staff initiated outreach identified include employee turnover, need for increase in trainings throughout the year to address any gaps in case management knowledge, and increase interdepartmental support in identifying and offering of PHQ-9 to appropriate Members. CY 2020, an increase in quarterly trainings was provided to ensure new staff were trained and continuous staff reminded of the importance of completing outreach for this measure. All Case Management was trained quarterly on how to identify those eligible for PHQ-9 assessment and the process to follow.

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

SCFHP did not choose to act upon these barriers in 2020.

Barrier and Opportunity Analysis Table (Factor 5):

Barrier	Opportunity	Intervention	Selected	Date Initiated
Case Managers not always offering a PHQ-9 assessment to members that indicate they have depression	Implement a process to ensure the PHQ-9 assessment is offered every time a member indicates depression on the health risk assessment	1) Create an automated trigger within the Essette Case Management system after HRA is entered to indicate need for PHQ-9 and PHQ-9 follow up 2) Ongoing Annual training on PHQ-9 program	N (#2) ongoing training internal – not an intervention but to be completed annually vs. quarterly moving forward as deemed appropriate by management)	n/a

Barrier	Opportunity	Intervention	Selected	Date Initiated
Lack of support – providers may not be aware of need to address Member's depression.	Notify Providers when their assigned members indicate that they have depression	Create a new provider letter that can be sent from the case management system with the member's PHQ-9 results included	N	n/a
Member access to PHQ-9 in preferred language	Provide Members with access to PHQ-9 in their preferred language	Submit PHQ-9 for translation and send by mail to member when requested	N	n/a

The barrier analysis completed identified that there are many members currently experiencing symptoms of depression and are in need of treatment interventions such as talk therapy as well as the need for support in having a conversation about their depression with their PCP or BH Provider; this supports the need for a PHQ-9 Program to allow for addressing such symptoms through a specific, monitored program. The COVID pandemic also affected how and how often members were meeting with Providers (medical and mental health). It was suggested at the BH Workgroup that internal systems could be created to increase SCFHP Case Manager awareness of appropriate Members for this program, thus increasing PHQ-9 completion and member appropriate interventions to address presented needs.

There has been a large change in case management staffing and despite trainings, awareness remains an important component in offering the PHQ-9. An intervention to create an automated trigger within the Essette Case Management system after HRA is entered to indicate need for PHQ-9 and PHQ-9 was reviewed and is being considered for implementation (in queue) while the tasks are available for case manager assignment manually at this time. Ongoing training on the PHQ-9 program will continue to take place and is being incorporated by the Case Management Director Raman Singh into the annual training schedule for case management. The intervention will remain in place for the measurement cycle to determine if the performance goal is attainable.

All Members who complete the PHQ-9 will be offered appropriate interventions for treatment as well as follow up. (Antidepressant medication discussed, therapy for psychosocial issues offered, for Severe Depression scores a mini suicide risk assessment to be completed as well). Please note that while the PHQ-9 is a helpful tool for intervention, it is not required for a Member to be referred for talk therapy.

PHQ-9 Assessments→

Score of:

10-14 Mild/Moderate Depression (Recommend: PCP for antidepressant + therapy)

15-19 Moderate/Severe Depression (Recommend: PCP for antidepressant + therapy)

20-27 Severe Depression (Recommend: PCP for antidepressant + therapy + complete mini Suicide risk assessment)

- Watch for any signs/symptoms which may indicate Severe Mental Illness as well as depression; likely referral needed for County to assess for SMH treatment (psychiatry and case management provided through county/community based organizations).

Factor 6: Special Needs of Members with severe and persistent mental illness – modified HEDIS measure of Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

SCFHP looks at the results of the HEDIS measure Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) to monitor that members with Schizophrenia and Cardiovascular Disease are being appropriately treated; for this reports purposes this measure has been *modified* to include additional Severe Mental Illness (SMI) diagnoses to allow for a larger total *N* population review.

Methodology

SCFHP utilized the SMC HEDIS measurement and expanded upon it to capture a larger group of SMI Members to monitor for the adherence in following up for Chronic Heart Failure (CHF) medical monitoring and treatment. SCFHP used the modified SMC HEDIS measurement guidelines to monitor the follow up on Cardiovascular Disease Care (LDL-C test) to include diagnoses of Schizophrenia, Schizoaffective Disorders, Bipolar Disorder diagnoses and Unspecified Psychosis. For our baseline data we reviewed HEDIS parameters for SMC in 2018 while including for our additional SMI disorders; with these diagnostic inclusions, SCFHP measures the following:

> *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia:* Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/

The codes were included for Severe and Persistent Mental Illness (SPMI) ICD codes (for Schizophrenia, Schizoaffective Disorders, Bipolar disorders, and Unspecified Psychosis): F20.3, F20.9, F25.0, F25.1, F25.8, F25.9, F29, F31.0, F31.10, F31.11, F31.12, F31.13, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.7, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9.

For measurement, all Members diagnosed with both SPMI diagnoses and Cardiovascular Disease (denominator) are reviewed through claims data to verify that they have been seen by their PCP for LDL-C blood work follow up (numerator). Data was collected for CY 2020 (1/1/2020 through 12/31/2020) in February 2020.

Goal = 75% of Total Members with SPMI & Cardio Vascular Disease diagnoses will have completed LDL-C blood work testing for follow up treatment care with their providers.

Quantitative Analysis

In CY 2020 SCFHP a total of 27 Members (N = 27) were identified as having both Cardiovascular Disease and SPMI diagnoses. Of the 27 total Members, (5/27) 18.5% followed up with their

Primary Care Physician in 2020 for LDL-C testing and review while (22/27) 81.5% did not. We did not meet our goal of 75%.

SCFHP did not meet the set goal by 56.5 percentage points. There was no noted difference in CY 2018 versus CY 2019 data results, with a 0.5% decrease noted in CY 2020.

TABLE. Comparison CY 2018, CY 2019, and CY 2020: Dually Diagnosed Members (SMI + Cardiovascular Disease) follow up testing

	Total SMI + CD Members	Members who COMPLETED LCL-C testing	Members who DID NOT COMPLETE LCL-C testing
CY 2018	31	6 / 31 = **19%**	25 / 31 = **81%**
CY 2019	42	8 / 42 = **19%**	34 / 42 = **81%**
CY 2020	27	5 / 27 = **18.5%**	22 / 27 = **81.5%**

Qualitative Analysis

To assist with our analysis, comparison of testing completed as based on diagnosis was also reported.

TABLE. Diagnosis Comparison CY 2018 & CY 2019: Follow Up Testing by Diagnosis

Diagnosis	CY 2018 (% completed LDL-C)	CY 2019 (% completed LDL-C)	CY 2020 (% completed LDL-C)
Schizophrenia Disorders	11 total - (27% completed)	9 total (11% completed)	1 total (20% completed)
Schizoaffective Disorders	5 total - (40% completed)	13 total – (23% completed)	0 total (0%)
Bipolar Disorders	14 total - (21% completed)	17 total – (11% completed)	4 total (80% completed)
Unspecified Psychosis	1 total – (0% completed)	3 total – (66% completed)	0 total (0%)

The Data Tables above show that there was no statistically significant indication of any person with a specific SPMI diagnosis would be more likely to follow up with care; there were no identified trends at this time. With a deeper dive into SCFHP data, information may show that those with both a thought disorder and a mood disorder (e.g. schizoaffective disorder) are better connected to behavioral health services and supports due to the severity of their symptoms and thus they received more support in completing follow-up lab work, but currently there is no evidence for this conclusion.

In an effort to meet the performance goal for 2020, an initial barrier analysis was completed to identify opportunities and interventions to increase the number of completed follow up lab work for cardiovascular disease treatment for those with SPMI diagnoses as well. SCFHP decided to retain the goal of 75% percentage completion rate for these Members.

In an effort to meet the performance goal for 2021, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of communication of behavioral health medications between medical and Behavioral Health Practitioners. SCFHP conducted a Behavioral Health Workgroup on July 17th, 2020 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Chief Medical MD [internal], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Director of Case Management (internal), Manager of Medical Case Manager (internal), and Manager of Behavioral Health Case Management (internal). All invited were able to attend, and materials regarding goals, measurements and data were provided for quick review prior to the meeting.

Barrier and Opportunity Analysis Table (Factor 6):

Barrier	Opportunity	Intervention	Selected	Date Initiated
Many Members diagnosed with SMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have medical follow up completed	Fax letter to providers (BH & PCP) for medical follow up need (LDL-C lab order)	Y	11/2020
Providers are prescribing medications without adhering to Standards of Practice; Member must be seen every 6-12 months for assessment	Provider Education & Reminder of Standards of Care for those with Cardiovascular Disease	Letter created and sent to Cardiologists of Members identified without follow up to encourage appointments and remind them of Standards of Care Practices	Y	9/2021
Lack of support – Member may have forgotten to follow up and complete necessary follow up for medical condition of CHF by completing LDL-C testing	Notify Members of identified need for LDL-C testing (3 outbound calls to Members)	Notify Members of identified need for LDL-C testing (3 outbound calls to Members) & offer assistance in obtaining PCP apt if desired.	Y	10/2019

It was suggested within the BH Workgroup that many members with severe mental Illnesses may lack support for follow up treatment recommendations regarding their own medical care.

An intervention to increase Member support to complete LDL-C testing for Cardiovascular Health was implemented October 2019 for baseline year CY 2018 and a new intervention completed in November 2020 for CY 2019. An intervention was chosen for implementation in October 2020 for CY 2021 as well to continue to modify our goal toward improvement in meeting our desired metric.

Unfortunately as shown within the Quantitative analysis, there was no significant change to our data despite implementation of our interventions. We acknowledge that this may be due to the lateness within the Calendar year of implementation and are working to improve the timeliness of data pull, analysis, and intervention completion next calendar year. The full impact of these interventions will be demonstrated in the CY data for 2021.

For the CY 2018 intervention, three outbound calls were completed for the identified CMC Members to encourage them to connect with their PCP to complete LDL-C testing for cardiovascular health monitoring and treatment recommendations. Assistance in completing this task was offered to Members who were reachable via telephone calls.

For the CY 2019 report, an intervention was completed in 2020 to increase Provider awareness of Members who are remiss in completing health care treatment recommendations. A letter was created and securely faxed (using Right Fax) to each Member's Behavioral Health Provider and established Primary Care Physician to promote outreach to Member for completing LDL -C testing for the monitoring of Cardiovascular Disease (emphasizing LDL-C testing) The SCFHP benefit of case management and care coordination was mentioned as part of the Cardiovascular Disease testing reminder memo, along with a phone number to Case Management Services to promote connection of Members with additional support. This intervention was completed on 12/10/2019 and both BH and PCP providers were included.

Overall, a total of 28 Member Providers were sent LDL-C reminder memos; 28 to PCPs and 20 to Behavioral Health (BH) Providers (limitations include lack of contract with BH clinic, lack of Member current connection to BH clinic). Faxes were all sent on 11/9/2020 and re-faxed if necessary due to incomplete sending on 11/16/2020.

For CY 2020 intervention, a letter was created for each Cardiologist identified for the Members who did not have PCP follow up within CY 2020. A Standards of Care letter was drafted with RN input and approved through Marketing as well as by the Health Plan's Chief Medical Officer for mailing in October 2021. The Letter speaks to the need for LDL-C screening annually at minimum, with need factors included that affect more frequent testing (e.g. 2-3 months post introduction of antipsychotic medication) and included a guideline on lipid panels as reminder for appropriate Standards of Care and Practice. The letter was sent to member Cardiologists

with recommendation to connect with the identified member for follow up appointment to review care needs. Total members/Cardiology letters sent include 15.

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[i] HEDIS AMM technical specifications link: http://icat/initiatives/ncqa_first_survey/Shared%20Documents/1.%20Project%20Management/Workgroups/QI6A/Data/Factor%202%20-%20AMM%20HEDIS%20Measure/Antidepressant%20Medication%20Management.docx

[ii] **Mild to Moderate** defined as ICD-10 codes of diagnoses Major Depressive Disorder, Bipolar Disorder and Other Mood Disorders with indication of being in partial or full remission, and indication of mild or moderate status were acceptable; any indication of above stated diagnoses with psychotic features were ruled out.

Santa Clara Family Health Plan™

Assessment of Cal MediConnect Member Understanding of Policies & Procedures: Call Code Analysis

A review of calls received between 7/1/2020 and 6/30/2021 from members calling within 90 days of their enrollment, to identify opportunities for improving member understanding of policies and procedures.

Date analysis completed: 7/23/2021

By: Theresa Zhang, Manager, Communications, and Chelsea Byom, Director, Marketing & Communications

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Process:

A call report was generated from the internal call reporting system for calls received between July 1, 2020 and June 30, 2021.The report contains the following fields:

Call_Date1
Create_User_ID1
Caller_ID
Type_Issue1
Within 90 day tag
LOB
Member_Full_Name
Member_HPID
Eff Date
dob
Provider_Name
Provider_ID
Status
ClosedDate
TAT
Resolution
Resolnotes
CallNotes
Assigned_To
Sampled

The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to focus the analysis. The following list contains the types of issues and their descriptions:

Type_Issue1	Description
Administrative	Materials Request
Administrative	Positive Feedback
Administrative	PQI
Inquiry Auth	INQ Auth Member Call Pharmacy

Type_Issue1	Description
Inquiry Auth	INQ Auth Provider Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Medical
Inquiry Benefit	INQ Benefit Behavioral Health Therapy (BHT)
Inquiry Benefit	INQ Benefit Case Management Support
Inquiry Benefit	INQ Benefit Continuity of Care
Inquiry Benefit	INQ Benefit Dental Service
Inquiry Benefit	INQ Benefit DME, Enteral and Parenteral Service
Inquiry Benefit	INQ Benefit Mental Health Service
Inquiry Benefit	INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP
Inquiry Benefit	INQ Benefit Other (need to specify)
Inquiry Benefit	INQ Benefit Pharmacy
Inquiry Benefit	INQ Benefit Reimbursement
Inquiry Benefit	INQ Benefit Specialist
Inquiry Benefit	INQ Benefit Vision Service
Inquiry Billing	INQ Billing Statement
Inquiry Claim	INQ Adminstrative Error
Inquiry Claim	INQ Claim Status
Inquiry General	INQ General Assistance with obtaining appointment
Inquiry General	INQ General HK Renewal Question
Inquiry General	INQ General HRA
Inquiry General	INQ General Medi-Care/CMC Inquiry
Inquiry General	INQ General Provider/Network Information Inquiry
Quality of Serv	GRV Adminstrative Issues
Quality of Serv	GRV ID Card
Quality of Serv	GRV Transportation Services (NEMT)
Quality of Serv	GRV Transportation Services (NMT)
Referral Grv	GRV Prior Auth/Appeal Process
Transportation	Transportation Benefit Inquiry

Next, the report was narrowed to include members that called within 90 days of their enrollment date with the Santa Clara Family Health Plan Cal MediConnect (Medicare-Medicaid Plan) Plan.

Member health plan IDs (HPID) were included in the call report. HPID was used to source the member's enrollment date from the internal enrollment data tables. The member's enrollment date was measured against the call date to identify if the member called within 90 days of their enrollment.

The following pivot table outlines the volume of calls distinct members made by the type of issue (call code) within 90 days of member's enrollment.

- Count of Member HPID indicates a count of unique members who called within 90 days of their enrollment.
- Count of Member HPID2 presents the results of the previous column in precentages.
- The pivot table excludes counts of multiple calls made by a unique member.

Row Labels	Count of Member HPID	Count of Member HPID2
Administrative-Materials Request	182	11.10%
Administrative-PQI	1	0.06%
Inquiry Auth-INQ Auth Member Call Pharmacy	11	0.67%
Inquiry Auth-INQ Auth Provider Call Medical	23	1.40%
Inquiry Auth-INQ Auth Provider Call Pharmacy	2	0.12%
Inquiry Benefit-INQ Benefit Case Management Support	76	4.63%
Inquiry Benefit-INQ Benefit Dental Service	87	5.30%
Inquiry Benefit-INQ Benefit DME, Enteral and Parenteral Service	82	5.00%
Inquiry Benefit-INQ Benefit Mental Health Service	12	0.73%
Inquiry Benefit-INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP	18	1.10%
Inquiry Benefit-INQ Benefit Other (need to specify)	346	21.10%
Inquiry Benefit-INQ Benefit Pharmacy	80	4.88%
Inquiry Benefit-INQ Benefit Reimbursement	3	0.18%
Inquiry Benefit-INQ Benefit Specialist	46	2.80%
Inquiry Benefit-INQ Benefit Vision Service	55	3.35%
Inquiry Billing-INQ Billing Statement	34	2.07%
Inquiry Claim-INQ Administrative Error	1	0.06%
Inquiry Claim-INQ Claim Status	93	5.67%
Inquiry General-INQ General Assistance with obtaining appointment	35	2.13%
Inquiry General-INQ General HRA	53	3.23%
Inquiry General-INQ General Medi-Care/CMC Inquiry	116	7.07%
Inquiry General-INQ General Provider/Network Information Inquiry	180	10.98%
Quality of Serv-GRV-Administrative Issues	1	0.06%
Quality of Serv-GRV-ID Card	1	0.06%
Quality of Serv-GRV-Transportation Services (NEMT)	3	0.18%
Quality of Serv-GRV-Transportation Services (NMT)	3	0.18%
Transportation-Transportation Benefit Inquiry	96	5.85%
Grand Total	**1640**	**100.00%**

Individual call records were grouped and assessed by issue type and description. The top three highest occurrence call types were:

1. Other (need to specify)	21.10%
2. Materials request	11.10%
3. General provider/network information inquiry	10.98%

Samples of call notes were reviewed within these categories to identify noticeable trends and opportunities for improvement. Themes identified in the call notes are summarized in the table below.

Themes identified in top call types:

Call Type	Specific Reason for Call
Other (need to specify)	Return missed call (HRA outreach)
	Confirm PCP or in-network provider
Materials request	Mail AOR (Appointment of Representative) form
General provider/network information inquiry	Confirm provider or specialist
	Request specific provider as PCP

In addition, 5 grievances filed with SCFHP from July 1, 2020 to June 30, 2021 that were categorized as “Marketing” were reviewed. The top theme identified in these grievances was related to members unable to find in-network providers or specialists accepting new patients from the online provider search tool.

Conclusion:

Upon detailed review of the call notes, highlighting the use of the member portal as a way to confirm or find in-network providers has been identified as an actionable opportunity for improvement. A significant number of call notes documented member confusion regarding identifying their primary care providers, and finding in-network providers and specialists. Member education via a mass communication vehicle would be an effective way to increase member understanding of the member portal to choose and change PCPs and the provider search tool to find in-network providers.

Additionally, improving member understanding of health plan ID cards for PCP information and other contact information has been identified as an actionable opportunity for improvement. Possible interventions include providing instructions on what information is printed on the ID cards, when and how to use it get medically necessary services in an educational member newsletter article and in the new member orientation.

Two of the top call types have been addressed through recent process improvements, including the addition of the Health Risk Assessment (HRA) form to the new member welcome packet and the addition of an instruction sheet to the Authorized Representative form.

Santa Clara Family Health Plan™

Member Experience Analysis 2020

Grievance & Appeals, Santa Clara Family Health Plan

August 2021

Methodology

- The Grievance & Appeals (G&A) Department created a report of all CMC cases received in 2020 and compared it to the CMC cases received in 2019.

- These cases are then divided into three tables:
  - **Grievances unrelated to BH**
  - **Appeals unrelated to BH**
  - **BH-related grievances and appeals**

- Once they are in these tables, these cases are then divided further into 5 separate categories:
  - **Access to Care**
  - **Quality of Care**
  - **Attitude/Service**
  - **Billing/Financial**
  - **Quality of Practitioner Office Site**

Grievance Rates

- SCFHP strives to maintain a rate below 5.0 cases per 1000 CMC members or demonstrate improvement year over year.
- In 2020, our average CMC membership is 9,069. Dividing this by 1000 gives us 9.069.
- We then divide the number of cases by category and quarter with this rate to give us our rate per 1000 CMC members.
- With 3 tables, 4 quarters, and 5 categories, we are overseeing 60 different rates.

Santa Clara Family Health Plan

Grievances (non-BH) – Table, CY2019

Complaint / Grievance Category	1Q-2019	2Q-2019	3Q-2019	4Q-2019	(Jan. 1-Dec. 31, 2019)	Grievances / per 1,000 members Average membership in 2019 = 8,051
Quality of Care	26 *3.23*	8 *0.99*	20 *2.48*	13 *1.61*	67	8.322
Access	10 *1.24*	11 *1.37*	17 *2.11*	28 *3.48*	66	8.198
Attitude/Service	121 *15.0*	101 *12.5*	136 *16.9*	123 *15.3*	481	59.744
Billing/Financial	151 *18.8*	168 *20.9*	167 *20.7*	115 *14.3*	601	74.649
Quality of Practitioner Office Site	0	1 *0.12*	0	0	1	0.124
Total	308	289	340	279	1216	151.037

Santa Clara Family Health Plan

Grievances (non-BH) – Table, CY2020

Complaint / Grievance Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020)	Grievances / per 1,000 members 9.069 = 2020 average
Quality of Care	35 *3.86*	27 *2.98*	35 *3.86*	39 *4.30*	136	14.996
Access	37 *4.07*	37 *4.07*	37 *4.07*	44 *4.85*	155	17.091
Attitude/Service	118 *13.0*	78 *8.60*	104 *11.5*	91 *10.0*	391	43.114
Billing/Financial	139 *15.3*	128 *14.1*	132 *14.6*	146 *16.1*	545	60.095
Quality of Practitioner Office Site	4 *0.44*	0	0	0	4	0.441
Total	333	270	308	320	1231	135.737

Grievances (non-BH) – Highlights

- We met our goal for every quarter of Quality of Care, Access, and Quality of Practitioner Office Site.
- Quality of Practitioner Office Site is low and has always been historically low. We only have 1 grievance subcategory (out of 70~) that corresponds to this category.
- Compared to CY2019, Access and Quality of Care received an increase in cases all year. We are getting closer and closer to exceeding the 5.0 rate.
- Billing/Financial continues to be the category with the most grievances. The biggest subcategory, Balance Billing, has 454 grievances total and makes up about 37% of all non-BH grievances received this year.
- Our intervention is to create and maintain a dashboard looking at specific providers. These providers make up a large portion of our highest volume grievances (transportation, balance billing). This will allow us to track and trend and then provide tailor-made fixes to those providers.

Santa Clara Family Health Plan

Appeals (non-BH) – Table, CY2019

Appeals Category	1Q-2019	2Q-2019	3Q-2019	4Q-2019	(Jan. 1-Dec. 31, 2019) Total Appeals	Appeals / per 1,000 members Total membership in 2019 = 8,051
Quality of Care	0	0	0	0	0	0.000
Access	75 *9.31*	95 *11.8*	74 *9.19*	67 *8.32*	314	39.001
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	5 *0.62*	21 *2.61*	20 *2.48*	36 *4.47*	82	10.185
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	80	116	94	103	396	49.186

Santa Clara Family Health Plan

Appeals (non-BH) – Table, CY2020

Appeals Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020) Total Appeals	Appeals / per 1,000 members 9.069 = 2020 average
Quality of Care	0	0	0	0	0	0.000
Access	76 *8.38*	73 *8.05*	91 *10.0*	94 *10.4*	334	36.829
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	27 *2.98*	21 *2.32*	20 *2.21*	24 *2.65*	92	10.144
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	103	94	111	118	426	46.973

Appeals (non-BH) – Methodology

- Appeals do not correspond to the categories as well as grievances do.
- Appeals are either Pre-Service or Post-Service.
  - A pre-service appeal is when a member or member representative disagrees with a denial of services or medication.
    - All pre-service appeals were put into the Access category, since they are not receiving services and/or medication.
  - A post-service appeal is when a member or provider disagrees with a denial of payment for services.
    - All post-service appeals were put into the Billing/Financial category, since that's the focus of the case.

Appeals (non-BH) – Highlights

- Due to methodology, it will be very difficult to reach our goal threshold for appeals, as all our appeals sort out into two of the five categories.

- A CMS memo in Q4 2020 reiterated that payment disputes involving Medicare non-participating providers would be considered an appeal. The body of work moved from SCFHP's Provider Disputes Resolution to G&A in late September 2020. This accounts for the increased amount of Billing/Financial appeals for Q4 2020.

- SCFHP is working on two interventions related to Billing/Financial appeals, specifically on its overturn/uphold ratio.

- G&A is also working with the MDs on an intervention involving clinical decision making.

Santa Clara Family Health Plan™

Victor Hernandez, QA Program Manager
Grievance & Appeals Department

Behavioral Health Member Experience Survey

Completion Rate

- 900 call attempts were completed
- Total of 150 members answered the call
- 77 members agreed to complete the survey resulting in a response rate of 23.4%, a decreased response rate from the previous year of 27%

Behavioral Health Member Experience Survey

Participant Demographics

Sex:	2019 N=104	%	2020 N = 77	%
Female	69	66%	55	71
Male	25	24%	21	27
Unavailable	10	10%	1	<1

Behavioral Health Member Experience Survey

Participant Demographics

Race/Ethnicity:	2019 N=100	%	2020 N = 77	%
Hispanic/Latino	31	31	23	30
White/Caucasian	31	31	26	34
Asian	24	24	18	23
Prefer not to answer	8	8	1	1
American Indian/Alaskan			1	1
Native Hawaiian/pacific Islander			1	1
Black/African American	6	6		

Behavioral Health Member Experience Survey

Participant Demographics

Age:	2019 N=99	%	2020 N = 76	%
+55	79	80	60	79
35-54	19	19	15	20
18-34	1	1	1	1

Behavioral Health Member Experience Survey Results

Comparison of 2020 to 2021

Survey Question	Always and Usually Response % 2020	Always and Usually Response % 2021
Q7 - appointment soon as wanted	77%	74%
Q8 - helped when needed right away	82%	74%
Q9 – helped over the phone	NA	73%
Q10 - counselor was respectful	92%	84%
Q11 - counselor explained in a way you understood	95%	78%
Q12 - counselor listened carefully	94%	78%
Q13 – counselor spends time with you	86%	65%
Q14 – feel comfortable raising issues/concerns	93%	74%

Opportunities for Improvement

Area for Improvement	Intervention
Access	Increase provider network
Member Education	Newsletter Articles, Events through the CRC
Provider Education	Tip Sheets, Memos, Updates to the Provider Portal
Partnership with the County	Participate in collaborative efforts and initiatives (i.e. Maternal Mental Health)

Santa Clara Family Health Plan
Member Experience, Including Behavioral Health: 2020 Analysis

Prepared by:

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For review by the Quality Improvement Committee: October 12, 2021

I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaints and appeals may impact overall member satisfaction, SCFHP tracks and trends compliant and appeal activity to identify barriers to care and identify potential interventions.

The behavioral health member satisfaction survey is another means to monitor the member experience. The member experience assessment is used to identify areas of improvement and help meet the specific needs of SCFHP members. SCFHP reviews data associated with complaints and appeals and the Behavioral Health Member Satisfaction Survey on an annual basis. The quantitative analysis process includes a review of results and compares those results against any established performance goals. In future measurement years, the quantitative analysis will also track trends year over year. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to improving performance and quality. The process incorporates opportunities and/or interventions to address the root cause. In CY2020, the following measures were monitored for aspects shaping the Member Experience by conducting at a minimum, a quantitative analysis of all of the results and a qualitative analysis of non-behavioral health results:

1. Member complaint and appeals categories:
    a. Non-Behavioral Health
    b. Behavioral Health
2. Member Satisfaction Survey
    a. Behavioral Health

1. Member Complaints and Appeals

SCFHP collects data on five major categories of member grievances and appeals.

Methodology: SCFHP's Grievance and Appeals (G&A) Department uses the QNXT information system and the Beacon Virtual Appeals Manager database to document, collect, store and calculate grievance and appeals data which includes behavioral health-related issues. The data included in this analysis was captured in calendar year 2019 and calendar year 2020 (January 1-December 31). All grievances and appeals are collected by the receipt date. Consumer

Assessment of Healthcare Providers & Systems (CAHPS) data was not used because SCFHP's Medicare membership is less than the 15,000 minimum enrollment threshold.

The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to five categories required by NCQA. The data is then collected for the entire SCFHP Cal MediConnect population and is aggregated into the following categories:

- Quality of Care
- Access
- Attitude/Service
- Billing/Financial
- Quality of Practitioner Office Site

Standards and Thresholds:

SCFHP's goals are to:

- Strive for a rate that is below 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and
- Strive for a rate that is below 5.0 Non-BH & BH grievances/appeals per 1000 members for each category

Membership total is based on an annual average. The total membership of each month is added together and then divided by the number of months in the year. This total number is then divided by 1000 to provide the rate per 1000 members. CY2020's average membership comes to 9,069, which means the rate per 1000 members is 9.069. Each grievance total per category per quarter is then divided by 9.069 to get the grievance rate. The goal is for these grievance rates to not exceed 5.0.

If a grievance and/or appeal exceeds this threshold, a root-cause analysis will be conducted to identify the root cause and develop initiatives to address underlying issues. Internal and external stakeholders will be included as needed to assist in the root-cause analysis as well as remediation of the issues.

Member Complaints/Grievances and Appeal Categories

Table 1. CMS Member Complaints/Grievances Categories for CY2019

Complaint / Grievance Category	1Q-2019	2Q-2019	3Q-2019	4Q-2019	(Jan. 1-Dec. 31, 2019)	Grievances / per 1,000 members 8.051 = 2019 average
Quality of Care	26 *3.23*	8 *0.99*	20 *2.48*	13 *1.61*	67	8.322
Access	10 *1.24*	11 *1.37*	17 *2.11*	28 *3.48*	66	8.198
Attitude/Service	121 *15.0*	101 *12.5*	136 *16.9*	123 *15.3*	481	59.744
Billing/Financial	151 *18.8*	168 *20.9*	167 *20.7*	115 *14.3*	601	74.649
Quality of Practitioner Office Site	0	1 *0.12*	0	0	1	0.124
Total	308	289	340	279	1216	151.037

Table 2. CMS Member Complaints/Grievances Categories for CY2020

Complaint / Grievance Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020)	Grievances / per 1,000 members 9.069 = 2020 average
Quality of Care	35 *3.86*	27 *2.98*	35 *3.86*	39 *4.30*	136	14.996
Access	37 *4.07*	37 *4.07*	37 *4.07*	44 *4.85*	155	17.091
Attitude/Service	118 *13.0*	78 *8.60*	104 *11.5*	91 *10.0*	391	43.114
Billing/Financial	139 *15.3*	128 *14.1*	132 *14.6*	146 *16.1*	545	60.095
Quality of Practitioner Office Site	4 *0.44*	0	0	0	4	0.441
Total	333	270	308	320	1231	135.737

Quantitative Analysis: Member Complaints/Grievances

SCFHP tracks and trends all member complaints/grievances for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all complaints from the Cal MediConnect membership. The data as shown in Table 1 and Table 2 represents all member complaints/grievances and is not a sample.

In 2020, the complaints/grievances analysis showed that two categories consistently did not meet the threshold throughout the year: Attitude/Service and Billing/Financial. Attitude/Service had fewer grievances in the second and fourth quarter, with a total of 78 and 91 respectively. It should be noted that the second quarter had fewer grievances all around, with a total of 270. That is the only quarter with less than 300 grievances. Attitude/Service has roughly 100 less grievances in CY2020 compared to CY2019. Q2, Q3, and Q4 all had about 30 less grievances in CY2020 when compared to CY2019. This may be a result of the COVID-19 pandemic and state of emergency, which started in Q2 2020.

Billing/Financial consistently had high grievances with little variance throughout the year. Its lowest number was 128 in the second quarter and its highest number was 146 in the fourth quarter. There was about a drop in 56 grievances in CY2020 compared to CY2019. With the exception of Q4 2020, there was a downward trend in this category.

All other categories remained below the established rate of 5 grievances per 1000 members on a quarterly basis. The highest quarter for Quality of Care was the fourth quarter with a total of 39 grievances. The highest quarter for Access to Care was also the fourth quarter, with a total of 44 grievances. The highest quarter for Quality of Practitioner Office Site was the second quarter, with a total of 4 grievances. Historically, this category has been significantly lower than the other categories assessed in this analysis. Quality of Care and Access to Care both had a higher volume all throughout CY2020 compared to CY2019.

Table 3. CMC Member Appeal Categories CY2019

Appeals Category	1Q-2019	2Q-2019	3Q-2019	4Q-2019	(Jan. 1-Dec. 31, 2019) Total Appeals	Appeals / per 1,000 members Total membership in 2019 = 8,051
Quality of Care	0	0	0	0	0	0.000
Access	75 *9.31*	95 *11.8*	74 *9.19*	67 *8.32*	314	39.001
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	5 *0.62*	21 *2.61*	20 *2.48*	36 *4.47*	82	10.185
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	80	116	94	103	396	49.186

Table 2. CMS Member Appeal Categories CY2020

Appeals Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020) Total Appeals	Appeals / per 1,000 members 9.069 = 2020 average
Quality of Care	0	0	0	0	0	0.000
Access	76 *8.38*	73 *8.05*	91 *10.0*	94 *10.4*	334	36.829
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	27 *2.98*	21 *2.32*	20 *2.21*	24 *2.65*	92	10.144
Quality of Practitioner Office Site	0	0	0	0	0	0.000

Total	**103**	**94**	**111**	**118**	**426**	**46.973**

Quantitative Analysis: Member Appeals

SCFHP tracks and trends all member appeals for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all appeals inclusive of pre-service authorization and post-service claims appeals filed by a member or member representative. The data as shown in Table 3 and 4 is representative of all member appeals and is not a sample.

Access appeals did not have much variance throughout CY2020 between Q1 and Q2, but had an increase in Q3 and Q4. When compared to CY2019, the numbers also had low variance with the exception of Q2. Comparing the data between both years, the lowest case volume was in Q2 2020 with 73 and the highest number was in Q2 2019 with 95, a difference of 22. This shows that SCFHP has a consistent intake of Access (pre-service) appeals.

Billing/Financial appeals had very low variance throughout CY2020. The highest number is 27 in Q1 2020 and the lowest number is 20 in Q3 2020, a variance of 7. This is different from CY2019. While Q2 and Q3 of 2019 is consistent with the CY2020 numbers, Q1 and Q4 had a spike at the beginning and end of the year. Q1 only had 5 appeals and Q4 had 36 appeals.

Access consistently did not meet their goal throughout the year on a quarterly basis. Billing/Financial met the goal by being below a rate of 5.0 appeals per 1000 members. The remaining three categories – Quality of Care, Attitude/Service and Quality of Practitioner Site – had results of zero appeals and, therefore, met the goal.

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 – 4)

The Grievance & Appeals Department reviewed the total number of grievance and appeals received in CY2020. The following grievance subcategories had more than 50 grievances throughout the year: Billing Statement with 50, Inappropriate Provider Care with 80, Non-Medical Transportation Services (NMT) with 105, and Balance Billing Statement with 454.

The management team prioritized root-cause analysis and work plans for NMT and Balance Billing Statement. This is because of the high volume of cases in those categories compared to all other categories. This is also because we can track and trend issues with a particular provider and can take quicker action as there are fewer distinct providers.

In addition, the Grievance & Appeals Department meets weekly to discuss trends in the short-term. In addition, the Grievance and Appeals Review Workgroup also reviews these trends on a quarterly basis. The Workgroup has representatives from the following departments at SCFHP: Executive team, Compliance, Provider Network Operations, Utilization Management, Quality Improvement, Customer Service, Case Management, and IT.

In analyzing the Billing/Financial complaints/grievances the following root cause was determined for the high amount of grievances:

- Out of the 545 Billing/Financial grievances, 454 of them are related to balance billing. When researching the providers associated with balance billing, one hospital was involved in 96 cases. In December 2020, SCFHP contacted that hospital and discussed ways to reduce their balance billing issues. The hospital staff responded that they will fix their database to flag SCFHP members with Cal MediConnect. This fix was completed around the end of December 2020.

In analyzing the Access appeals the following root causes were determined to be responsible for the increase:

- While SCFHP currently has a Timely Access workgroup, this workgroup focuses primarily on grievances relating to Access to Care. We were informed to start focusing on access to care from the appeals' standpoint. There were adjustments to data collecting to better facilitate trend analysis. This is largely because the G&A Database, Virtual Appeals Manager, collects grievance data and appeals data in different ways.

In analyzing the Billing/Financial appeals the following root causes were determined to be responsible for the increase:

- The Billing/Financial appeals category is made up of Part C post-service (claims) appeals requested by members. SCFHP found that many of the overturn appeals are related to non-contracted providers. In addition, those non-contracted providers are appealing claims that were part of an approved admission to a skilled nursing facility or hospital. Since the admission is approved, they are already medically necessary and the claim would be approved if appealed. As a result, the Claims Department is reviewing their system configuration to approve these claims rather than deny them during the first review.

- In addition, a further analysis revealed that many overturns from the claims appeals were from a specific non-contracted provider group. However, that non-contracted provider group works very closely with a prominent contracted hospital. As a result, many denied claims are actually a part of plan-directed care and would be approvable,

despite the provider group being non-contracted. Provider Network Operations is in discussion with the non-contracted provider group to become contracted.

- To address this, the Grievance & Appeals Department plans to adjust the method in which appeals are being reviewed. The appeals are often initially denied because no authorization was obtained, as stated in the SCFHP Authorization Grid. In CY 2019 and CY 2020, the Medical Directors approached the appeals by only looking at medical necessity rather than the SCFHP benefit rules. The Medical Directors will be shifting the method of review to appropriately consider whether authorization was obtained prior to the rendering of services. This should encourage the providers to obtain authorization through the Utilization Management Department, thereby reducing the number of post-service appeals.

Time Frame: January 1, 2019 - December 31, 2019						
Behavioral Health Complaint / Grievance/Appeal Category	**1Q-2019**	**2Q-2019**	**3Q-2019**	**4Q-2019**	**Total Grievances**	**BH Grievances/per 1,000 members Total CMC Membership in 2019 = 8,051**
Quality of Care	0	0	0	0	0	0
Access	0	0	0	0	0	0
Attitude/Service	0	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	0

Time Frame: January 1, 2020 - December 31, 2020						
Behavioral Health Complaint / Grievance/Appeal Category	**1Q-2020**	**2Q-2020**	**3Q-2020**	**4Q-2020**	**Total Grievances**	**BH Grievances/per 1,000 members 9.069 = 2020 average**
Quality of Care	**0**	**0**	**0**	**0**	**0**	**0**
Access	**3** *0.33*	**0**	**0**	**0**	**3**	**0.331**
Attitude/Service	**1** *0.11*	**0**	**1** *0.11*	**0**	**2**	**0.221**

Billing/Financial	**0**	**0**	**3** *0.33*	**2** *0.22*	**5**	**0.551**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0**
Total	**4**	**0**	**4**	**0**	**9**	**0.992**

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals

In CY2019, there were no grievances or appeals relating to behavioral health. In CY2020, there were 9 grievances and appeals relating to behavioral health. This is a low volume of cases. As a result, there are no trends to analyze and no interventions.

2. Member Satisfaction Survey – Behavioral Health

Methodology:

SCFHP conducts an annual telephonic member satisfaction survey for Cal MediConnect (CMC) members who receive behavioral health services. Members are identified through claims based on outpatient mental health services received in the previous calendar year. The total population for 2020 identified 2259 members. The health plan used a sample size calculator with a 95% confidence interval and a margin of error of 5 which resulted in a target sample size of 328.

Up to three calls were attempted for each member, with attention paid to the time of day (e.g. calling in the afternoon if not reached during the morning), alternate numbers (if available) and member language needs. Interpreter services were used for calls requiring a language other than that of the caller. All calls were made between the dates of April 19 and May 7, 2021 and were completed by health plan staff. A standard script was used as well as training to minimize discrepancies amongst staff in delivering the questionnaire to the members.

The results were recorded in the care management software, Essette, in the form of an assessment. Results were provided in the form of a report. Questions 1-6 are demographic questions which got populated after successful completion of a survey in order to be easily extracted into a report.

The majority of the survey questions are adapted from the CAPHS survey.

Questions 7-9 are related to access and are as follows:

7) How often did you get an appointment as soon as you wanted?
8) How often did you see someone as soon as you wanted when you needed help right away?How often did you get the help or advice you needed over the phone?

Questions 10-14 are related to the quality of care and are as follows:

9) How often did your counselor show respect for what you had to say?
10) How often did your counselor explain things in a way that you could understand? -
11) How often did your counselor listen carefully?
12) How often did your counselor spend any time with you?

The remainder of the question are asked to determine overall progress of members using behavioral health services and are as follows:

15) Compared to 12 months ago, how would you rate your ability to deal with daily problems?
16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations?
17) Compared to 12 months ago, how would you rate your ability to accomplish the things you wanted to do?
18) Compared to 12 months ago, how would you rate your ability to deal with social situations?
19) What effect has your counseling had on your symptoms and problems?
20) What effect has your counseling had on the quality of your life?

Behavioral Health: Members Satisfaction Survey Results

Sample Size:	**2019 Total Outreach N = 385 members**	**2020 Total Outreach N = 328 members**
Completed Survey:	104 (27%)	77 (23.4%)
Survey Not Completed:	281 (73%)	245 (74.7%)
Survey Not Completed (sub results):	281	245
Unable to reach:	218 (76%)	112 (46%)
Member/Caregiver was busy:	16 (6%)	5 (2%)
Did not remember provider:	8 (3%)	2 (<1%)
Declined/no reason:	3 (<1%)	56 (23%)
Member coverage termed:		18 (7%)
Member expired:		4 (2%)
Member denied BH receiving treatment:		3 (1%)
No reason given:	3(<1%)	45 (18%)
Didn't feel comfortable	3(<1%)	

Said already completed	2(<1%)	

Sex:	2019 N=104	%	2020 N = 77	%
Female	69	66%	55	71
Male	25	24%	21	27
Unavailable	10	10%	1	<1

Race/Ethnicity:	2019 N=100	%	2020 N = 77	%
Hispanic/Latino	31	31	23	30
White/Caucasian	31	31	26	34
Asian	24	24	18	23
Prefer not to answer	8	8	1	1
American Indian/Alaskan			1	1
Native Hawaiian/pacific Islander			1	1
Black/African American	6	6		
Age:	**2019 N=99**	**%**	**2020 N = 76**	**%**
+55	79	80	60	79
35-54	19	19	15	20
18-34	1	1	1	1

Q7- "How often did you get an appointment as soon as you wanted?"

Q7 Responses -	2019 N=104	%	2020 N = 71	%
Always	68	65	33	46
Usually	12	12	20	28
Sometimes	21	20	13	18
Never	3	3	5	7

Q8 – "How often did you see someone as soon as you wanted when you need help right away?"

Q8 Responses -	2019 N=102	%	2020 N = 70	%
Always	64	62	28	40
Usually	20	20	24	34
Sometimes	14	14	12	17
Never	4	4	6	9

Q9 – "How often did you get the help or advice you needed over the phone?"

Q9 Responses -	2019 N=	%	2020 N = 70	%
Always	29	28	34	49
Usually	14	13	17	24
Sometimes	22	21	11	16
Never	39	38	8	11

Q10 – "How often did your counselor show respect for what you had to say?"

Q10 Responses -	2019 N=104	%	2020 N = 63	%
Always	82	79	43	68
Usually	14	13	10	16
Sometimes	6	6	2	3
Never	2	2	8	13

Q11 – "How often did your counselor explain things in a way that you could understand?"

Q11 Responses -	2019 N=104	%	2020 N = 64	%
Always	91	87	41	64
Usually	8	8	9	14
Sometimes	3	3	6	9
Never	2	2	8	13

Q12 – "How often did your counselor listen carefully?"

Q12 Responses -	2019 N=104	%	2019 N = 64	%
Always	88	84	44	69
Usually	10	10	6	9
Sometimes	4	4	6	9
Never	2	2	8	12

Q13 – "How often did your counselor spend any time with you?"

Q13 Responses -	2019 N=104	%	N = 63	%
Always	71	68	29	46
Usually	19	18	12	19
Sometimes	13	13	10	16
Never	1	1	12	19

Q*14 – "How often did you feel comfortable raising issues or concerns?"*

Q14 Responses -	2019 N=104	%	2020 N = 68	%
Always	93	89	38	56
Usually	4	4	12	18
Sometimes	5	5	11	16
Never	2	2	7	10

Q15 – "Compared to 12 months ago, how would you rate your ability to deal with daily problems?"

Q15 Responses -	2019 N=18	%	2020 N = 67	%
Much Better	4	22	10	15
A Little Better	6	33	21	31
About the Same	6	33	23	34
A Little Worse	1	6	9	13
Much Worse	1	6	4	6

Q16 – "Compared to 12 months ago, how would you rate your ability to deal with crisis situations?"

Q16 Responses -	2019 N=17	%	2020 N = 65	%
Much Better	3	18	11	17
A Little Better	6	35	20	31
About the Same	7	41	25	38
A Little Worse	1	6	6	9
Much Worse	0	0	3	5

Q17 – "Compared to 12 months ago, how would you rate your ability to accomplish the things you wanted to do?"

Q17 Responses -	2019 N=17	%	2020 N = 67	%
Much Better	4	24	6	9
A Little Better	6	35	21	31

About the Same	4	24	24	36
A Little Worse	2	12	12	18
Much Worse	1	6	4	6

Q18 – "Compared to 12 months ago, how would you rate your ability to deal with social situations?"

Q18 Responses -	2019 N=17	%	N = 67	%
Much Better	4	24	8	12
A little Better	3	18	12	18
About the Same	9	53	36	53
A Little Worse	1	6	9	13
Much Worse	0	0	2	3

Q19 – "What effect has your counseling had on your symptoms and problems?"

Q19 Responses -	2019 N=18	%	N = 64	%
Very Helpful	11	61	23	36
A Little Helpful	6	33	27	42
Not Helpful or Harmful	1	6	9	14
A Little or Very Harmful			5	7

Q20 – "What effect has your counseling had on the quality of your life?"

Q20 Responses -	2019 N=17	%	2020 N = 63	%
Very Helpful	13	76	25	40
A Little Helpful	3	18	24	38
Not Helpful or Harmful	1	6	10	16
A Little or Very Harmful			4	6

Quantitative Analysis: Behavioral Health Member Satisfaction Survey Results

After over 900 call attempts, a total of 150 members answered the call. As a result, 77 members agreed to complete the survey resulting in a response rate of 23.4%, a decreased response rate from the previous year of 27%.

Of the 251 surveys not completed, 178 were members we were unable to reach. In 2019, 281 surveys were not completed due to members not able to be reached. Those unable to reach include members whose coverage may have termed, members who have expired, and members with invalid/disconnected phone numbers without any other known contact numbers. Members with severe needs that receive specialty mental health services through the county are

consistently a challenging population to reach for many reasons including changing addresses and contact information, changes to where they access and receive behavioral health care treatment, social determinates such as homelessness, lack of access to phones. Some respondents denied receiving any behavioral health treatment at all in CY2020. This indicates a lack of defining what includes behavioral health care and treatment either during treatment or during completion of the survey itself, or stigma to admission of receiving such treatment.

The survey questions were not updated, reworded, or deleted from the previous year and the outreach remained the same. The percentage of invalid phone numbers effects the ability to offer the surveys for feedback from members who received behavioral health treatment in CY2020. It will be helpful to consider alternate forms of survey completion, to increase response rate. The questions that make up the survey may not include situations all members identified as receiving behavioral health treatment from a provider. For example, the questions that inquire about the quality of the provider use the term counselor, and some respondents stated they do not have a "counselor."

Table: % of combined "Always" and "Usually" Responses for Questions 7-14

Survey Question	Always and Usually Response % 2020	Always and Usually Response % 2021
Q7 - appointment soon as wanted	77%	74%
Q8 - helped when needed right away	82%	74%
Q9 – helped over the phone	NA	73%
Q10 - counselor was respectful	92%	84%
Q11 - counselor explained in a way you understood	95%	78%
Q12 - counselor listened carefully	94%	78%
Q13 – counselor spends time with you	86%	65%
Q14 – feel comfortable raising issues/concerns	93%	74%

Qualitative Analysis: Behavioral Health Member Satisfaction Survey Results

The goal of obtaining greater or equal to 85% of Always and Usually categories was not met for any of the questions in 2021. In comparison to the previous year results, each of the always and usually responses have statistically decreased.

The effect of the COVID pandemic may have contributed to respondent's experience with behavioral health provider and access to care and treatment. Changes to format (office vs. telemedicine), increased community need for behavioral health creating waitlists for initial treatment and ongoing needs, higher case-loads for providers limiting availability, and the overall response to the pandemic has affected our members and overall community. Interventions to support membership during the pandemic included information on coping strategies placed on the SCFHP website and on social media, presentation on coping strategies at the Consumer Advisory Committee.

Access has consistently been a barrier experienced by SCFHP membership. Unfortunately, the community need for behavioral health care has greatly increased caused by the effects of the pandemic. SCFHP has contracted with a new telemedicine provider group, Array. We expect with this new provider group; it will result in increased access for the mild to moderate population who would like to continue with a telemedicine platform. Array's contract will be effective 8/1/2021. In April of 2020, efforts to increase the network were made by cold calling 10 local Medicare providers found on Psychology Today (a platform to locate providers) to inquire if they are interested in contracting with SCFHP. Unfortunately, none of those reached resulted in any contracts.

Overall, there is an opportunity to educate members and their providers about how to access behavioral health services. Creating a section on the SCFHP website and provider portal explaining how to access behavioral health care for their members, uploading tip sheets, and FAQs specific to member or provider is in process.

Reporting

Table: Committee Approval

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan™

Annual Cal Medi-Connect Continuity and Coordination of Medical Care Analysis (2021)

Presenter: Lan Tran, Quality Improvement Nurse

SCFHP monitors following measures

	Name of Measure	Movement Across Settings	Movement Across Practitioners
Measure 1	Transition of care – Medication Reconciliation (TRC-MRP)	**[X]**	
Measure 2	Comprehensive Diabetes Care (CDC)- Eye Exam Rate		**[X]**
Measure 3	PCP Follow up After 30 days of Discharge	**[X]**	
Measure 4	Plan All-Cause Readmissions (PCR)	**[X]**	

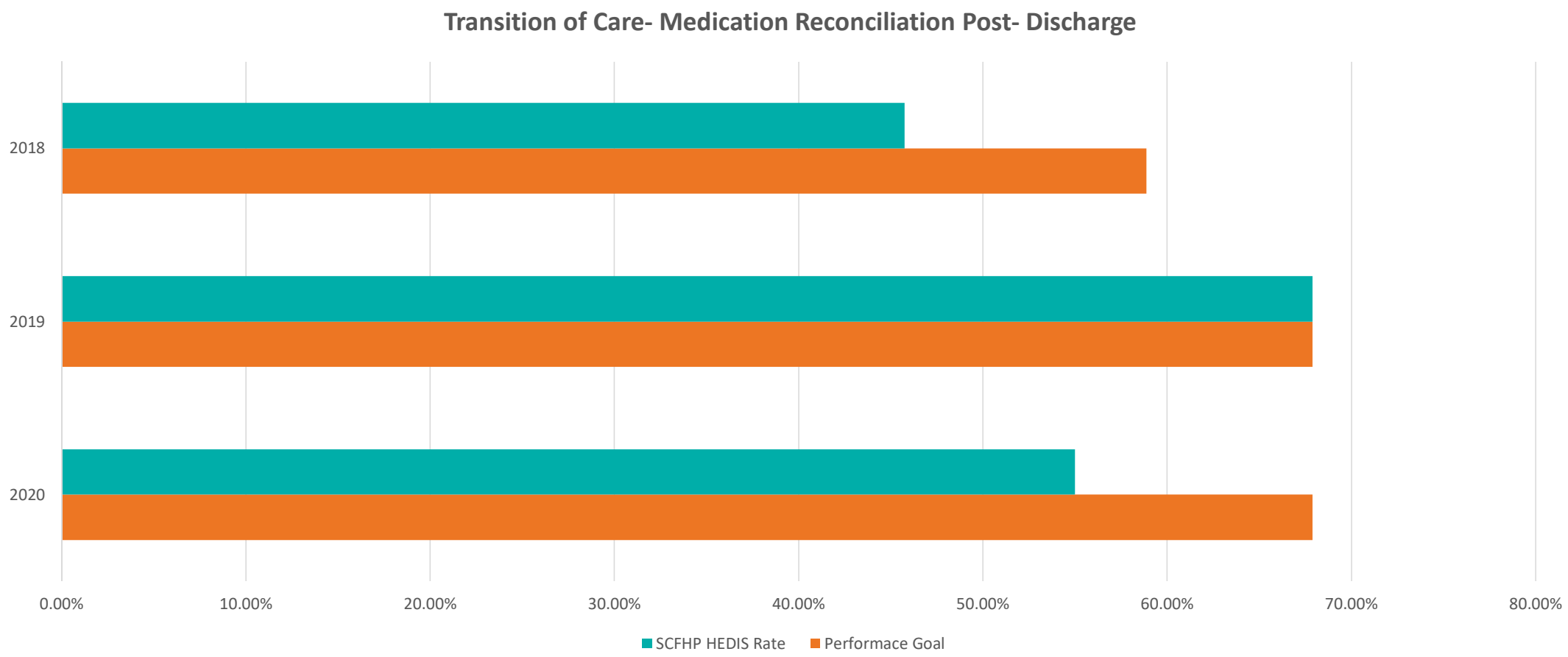
Transition of Care- Medication Reconciliation Post Discharge (TRC- MRP)

HEDIS Measure

Description: For members, 18 years of age and older, this measure identifies the percentage of discharges within the measurement/calendar year for whom medications were reconciled from the date of discharge through 30 days post-discharge (31 total days).

Proposed goal for MY 2021: 75th percentile

Results


Transition of Care- Medication Reconciliation Post- Discharge
2018
2019
2020
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
SCFHP HEDIS Rate
Performace Goal

Barrier and Analysis

Barrier: Identified that not all practitioners have the time to complete and document a thorough medication reconciliation at the initial visit post- discharge.

Interventions:

- Provider Network Operations (PNO) to work with QI to build a check-box for medication reconciliation template for 10 Provider sites with paper charting to decrease the administrative burden of medication reconciliation. PNO to educate the provider on utilizing the other staff to complete activities. **Targeting Q1 2022.**
- Develop CMC provider communication with the assistance of PNO on the importance of completing and documenting medication reconciliation within 30 days. **Targeting Q4 2021 & Q2 2022.**

Barrier and Analysis

Barrier: Identified that often Providers need reminders on operational priorities and information.

Interventions:

- Provider Network Operations will continue to recap on Provider Memos sent during Quality Calls with Provider and Staff. **Since August 2021.**

Comprehensive Diabetes Care (CDC) Eye Exam Rate

HEDIS Measure

- Description: This measure measures the members 18-75 years of age with diabetes (type 1 or type 2) who received a diabetic retinal eye examination within measurement year.
- Proposed goal for MY 2021: 75th percentile

Results

Measure 2: CDC Eye Exam Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2018	320	411	77.86%	65.56%	Y
Measurement Y2 2019	328	411	79.81%	82.05%	N
Measurement Y3 2020	317	411	77.13%	82.05%	N

Barrier and Analysis

Barrier: Lack of education among members about the importance of retinal eye exam.

Interventions:

- Develop gaps in care alert system in QNXT to notify internal staff to remind members about their due visit for retinal eye exam. **Since August 2018.**
- Quality Improvement Department to continue to work with IT and VSP to send out reminder letters to members diagnosed with Diabetes. **Since September 2021.**
- Develop health education materials to promote importance of diabetic care. **Targeting Q4 2022.**

Barrier and Analysis

Barrier: Medical record review suggest that optometrist/ophthalmologist do conduct eye exam for visual acuity screening but they do not always offer retinal eye exam to diabetic members.

Intervention:

- Develop health education material for practitioners on importance of diabetes care and treatment. **Done August 2021.**
- Attend VSP JOC October 13, 2021 to remind optometrist and ophthalmologist on identifying and offering retinal eye exam to diabetic members whose care are due. **Targeting Q4 2021.**

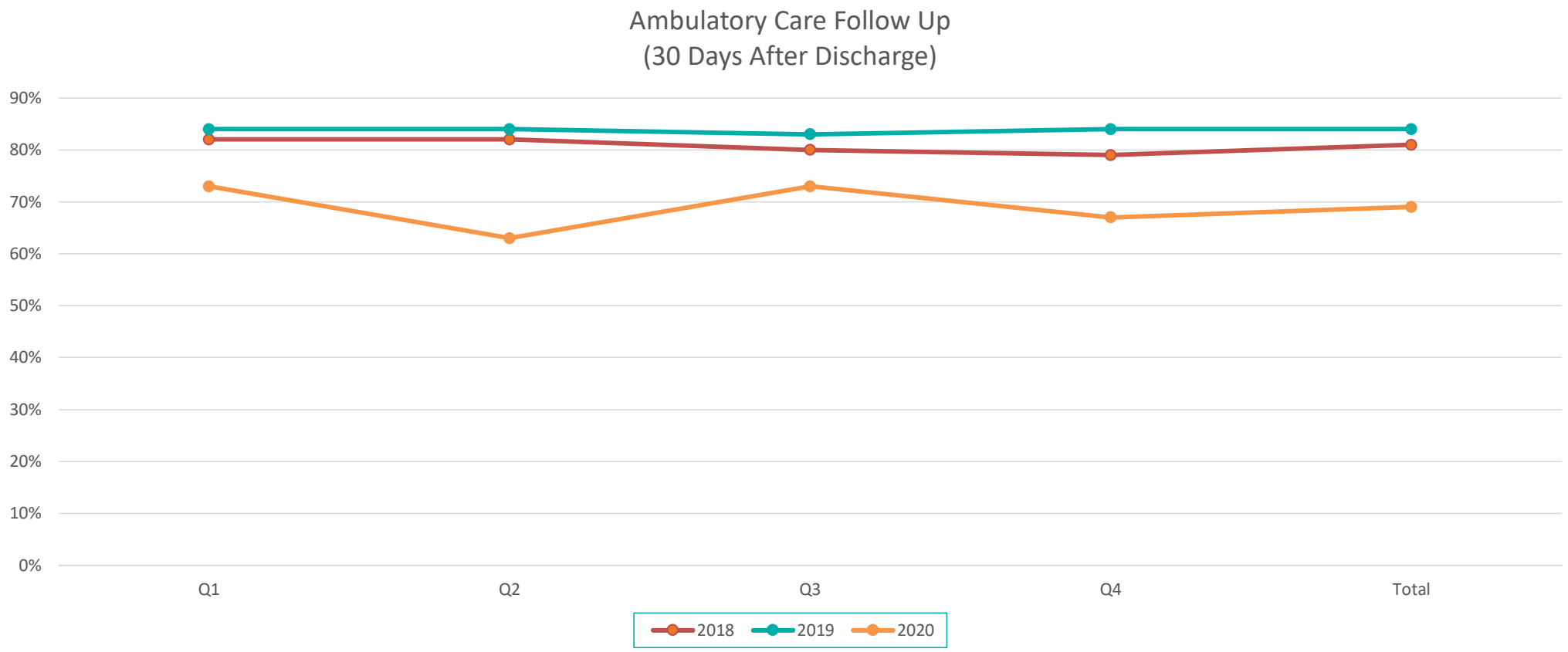
PCP follow up after 30 days of Discharge Rate

Regulatory requirement

- **Numerator definition**: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.
- **Denominator definition:** Total number of acute inpatient hospital discharges during the reporting period.
- **Goal for comparison**: 85% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge

- Proposed goal for MY 2021: 85%

Results


Ambulatory Care Follow Up
(30 Days After Discharge)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q1
Q2
Q3
Q4
Total
2018
2019
2020

Barrier and Analysis

Barrier: SCFHP currently lacks a centralized notification system from contracted hospitals to notify PCP about admission.

Interventions:

- Work with IT to build an IT report that automates the PCP admission notification reporting process. **Targeting Q4 2021.**
- Completed contracted County and HCA hospital required data sharing agreement separate from provider contract. **Done 2020-2021.**
- SCFHP has worked with IT to build the system to get census data from most of the contracted hospitals in the year 2019-2020.

Barrier and Analysis

Barrier: PCPs are not always aware their patients have been discharged to home.

Interventions:

- CM to send notification letter to PCP with discharge information in an SBAR format for PCP to follow up care post discharge by fax. **Since 2018.**

Plan All-Cause Readmissions (PCR)

HEDIS Rate

Denominator: County of Index Hospital Stays (IHS)

- An IHS is defined as an acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year.

Numerator: Count of 30-day Readmissions

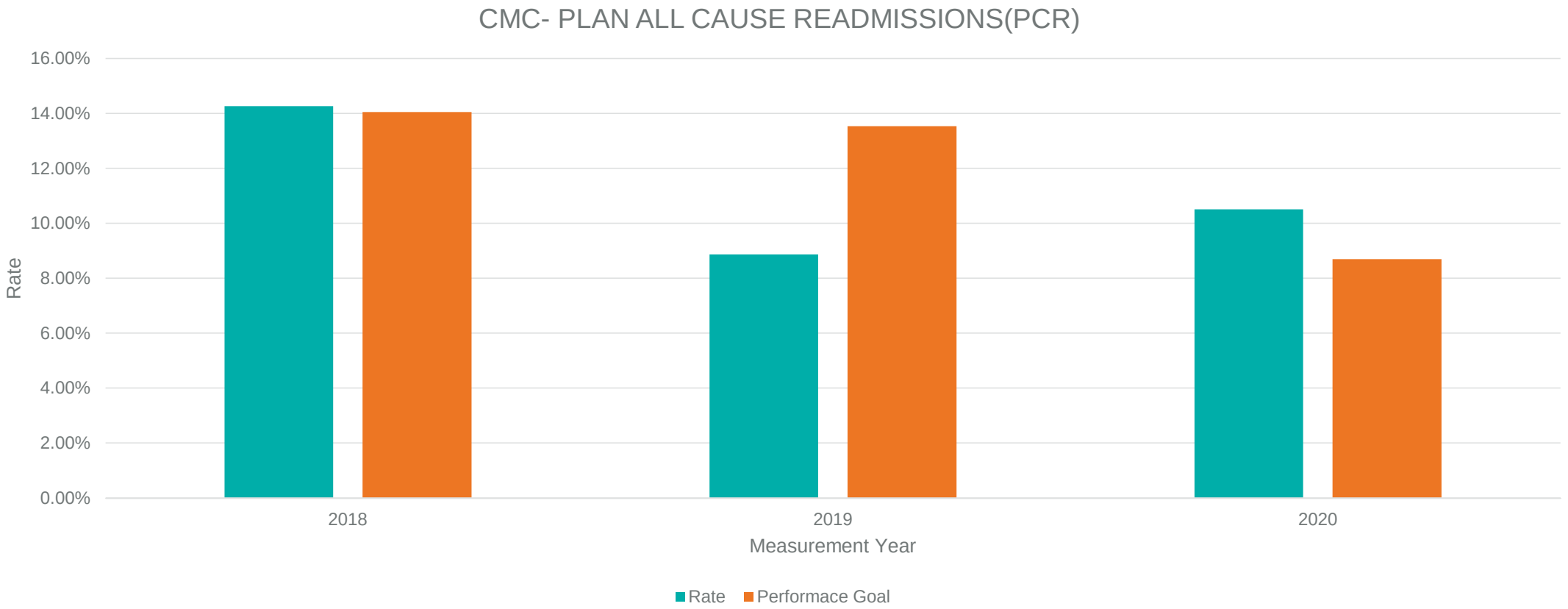
- Defined as an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date

Expected Readmission Rate for MY 2020

- Performance Goal: 8.69%

Proposed goal for MY 2021: 8.69%

Results


CMC- PLAN ALL CAUSE READMISSIONS(PCR)
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
Rate
2018
2019
2020
Measurement Year
Rate
Performace Goal

Barrier and Analysis

Barrier: Limited staff resources to conduct TOC calls.

Intervention:

- Assign member cases to CM care team with responsibility for Transition Of Care calls, prior responsibility was UM department. **Since May 2021.**
- SCFHP expanded the scope of the TOC call program in 2019 to complete follow up calls to members within 72 hours post discharge. **Ongoing since 2019.**
- CM developed and provided annual staff training on importance of transition of care. **Since May 2021.**

Barrier and Analysis

Barrier: Remind members to schedule a PCP visit post discharge.

Intervention:

- TOC call to member to review discharge instructions and provide information on scheduling PCP follow up visit. **Since 2018.**

Santa Clara Family Health Plan

Questions?

Santa Clara Family Health Plan™

Thank you!

Lan Tran, Quality Improvement Nurse

Continuity and Coordination of Medical Care: 2021 Analysis

Quality Improvement Committee: October 12, 2021

Author:
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Overview

Santa Clara Family Health Plan (SCFHP) monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Annually, SCFHP reviews data associated with member movement between practitioners and member movement between settings. Through analysis, SCFHP identified four opportunities for improvement. During 2021 the following opportunities were monitored for aspects of continuity and coordination of medical care:

- Measure 1: Transition of Care – Medication Reconciliation Post-Discharge(TRC-MRP) - HEDIS
- Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate - HEDIS
- Measure 3: PCP Follow up After 30 days of Discharge
- Measure 4: Plan All-Cause Readmissions (PCR) – HEDIS

	Name of Measure	Movement Across Settings	Movement Across Practitioners
Measure 1	Transition of care – Medication Reconciliation Post-Discharge (TRC-MRP)	**[X]**	
Measure 2	Comprehensive Diabetes Care (CDC) Eye Exam Rate		**[X]**
Measure 3	PCP Follow up After 30 days of Discharge	**[X]**	
Measure 4	Plan All-Cause Readmissions (PCR)	**[X]**	

SCFHP sets performance goals for each measure, and through the analysis process, identifies opportunities to improve the coordination and continuity of medical care between practitioners and settings. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable against achieving the performance goal. The process incorporates opportunities and interventions to remediate negative impact that is a direct effect of the root cause. Calendar year 2018 is the baseline year for data collection. SCFHP collected data to evaluate opportunities to improve the coordination of care between practitioners and across settings. The baseline date indicated the above noted transitions in care that warranted additional actions to improve coordination.

I. Measure 1: Transition of Care- Medication reconciliation Post Discharge (TRC- MRP)

a. Methodology

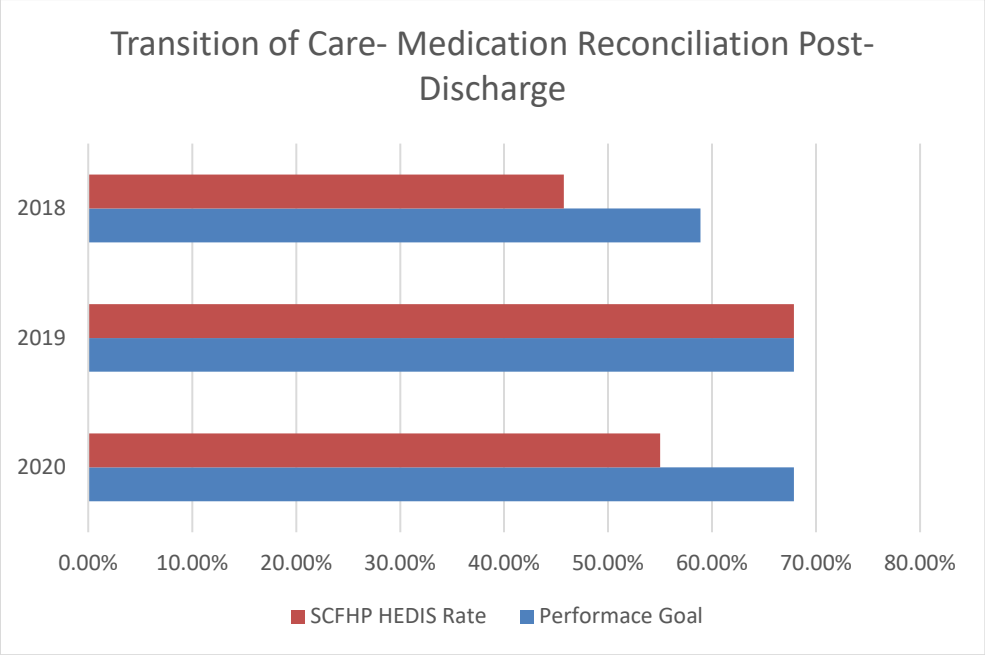
A high rate of within 30 days readmissions may indicate the inadequate quality of care in the hospital, unclear discharge instructions, and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. Therefore, medication reconciliation is an integral part of patient safety. Adverse drug interaction can also be prevented with medication reconciliation especially when people are on multiple prescription medications. Patient safety can be improved by standardizing and focusing on coordination of care after discharge and increasing support for patient self-management.

SCFHP monitors Transition of Care-Medication Reconciliation Post-discharge annually as part of HEDIS reporting. For members, 18 years of age and older, this measure identifies the percentage of discharges within the measurement/calendar year for whom medications were reconciled from the date of discharge through 30 days post-discharge (31 total days). TRC-MR name changed to TRC-MRP but there are no changes to the tech specifications.

The rate provided is measured from 1/1/2020 – 12/31/2020 and reported for the year 2021. SCFHP monitors this rate annually and sets performance goals based on the previous year performance.

b. Analysis

i. Result



Measure 1: TRC- MRP	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2018	188	411	45.74%	58.88%	N
Measurement Y2 2019	279	411	67.88%	67.88%	Y
Measurement Y3 2020	226	411	54.99%	67.88%	N

ii. **Quantitative analysis**

The transition of care – Medication reconciliation post-discharge (TRC-MRP) performance goal for MY 2018 was 58.88%, and MY 2019 was 67.88%. In MY 1 (2018), SCFHP was not able to meet the annual performance goal of 58.88%, but had a performance rate of 45.74%. In MY 2 (2019), SCFHP was able to meet the annual performance goal of 67.88% of members' medications that were reconciled within 30 days of discharge, thus showing an overall improvement from the previous measurement period. In MY 3 (2020), the performance goal of targeting 75th percentile remained the same due to the anticipation of a decrease in post-discharge medication reconciliation in MY 2020 as the pandemic continued. The performance rate decreased by 12.89 percentage points from the previous year so we did not meet goal for MY 2020.

iii. **Qualitative analysis**

The best available source to measure the Transition of Care- Medication Reconciliation (TRC-MRP) is our HEDIS data. The admin rate was relatively low; 3.22% for MY 2019 and 2.89% for MY 2020. When we reviewed the hybrid charts, we saw a marked increase the rate of up to 67.88% for MY 2019 and 54.99% MY 2020.

In MY 2020, SCFHP provided health education on medication reconciliation to practitioners through a provider memo campaign. SCFHP educated practitioners on appropriate procedure code to bill the medication reconciliation as a part of the transition of care management. Through the provider education efforts in previous measurement years, the TRC-MRP rate has improved drastically from 45.74% (MY 2018) to 67.88% (MY2019) from the previous interventions. The cross-functional workgroup, comprised of a representative from Utilization Management (UM), Case Management (CM), Quality Improvement (QI), Information Technology (IT) and Provider Network Operations (PNO) identified during medical record review that not all practitioners have the time to complete and document a thorough medication reconciliation at the initial visit post-discharge. Due to competing priorities, the practice transformation group was not able to create templates to document medication reconciliation in 2020. In 2021, the focus will be offices without electronic

medical records. Provider Network Operations will work with Providers on implementing a new template or incorporating a checkbox into their existing template for 10 Provider sites with paper charting.

The cross-functional workgroup also identified a possible lack of knowledge about the importance of performing medication reconciliation as barriers. In year 2019, a Provider Memo was developed and was sent to remind Providers about Medication Reconciliation Post Hospitalization criteria on January 15, 2020. A new Provider Memo regarding the importance of completing and documenting medication reconciliation within 30 days was not completed by Q2 2021 due to competing priorities and will be rescheduled to be sent Q4 2021. Provider Network Operations identified a need for reminder on operational information provided by SCFHP. SCFHP proposed that during the monthly Quality Calls where Providers and Staff will be in attendance, there will be a recap on the memos that have been sent out. This was implemented in August 2021 by adding 'Provider Services Updates' to Quality calls and will continue to MY 2022.

Benchmark was barely met in MY 2019 and in MY 2020, there was a signification decrease in rate most likely attributed to the ongoing pandemic. The intervention was effective 2018-2019 but MY 2019-MY 2020 rates may have been decreased due to environmental issues with COVID 19 than the actual intervention. The Public Health Emergency impacted the entire nation, specifically Santa Clara County (SCC). SCC witnessed a high surge of COVID-19 cases, shelter in place order was implemented, and many providers initially did not have the technology to do telehealth visits. Centers for Medicare and Medicaid Services (CMS) expanded telehealth benefits for Medicare patients during the Public Health Emergency as a way to safely provide care to members. In MY 2020, SCFHP created a Tipsheet on process for billing and documenting telehealth visits to encourage Providers to use telehealth visits as follow up as these are reimbursable. Considering all of these factors, the work-group had a concern in 2019 and 2020 that the rate will most likely decrease because members are not getting in to see Primary Care Provider (PCP). Therefore we foresee that there will be a decrease in post-discharge medication reconciliation in MY 2021 as the pandemic continues. SCFHP will continue on-going monitoring of proposed interventions to exceed the performance goal of the 75th percentile in MY 2021**.**

iv. 2021 Barrier and Analysis Table

Barrier	Opportunity	Intervention	Selected for	Date Initiated
Identified during medical record review that not all practitioners have the time to complete and document a thorough medication reconciliation at the initial visit post-discharge.	Provide technical support to decrease the administrative burden of medication reconciliation. Educate on the use of other staff to complete and document medication reconciliation.	Provider Network Operations (PNO) to work with QI to build a check-box for medication reconciliation template for 10 Provider sites with paper charting to decrease the administrative burden of medication reconciliation. PNO to educate the provider on utilizing the other staff to complete activities.	Y	Targeting Q1 2022
	Educate on the importance of completing the medication reconciliation within 30 days.	Develop CMC provider communication with the assistance of Provider Network Operations on the importance of completing and documenting medication reconciliation within 30 days. Develop CMC provider communication with the assistance of Provider Network Operations on the importance of completing and documenting medication reconciliation within 30 days.	Y	Previous memo sent Jan 2020 New memo targeting Q4 2021 New memo targeting Q2 2022
Identified often that Providers need reminders on operational priorities and information.	Educate and remind on the importance of completing the medication reconciliation within 30 days during Quality Calls.	Provider Network Operations will continue to recap on Provider Memos sent during Quality Calls with Provider and Staff.	Y	Since Aug 2021

II. Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate - HEDIS

a. Methodology

SCFHP monitors the Comprehensive Diabetes Care -Eye Exam (CDC-E) HEDIS rate to assess the movement of diabetic patients between practitioners. This rate measures the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam performed. The retinal eye examination is a vital preventive service for diabetic members to monitor their compliance with treatment and prevent blindness.

SCFHP uses the HEDIS methodology to measure the members who received a diabetic retinal eye examination. SCFHP monitors this rate annually and sets performance goals based on the previous year's performance. This rate is measured from 01/01/2020- 12/31/2020 and reported in the year 2021. Performance goal for MY 2018 were set at 25th percentile. SCFHP set the performance goal to 75th percentile for MY 2019 and MY 2020.

b. Analysis

i. Result

Measure 2: CDC Eye Exam Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2018	320	411	77.86%	65.56%	Y
Measurement Y2 2019	328	411	79.81%	82.05%	N
Measurement Y3 2020	317	411	77.13%	82.05%	N

ii. Quantitative analysis

The 25th percentile goal had been set for MY 2018. SCFHP performed approximately 10 percentage points above the performance goal for MY 2018 (65.56%). Therefore SCFHP decided to increase the performance goal to the 75th percentile for MY2019. SCFHP did not meet the goal of 82.05% for MY 2019. Since we did not meet the 75th percentile goal in MY 2019, the work-group decided to continue to improve this measure by reminding members to schedule and complete an annual eye exam. SCFHP targeted to meet the 75th percentile goal in MY 2020 but did not meet performance goal by 4.92 percentage points most likely attributed to the ongoing pandemic.

iii. Qualitative analysis

A barrier analysis was completed by an internal cross-function group that consists of Utilization Management (UM), Case Management (CM), Quality Improvement (QI), and

Provider Network Operation's representatives. The group identified a lack of education among members about the importance of retinal eye exam. SCFHP published Diabetes health education material for members in October 2020 and a newsletter article related to vision program was published in July 2021 and mailed to member's home. Since we did send in October 2020, it won't be realized until 2021 measurement year. The intervention of gaps in care alert and providing member education has shown effectiveness because with the ongoing pandemic and a period of time of shelter in place, we only had a slight decrease of 2.68 percentage points the previous measurement year rate. SCFHP achieved a higher rate in MY 18 by implementing gaps in the care alert system for CDC-E measures to remind diabetic members who are due for their eye exams. Quality Improvement Department identified another opportunity of notifying diabetic members of the need for retinal eye exam. SCFHP collaborated with VSP Vision Care and sent reminder letters to diabetic members about their need to schedule their retinal eye exam starting September 2021.

The internal cross-function group identified another barrier that providers are not consciously offering retinal exams to diabetic members. SCFHP published Diabetes health education material for providers in October 2020. SCFHP's Quality Improvement Department developed a Provider Newsletter article and was approved to send August 2021 to provide health education materials for practitioners on importance of diabetes care and treatment. A limitation to using HEDIS data is that a random sample of member is drawn which may not reflect the practice patterns of Providers therefore we may not able to identify the providers specifically to target. SCFHP did not develop a Provider Communication because SCFHP found it would be more beneficial to attend VSP Vision Care Joint Operations Committee Meeting (JOC) October 13, 2021 to educate optometrist and ophthalmologist on identifying and offering retinal eye exam to diabetic members whose care are due. The work-group agreed to implement the same and some new interventions next year and SCFHP set the Performance Goal of the 75th percentile in MY 2021.

iv. 2021 Barrier and Analysis Table

Barrier	Opportunity	Intervention	Selected for	Date Initiated
Lack of education among members about the importance of retinal eye exam.	Remind members about their due visit for retinal eye exam through gaps in care alert system.	Develop gaps in care alert system in QNXT to notify internal staff to remind members about their due visit for retinal eye exam.	Y	Since August 2018

	Remind members about their due visit for retinal eye exam through reminder letters.	Quality Improvement Department to continue to work with IT and VSP Vision Care to send out reminder letters to members diagnosed with Diabetes.	Y	Sept 2021
	Provide education on importance of retinal eye exam to diabetic members through health education materials.	Develop health education materials to promote importance of retinal eye exam for diabetic members.	Y	News published in Oct 2020 News published July 2021
	Provide education on importance of diabetes care through health education materials.	Develop health education materials to promote importance of diabetic care.	Y	Targeting Q4 2022
Medical record review suggest that optometrist/ophthal-mologist do conduct eye exam for visual acuity screening but they do not always offer retinal eye exam to diabetic members.	Understand which providers are successfully completing eye exam for visual acuity screening but do not always offer retinal eye exam.	Develop health education material for practitioners on importance of diabetes care and treatment. Attend VSP Vision Care JOC October 13, 2021 to remind optometrist and ophthalmologist on identifying and offering retinal eye exam to diabetic members whose care are due.	Y	News published in Oct 2020 News published in Aug 2021 Targeting Q4 2021

III. Measure 3: PCP follow up after 30 days of Discharge Rate

a. Methodology

The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another. The setting of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities. The transition between the inpatient and outpatient setting is a high-risk period for patients. The transitions of care may increase the risk of adverse events due to the potential for miscommunication as responsibility has is given to new parties. The role of the primary care provider (PCP) is critical during this transition. Visit with primary care provider after 30 days post-discharge may decrease the hospital readmission, increase patient safety and improve quality of care.

Quarterly, SCFHP monitors CMC members that have an acute inpatient hospital discharge and a follow-up visit within 30 days post-discharge. An ambulatory care follow-up visit is defined as a follow-up visit to assess the member's health following a hospitalization. Monitoring this measure is a requirement of all Medicare-Medicaid Plans (MMPs) under the "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements". This state-specific measure, among others, supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®1 and HOS. The detailed methodology is in the following reporting requirements (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAReportingRequirements2019.pdf) SCFHP reports this data to CMS and the State of California quarterly for evaluation. Regulatory agencies have not prescribed a performance goal for this measure. Given that the 2018 and 2019 results of 90% were not feasible, SCFHP Workgroup discussed and determined that an annual stretch goal of 85% follow-up rate was more realistic and attainable.

Measure 3 – Ambulatory Care Follow Up Visit 30 Days after Discharge

a. **Numerator definition**: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.
b. **Denominator definition:** Total number of acute inpatient hospital discharges during the reporting period.
c. **Goal for comparison**: 85% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge

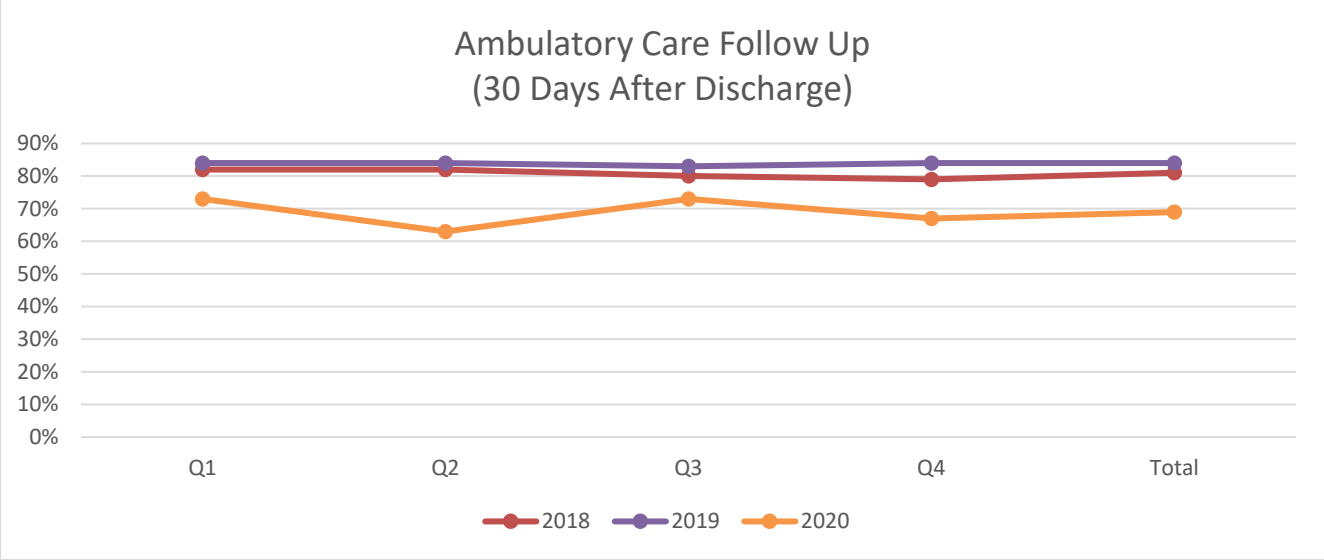
b. Analysis

i. Result

Ambulatory Care Follow Up 30 Days After Discharge (Year 1 – 2018)		**Q1**	**Q2**	**Q3**	**Q4**	**2018 Total**
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge	283	249	253	233	1018
Denominator	Total number of hospital discharges.	346	302	315	296	1259
Rate:		**82%**	**82%**	**80%**	**79%**	**81%**

Ambulatory Care Follow Up 30 Days After Discharge (Year 2 – 2019)		**Q1**	**Q2**	**Q3**	**Q4**	**2019 Total**
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge	295	302	269	281	1147
Denominator	Total number of hospital discharges.	352	358	323	335	1368
Rate:		84%	84%	83%	84%	**84%**

Ambulatory Care Follow Up 30 Days After Discharge (Year 3 – 2020)		**Q1**	**Q2**	**Q3**	**Q4**	**2020 Total**
Numerator	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge	255	172	237	240	904
Denominator	Total number of hospital discharges.	350	274	326	357	1307
Rate:		73%	63%	73%	67%	**69%**



ii. **Quantitative analysis**

SCFHP did not meet the performance goal of 85% cumulatively in MY 2020, nor was it met at any point in Q1-Q4. Performance rates stayed between 63% - 73% throughout MY 2020. The 2020 cumulative rate of 69% shows a significant decrease from MY 2019 (84%) most likely attributed to the ongoing pandemic. This gap indicates opportunities for continuous improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay.

iii. **Qualitative analysis**

The Internal Cross-Functional Work Group comprised of representatives from Utilization Management (UM), Case Management (CM), Quality, and IT completed barrier analysis. A barrier analysis helped the group to identify opportunities and interventions to improve the rate of members receiving 30-day follow up. The group identified PCPs are not always aware that their patients have been admitted or subsequently discharged to home. Implementation of the PCP admission and discharge notification system may improve the rate of ambulatory care follow up visit 30 days post-discharge.

PCP discharge notification from SCFHP did not effectively reduce readmission in year 2020. Current discharge notification process is an internal manual process that notifies PCPs when members are discharged. In year 2020 SCFHP attempted to develop a process for more timely discharge notification from hospitalist. A meeting was held 2/2021 date from Regional Medical Center Hospital and it was determined there were system limitations and not all provider information is available to the hospital and hospitalist for many members. The process would be manual process and due to the pandemic, this was not a course of action that the hospitals could pursue at this time.

SCFHP attempted to develop an automated notification process using census data from hospitals for PCP notification of member discharge. Due to inconsistencies in census information from the hospitals and lack of data sharing agreements with the hospitals, this process was delayed. SCFHP had been able to obtain data agreement from contracted County and HCA hospitals that required Data Sharing Agreement separate from Provider Contract and is working on a consistent data submission format to allow automated notification to PCP. Due to competing priorities, SCFHP was not able to have physician contact information be consistently updated automatically across all systems however there is a file staff can refer to with all updated physician contact information.

The combinations of interventions of PCP discharge notification and TOC calls has improved ambulatory follow up. From MY 2018 and MY 2019, SCFHP has improved the ambulatory care follow-up rate by approximately 3 percentage points through the discharge notification process. The interventions have been effective based on annual improvement MY 2018 and MY 2019. The improvement in the follow-up rate was encouraging but in MY 2020, there was a decrease in rates likely due to the impact of the pandemic. Members are not getting in to see Primary care Provider (PCP) and many providers initially did not have the technology to do Telehealth visits. In year 2020 a process was implemented to automatically refer admission authorization notification sent by inpatient staff to UM's platform QNXT to CM's platform Essette for monitoring and follow up. Since there's a delay of getting census data in real time from hospitals, in the beginning of last fiscal year, CM worked on Essette Configuration to support automatic assignment in QNXT when admission based authorizations are sent by hospitals. This system was developed in early fiscal year 2021 and was deployed on August 2021 so CM could send PCPs TOC SBAR discharge letters for follow up by fax. There's an existing letter but there is not an automatic way to send by bulk. CM will continue notifying PCP with discharge information in an SBAR format upon the completion of conducting TOC (Transition of Care) calls. SCFHP is working on automating discharge authorization notification to automate in Essette from QNXT.

SCFHP has decided to continue monitoring interventions to ensure we meet the 85% performance goal in MY 2021.

iv. 2021 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2020	Date Initiated
SCFHP currently lacks a centralized notification system from contracted hospitals to notify PCP of admission.	Improve admission notification to member's assigned PCP's by utilizing census reports.	Work with IT to build an IT report that automates the PCP admission notification reporting process. Completed contracted County and HCA hospital required data sharing agreement separate from provider contract. SCFHP has worked with IT to build the system to get census data from most of the contracted hospitals in the year 2019-2020.	Y	Targeting Q4 2021 2020-2021 2019-2020
PCPs are not always aware their patients have been discharged to home.	Work to notify member's assigned primary care providers/BH Providers when members transition from inpatient to outpatient	CM to send notification letter to PCP with discharge information in an SBAR format for PCP to follow up care post discharge by fax.	Y	Ongoing since 2018

IV. Measure 4: Plan All-Cause Readmissions (PCR) HEDIS Rate

a. Methodology

The Plan All-Cause Readmission (PCR) measure assesses the percentage of acute inpatient hospital discharge resulting in unplanned hospital readmission within 30 days. Readmissions occurred when a patient admitted back to the hospital in a short time after discharged from the hospital. Inadequate quality of care in the hospital and or lack of appropriate post-discharge planning and care coordination possibly increase the rate of patient readmissions. Increased mortality and higher health care costs are associated with unplanned hospital readmissions. Improving care coordination post-discharge and standardizing discharge planning protocols may prevent hospital readmission.

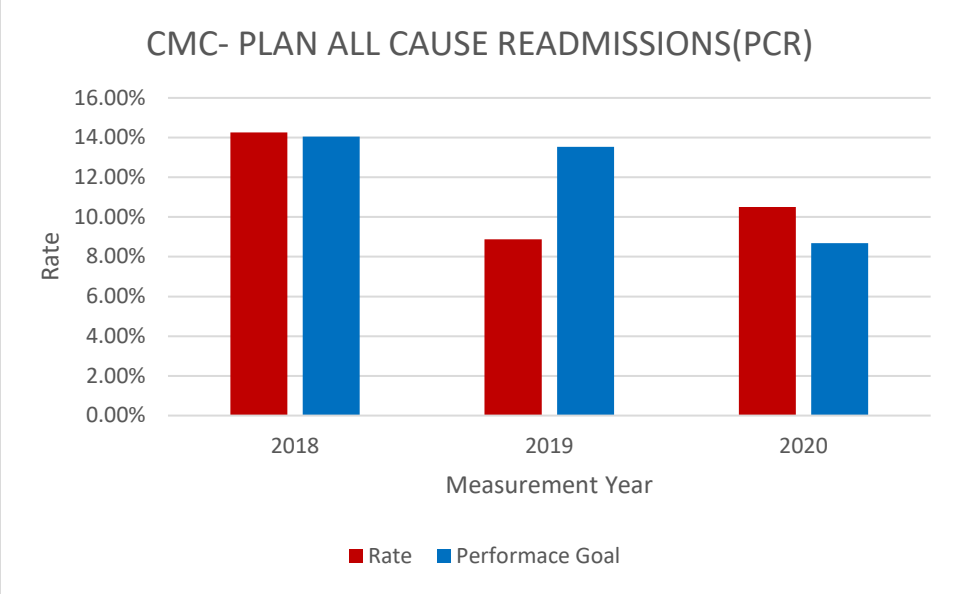
SCFHP monitors PCR rate annually as part of HEDIS reporting and as part of the Quality Withhold data set. For Quality Withhold, Medicare and Medicaid withhold a percentage of capitation rates to incent MMPs to provide high-quality care and conduct quality improvement. For members 18 years of age and older, this measure identifies the number of acute inpatient stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of acute readmission. SCFHP set the performance goal for MY 2019 for this measure by a 5% improvement from the MY2018's performance, which is 13.54%. SCFHP set the performance goal for MY 2020 for this measure by a 2% improvement from the MY2019's performance, which is 8.69%. NCQA combined PCR A (members age 18-64 ages) and PCR B (members age 65 & up) for MY 2019 reporting and also eliminated members who had four or more inpatient hospital stay in MY 2019. Data for this measure is reported in the following categories:

- **Denominator**: Count of Index Hospital Stays (IHS)
  - An IHS is defined as an acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year.
- **Numerator**: Count of 30-Day Readmissions
  - Defined as an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
- **Expected Readmissions Rate**
  - Performance Goal: 8.69%

b. Analysis

i. Result

Measure 4: PCR Rate	Numerator	Denominator	Rate	Performance Goal	Goal Met?
Measurement Y1 2018	185	1,297	14.26%	14.05%	N
Measurement Y2 2019	87	981	8.87%	13.54%	Y
Measurement Y3 2020	99	943	10.50%	8.69%	N



ii. **Quantitative analysis**

In MY 2018, SCFHP was close to a performance goal of 14.05%. In MY 2019, SCFHP exceeded the performance goal of 13.54%, which indicates a decreasing overall trend. Please note that NCQA combined PCR A (members age 18-64 ages) and PCR B (members age 65 & up) for MY 2019 reporting also eliminated members who had four or more inpatient hospital stay in MY 2019, therefore MY 2018, and MY 2019 rates cannot compare based on the same tech specs. In MY 2020, there was an increase in rate 1.63 percentage points from the previous year and we did not meet performance goal most likely attributed to the ongoing pandemic. While an improvement from 2018, opportunities remain to improve internal and external processes to prevent unplanned acute readmissions within 30 days of discharge.

iii. **Qualitative analysis**

The Internal Cross-Functional Work Group comprised of representatives from Utilization Management (UM), Case Management (CM), Quality, and IT completed barrier analysis. A barrier analysis helped the group to identify opportunities and interventions to decrease the rate of members readmitted within 30 days of discharge. The group agreed that readmissions are most likely to occur because of a lack of timely follow-up care and noncompliance with/and or not receiving discharge instructions. Implementation of the PCP admission and discharge notification system along with Transition of Care (TOC) call follow up may improve the rate of ambulatory care follow up visit with PCP and reduce readmission rate.

The group implemented the transition of care call follow up program in 2018. SCFHP expanded the scope of the TOC call program to complete follow-up calls to members within 72 hours of discharge in the year 2019. There was not a significant improvement in the PCR rate MY 2018 because SCFHP TOC program had limited scope due to staff turnover and capacity. The health plan redistributed TOC task from CM to the UM department to improve the staffing shortage in the year 2020. In MY 2020, of the 285 successful TOC contact, 257 resulted in no readmission

which is 90.18%.This shows how effective TOC calls are when it's implemented. CM resumed full scope responsibility of TOC May 3, 2021. SCFHP will continue to remind members to schedule a PCP visit post discharge through TOC call.

The work-group identified that census data from all contracted hospitals might increase the TOC call volume and possibly reduce preventable hospital readmissions. In the year 2019, SCFHP received census data on admission and discharge from only a few hospitals, and the UM staff forwarded this information to the case management team to complete, document, and follow up on TOC outreach calls. In the year 2019-2020, SCFHP worked with IT to build a system to get the census data from the majority of the contracted hospitals which will allow CM to initiate TOC calls. Since SCFHP has the system to get the census data from contracted hospitals, the work-group agreed that the rates might improve by defining the workflow to incorporate census data from all contracted hospitals to a centralized database allowing CM to initiate the TOC call. When trying to develop the workflow, it became apparent that the necessary data sharing agreements weren't in place for hospitals that required it separate from Provider Contract but now are to allow exchange of information. SCFHP will continue working on a consistent data submission format to allow automated notification to PCP from contracted hospitals targeted Q4 2021.

The group also identified in the previous year that there are potential opportunities to develop a cross-functional work-group between IT, UM, and CM to align and improve the current process by utilizing an evidence-based model for the transition of care. There's been ongoing enhancements to the TOC program. In May 2021, CM updated policies and procedures, workflows were updated, staff were trained, configurations were made to support the program. CM is also in the process of working with IT to look at the reports to see how we can optimize the existing report. The performance goal for MY 2021 will remain the same from the previous year's performance goal of 8.69%. SCFHP has decided to continue monitoring interventions to ensure we meet the 8.69% performance goal in MY 2021.

iv. 2021 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2020?	Date Initiated
Limited staff resources to conduct TOC calls.	Improve TOC call implementation and consistent follow up by redistribution of TOC task from UM to CM.	Assign member cases to CM care team with responsibility for TOC calls.	Y	May 2021
	Realign TOC workflow and staffing resources in the case management department for timely completion of all TOC calls with prioritization for identifying the patient population with the highest needs.	SCFHP expanded the scope of the TOC call program in 2019 to complete follow up calls to members within 72 hours post discharge. CM developed and provided annual staff training on importance of transition of care.	Y	Ongoing since 2019 May 2021
Remind members to schedule a PCP visit post discharge.	Improve the timeliness of PCP follow up post discharge.	TOC call to member to review discharge instructions and provide information on scheduling PCP follow up visit.	Y	Ongoing since 2018

Committee Review

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	October 12, 2021	

Santa Clara Family Health Plan™

Quality Improvement Committee

Q2 2021 Grievance & Appeals Data

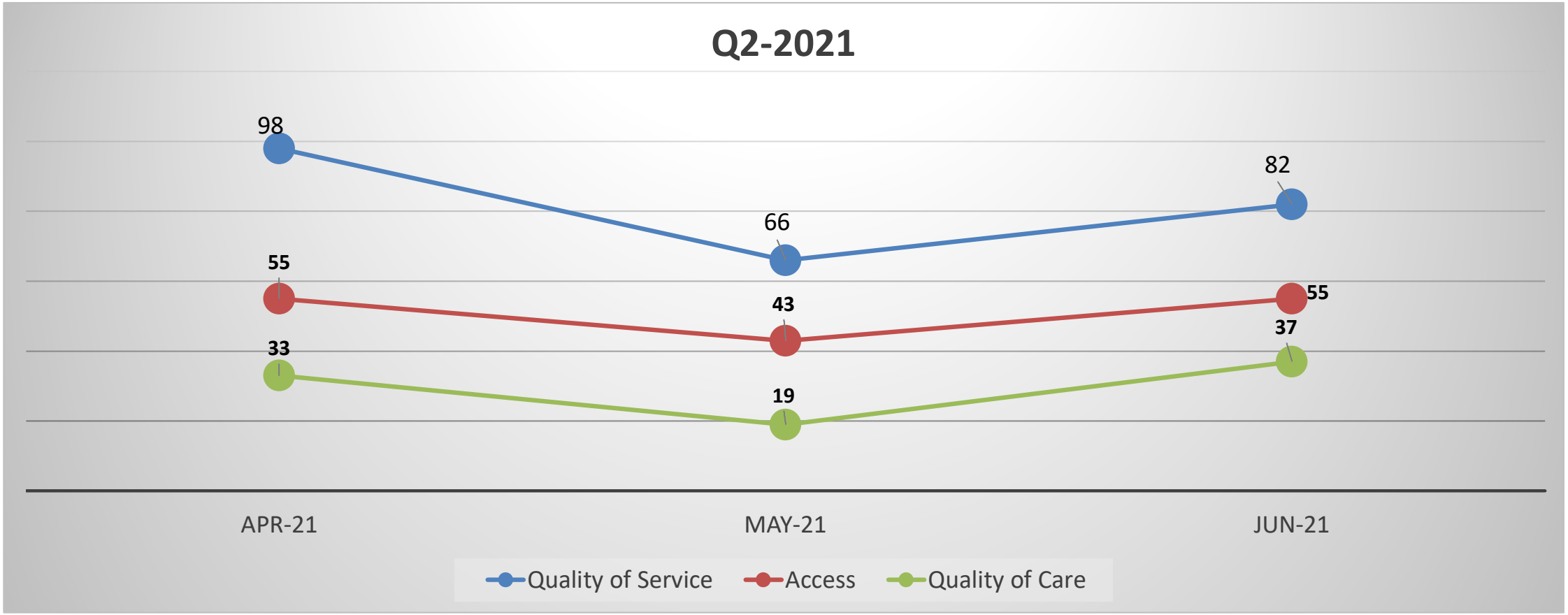
Total Grievances & Appeals

(*Rate per 1000 Members)*

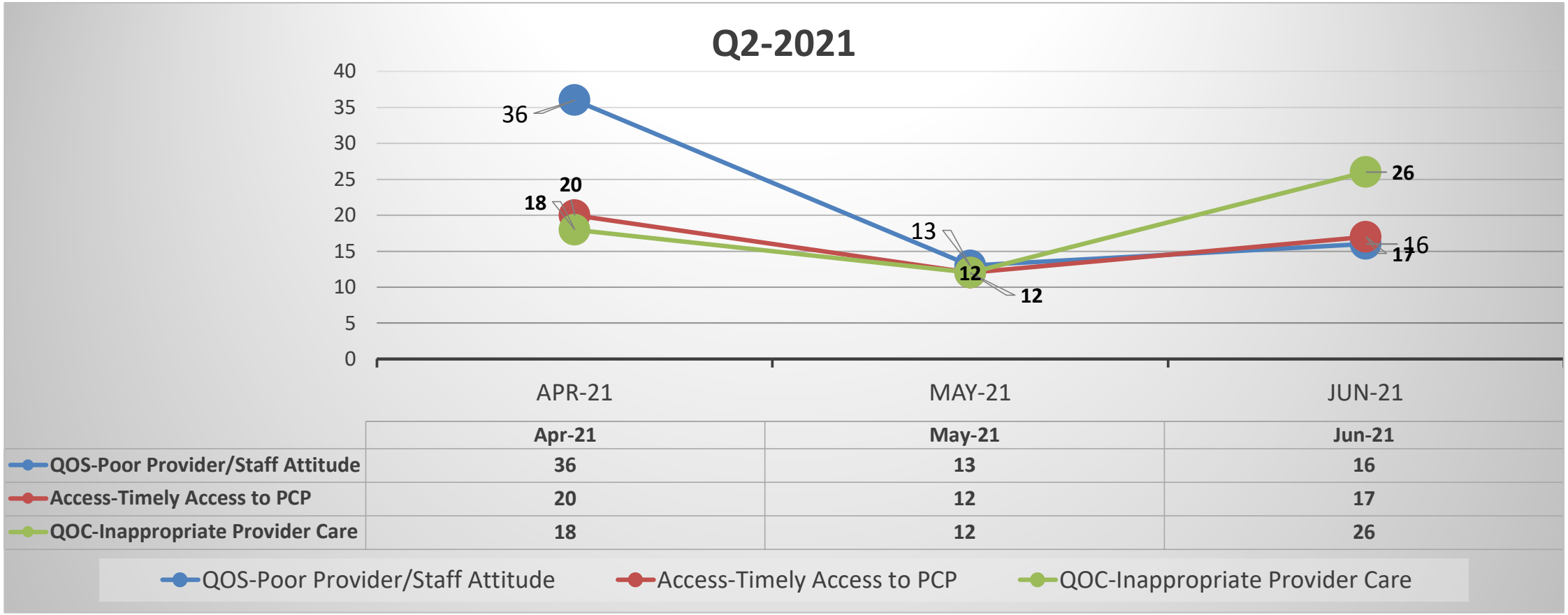
	Apr-20	May-20	Jun-20	Apr-21	May-21	Jun-21
Total Appeals	**49**	**36**	**33**	**89**	**58**	**60**
CMC Total Membership				**9,924**	**9,989**	**10,080**
Rate per 1,000				8.96816	5.80639	5.95238
Total Grievances	**98**	**69**	**87**	**128**	**101**	**99**
CMC Total Membership				**9,924**	**9,989**	**10,080**
Rate per 1,000				12.8980	10.1111	9.82143

	Apr-20	May-20	Jun-20	Apr-21	May-21	Jun-21
Total Appeals	43	38	47	92	87	124
MC Total Membership				**269,043**	**271,246**	**272,590**
Rate per 1,000				0.34195	0.32074	0.45490
Total Grievances	141	117	126	199	147	196
MC Total Membership				**269,043**	**271,246**	**272,590**
Rate per 1,000				0.73966	0.54194	0.71903

Q2 2021:Top 3 Medi-Cal Grievance Categories

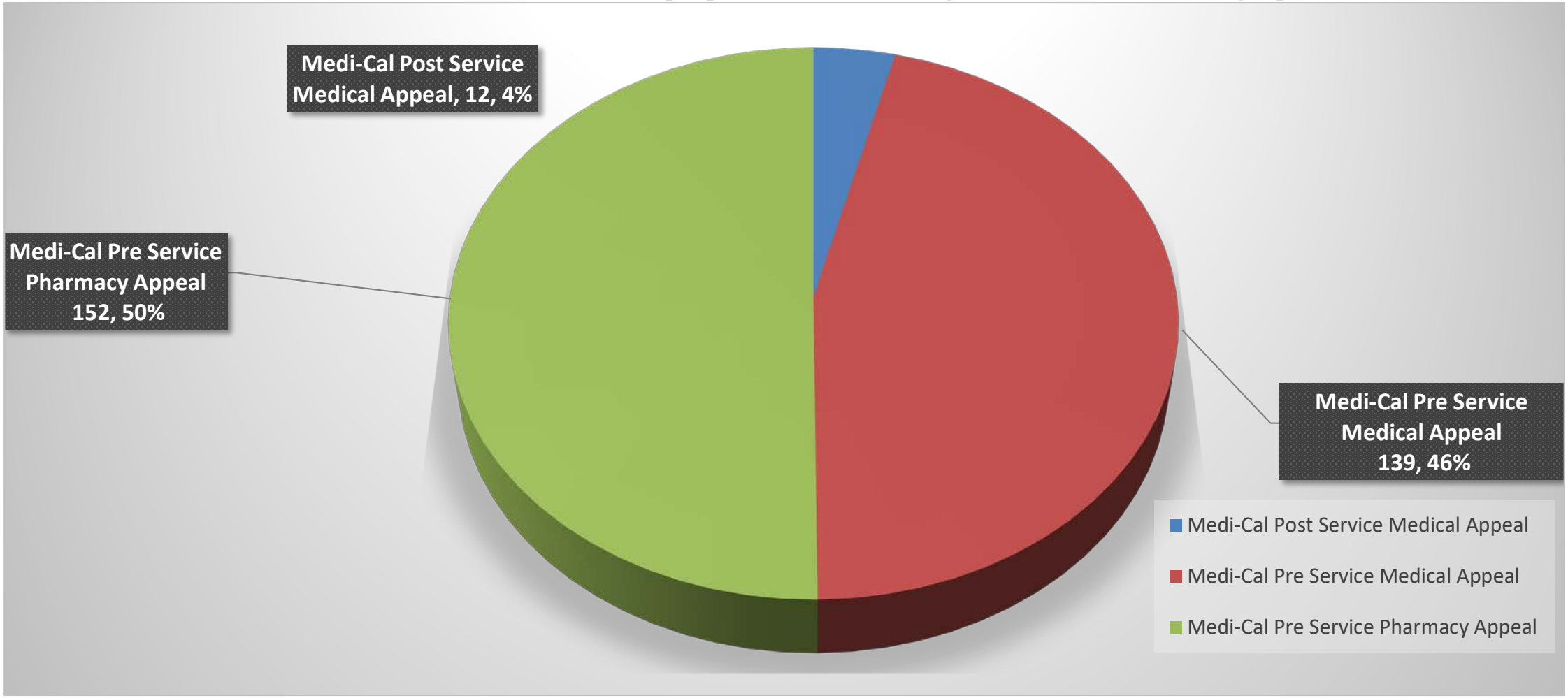


Q2 2021:Top 3 Medi-Cal Grievance Subcategories

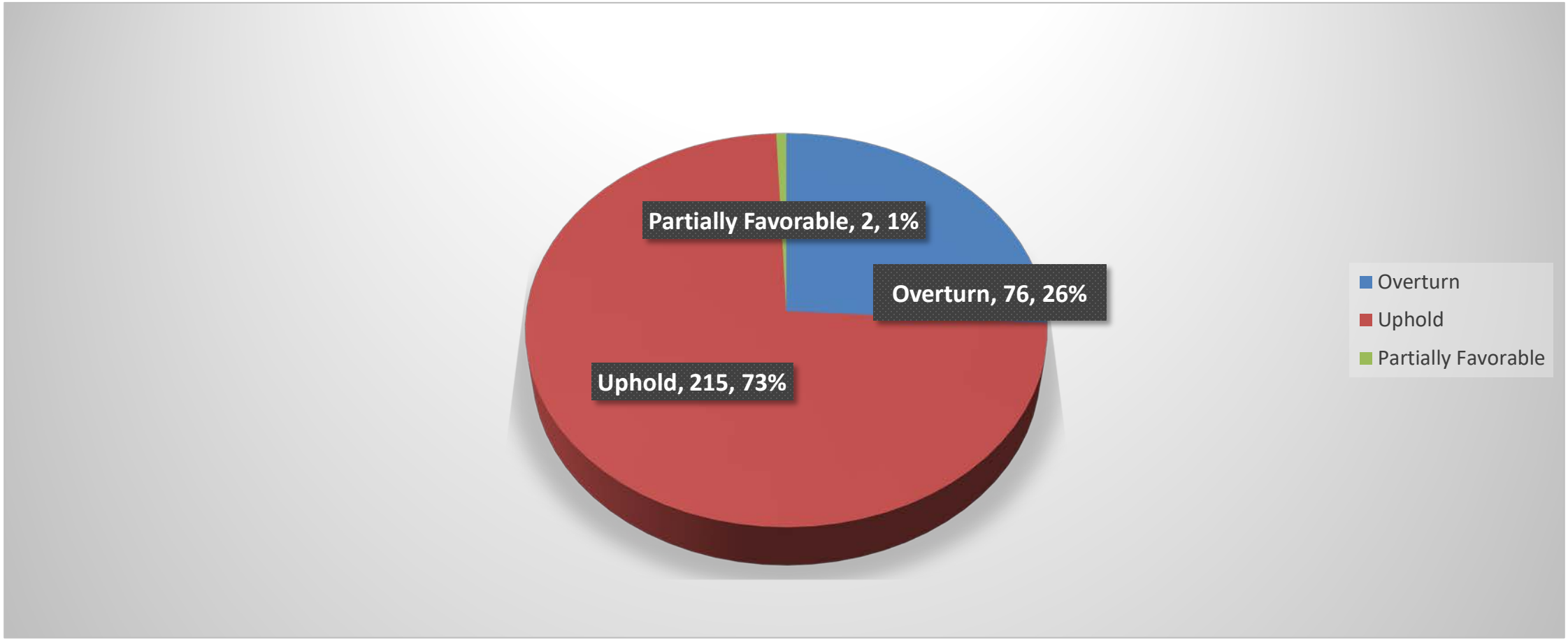


	Apr-21	May-21	Jun-21
QOS-Poor Provider/Staff Attitude	36	13	16
Access-Timely Access to PCP	20	12	17
QOC-Inappropriate Provider Care	18	12	26

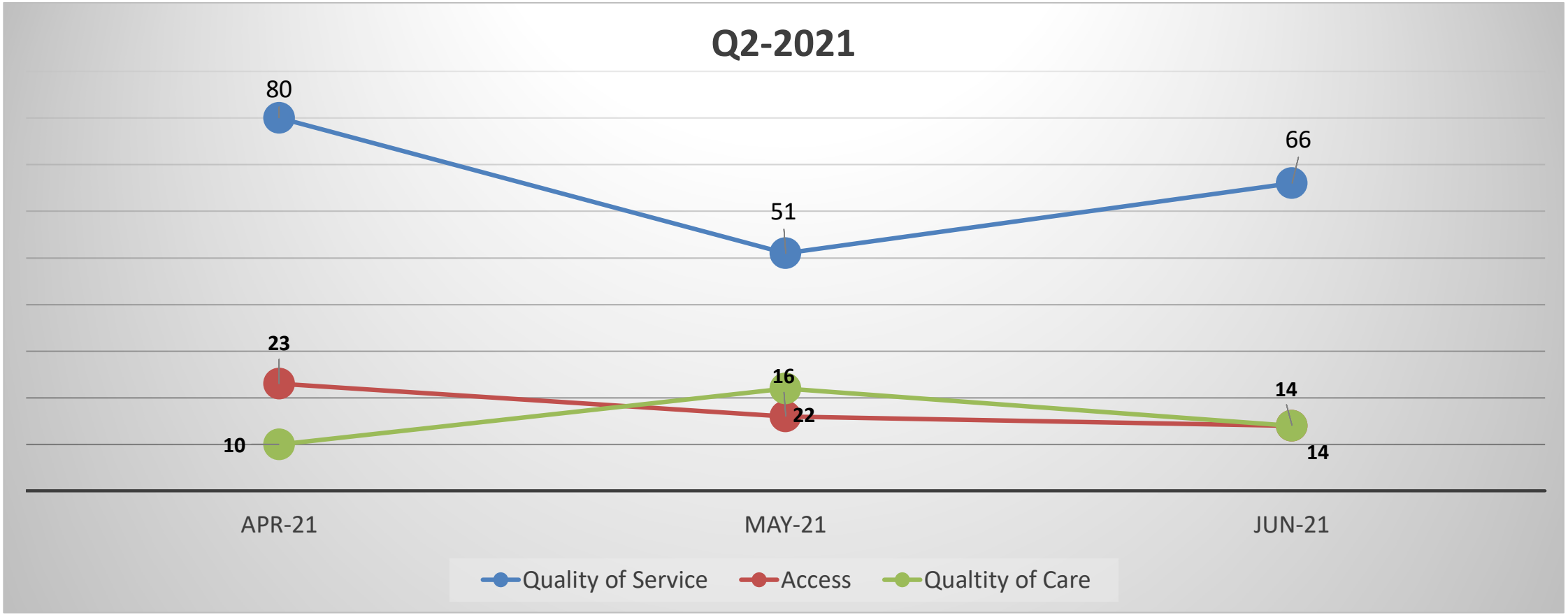
Q2 2021 Medi-Cal Appeals by Case Type



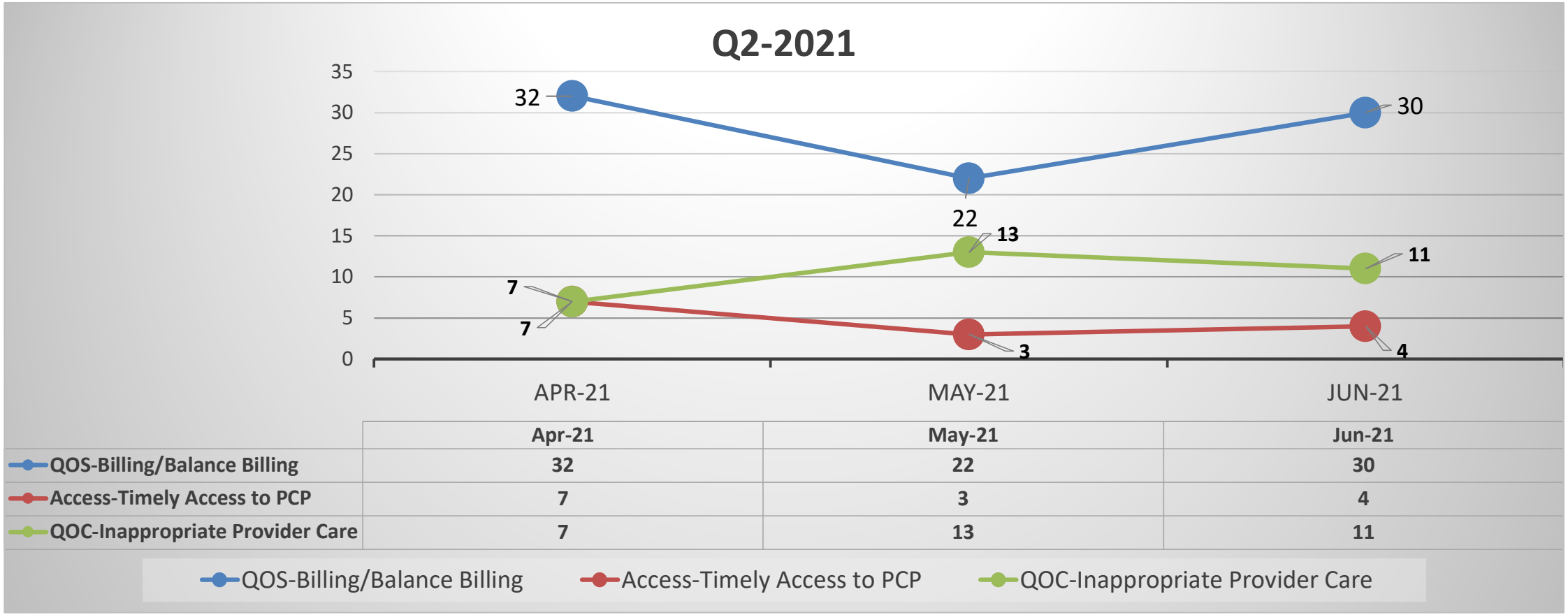
Q2 2021 MC Appeals by Disposition



Q2 2021:Top 3 Cal MediConnect Grievance Categories

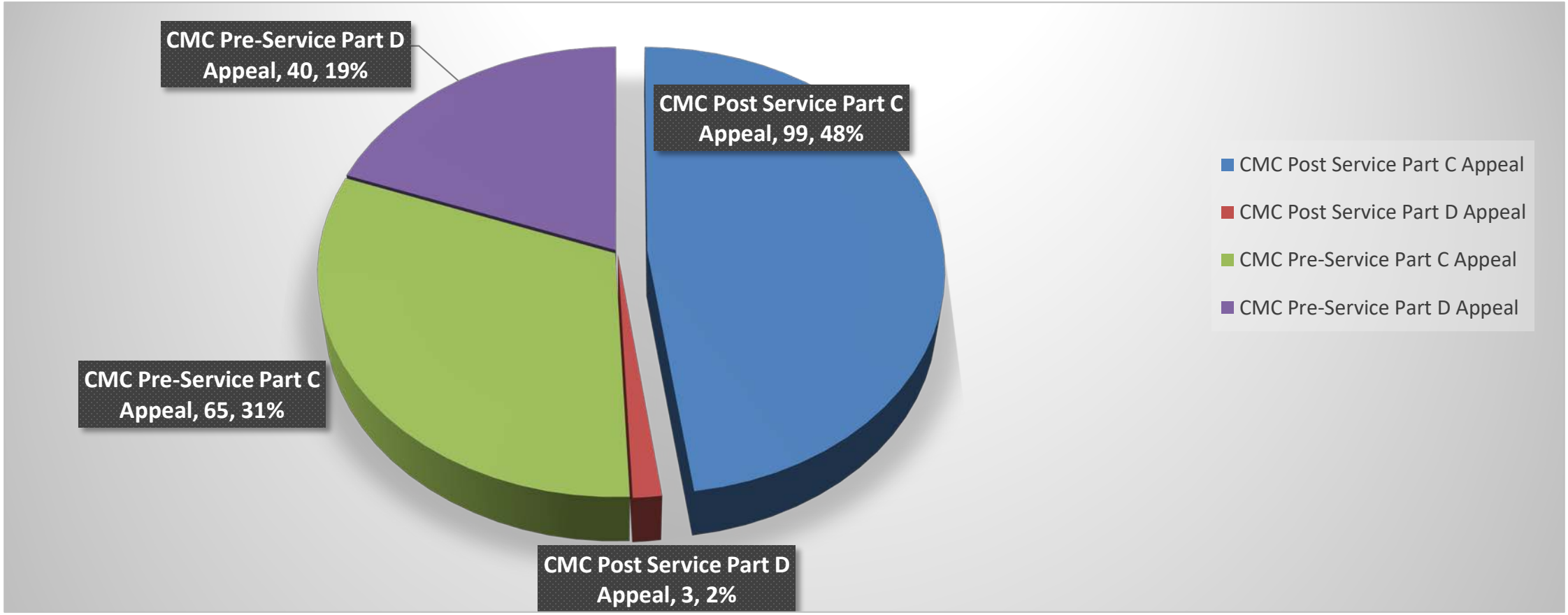


Q2 2021:Top 3 Cal MediConnect Grievance Subcategories

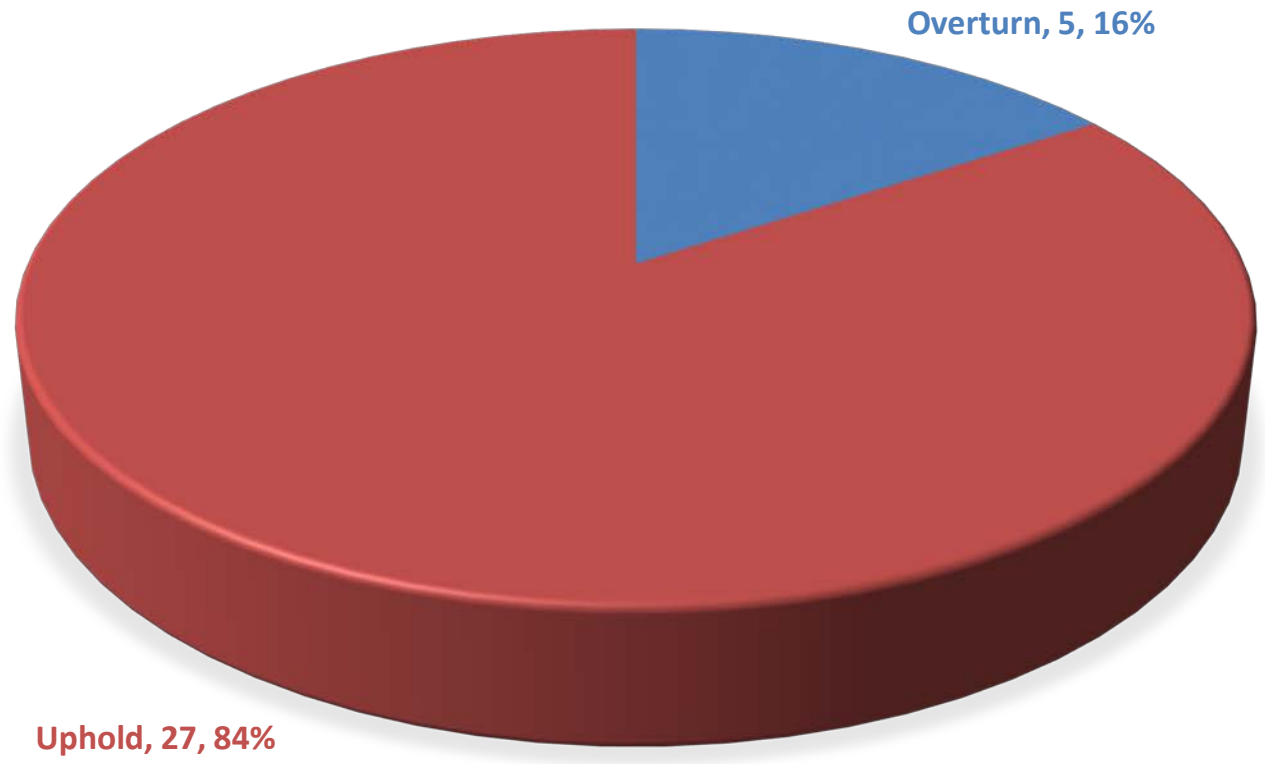


	Apr-21	May-21	Jun-21
QOS-Billing/Balance Billing	32	22	30
Access-Timely Access to PCP	7	3	4
QOC-Inappropriate Provider Care	7	13	11

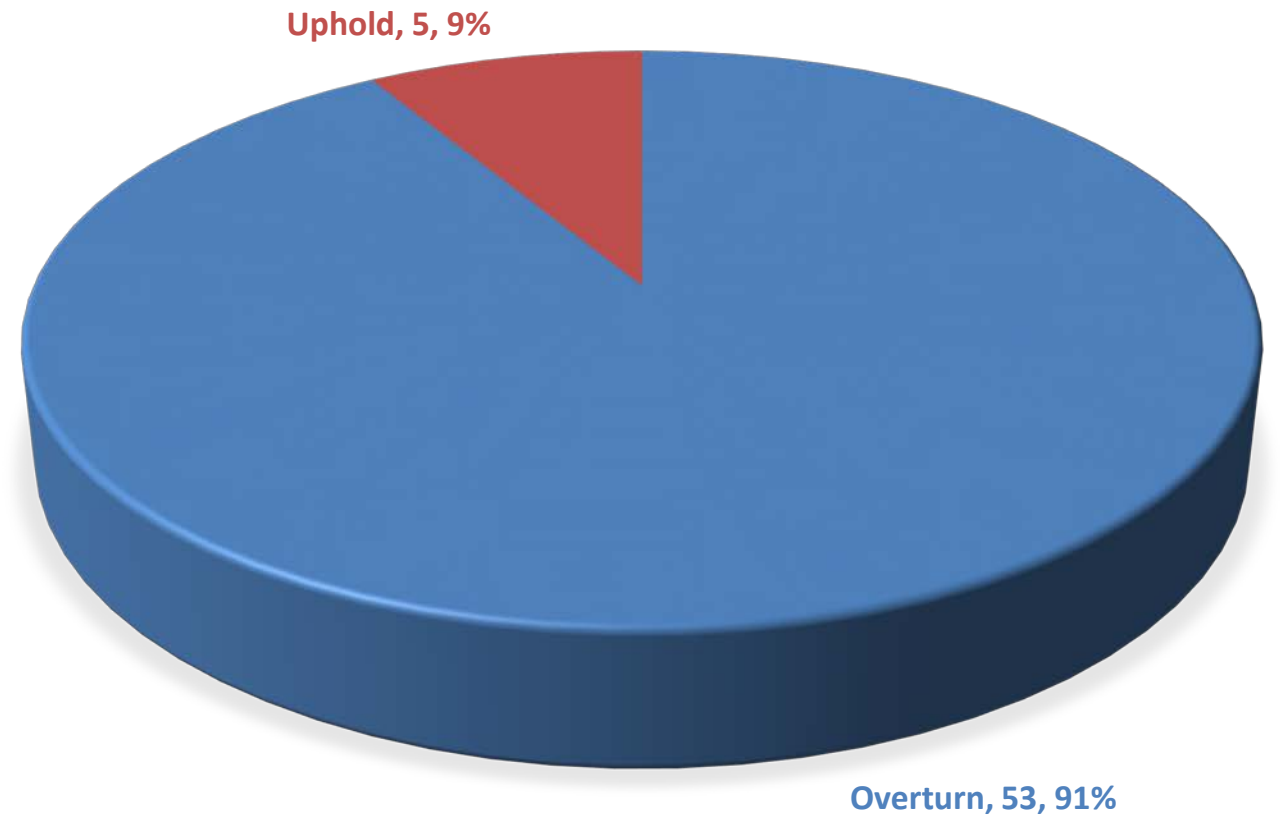
Q2 2021 CMC Appeals by Case Type



Q2 2021 CMC Pre-Service Appeals by Disposition



Q2 2021 CMC Post-Service Appeals by Disposition



Santa Clara Family Health Plan™

Quality Improvement Committee

Q2 2021 Grievance & Appeals Data

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 08/04/2021

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	22	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	33	
Number practitioners recredentialed within 36-month timeline	33	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 07/31/2021	318	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1338	1072	772	799	408	148

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Ad Hoc Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Tuesday, November 16, 2021, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes – Draft

Members Present	Specialty	Staff Present
Ria Paul, MD, Chair	Emergency Medicine	Janet Gambatese, Director, Provider Network Operations
Ali Alkoraishi, MD	Adult & Child Psychiatry	Chelsea Byom, Director, Marketing and Communications
Jennifer Foreman, MD	Pediatrics	Tyler Haskell, Interim Compliance Officer
Jimmy Lin, MD	Internist	Lan Tran, Quality Improvement Nurse
Laurie Nakahira, D.O., Chief Medical Officer		Natalie McKelvey, Manager, Behavioral Health
Christine Tomcala, Chief Executive Officer		Neha Patel, Manager, Clinical Quality & Safety
		Mauro Oliveira, Manager, Grievance and Appeals
Members Absent		Gaya Amirthavasar, Process Improvement Project Manager, QI
Nayyara Dawood, MD	Pediatrics	Byron Lu, Process Improvement Project Manager, QI
		Karen Fadley, Provider Database Analyst
		Victor Hernandez, Quality Assurance Process Manager, Grievance & Appeals
		Tiffany Franke, Behavioral Health Case Manager
		Nancy Aguirre, Administrative Assistant

1. **Roll Call**

   Ria Paul, MD, Chair, called the meeting to order at 6:02 pm. Roll call was taken and quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Open Meeting Minutes**

   Open Minutes of the 10/12/2021 Quality Improvement Committee (QIC) meeting were reviewed.

   It was moved, seconded and the minutes of the 10/12/2021 QIC meeting were **unanimously approved.**

   Motion: Dr. Lin
   Second: Dr. Nakahira
   Ayes: Dr. Alkoraishi, Dr. Paul, Ms. Tomcala
   Absent: Dr. Dawood, Dr. Foreman

4. Closed Meeting Minutes

Closed Minutes of the 10/12/2021 QIC meeting were voted upon.

It was moved, seconded and the minutes of the 10/12/2021 QIC meeting were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Paul, Ms. Tomcala
Absent: Dr. Dawood, Dr. Foreman

5. Member Experience Analysis 2020 Update

Victor Hernandez, Quality Assurance Process Manager, Grievance and Appeals (G&A), presented updates to the G&A portion of the Member Experience Analysis 2020. The annual goals were clarified as follows: 1) Continue to strive for a rate that is below 5.0 for non-BH G&A per 1,000 members for each quarter and category; 2) Reduce the annual volume of non-BH G&A each by 5% and; 3) Maintain the rate for BH G&A per 1,000 members for each quarter and category.

Additionally, the formatting of the non-BH G&A portion of the report was updated to meet NCQA requirements. This includes emphasizing the opportunities identified, as well as a qualitative and quantitative analysis of the BH G&As.

Natalie McKelvey, Manager, Behavioral Health (BH), presented the BH portion of the Member Experience Analysis 2020 Update. Ms. McKelvey clarified the method used in measuring the opportunities for improvement of BH satisfaction. In one of the areas of improvement, the intervention is to increase BH education by providing more information on BH resources and access to care on provider and member portals, as well as the website. Website visits for BH information will be analyzed as part of the intervention.

Jennifer Foreman, MD joined at 6:14PM.

6. Appointment Availability Analysis MY 2021

Karen Fadley, Provider Database Analyst, presented the Appointment Availability Analysis MY 2021, specific to the Cal MediConnect (CMC) line of business. The reports presented include partial appointment availability survey data, as survey administration was delayed due to COVID-19. The Provider Network Management (PNO) team elected to bring the reports to the committee to move closer to the pre-COVID review cycle. Reports will be updated once the complete data set is received and analyzed.

The following provider types were targeted to participate in the survey: 1) Primary Care Providers (PCP); 2) Specialists (SPC); 3) Behavioral Health Providers (BH); and, 4) Ancillary (ANCI).

Ms. Fadley reviewed the methodology, performance measures, goals, and results. Also reviewed were barriers, opportunities for improvement, and interventions. SCFHP is pleased that most measures met the performance goals, and the overall results indicate strengths in most operational areas.

SCFHP business units will collaborate internally on specific areas, and if operational issues are identified, a correction plan will be established.

It was moved, seconded and the Appointment Availability Analysis MY 2021 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Foreman, Paul, Ms. Tomcala
Absent: Dr. Dawood

7. Annual Assessment of Network Adequacy

Ms. Fadley presented the Annual Assessment of Network Adequacy. On an annual basis, SCFHP conducts a quantitative analysis against availability and accessibility standards, and a qualitative analysis on performance. Providers included in this assessment are primary care, high volume specialists, high impact specialists, and high volume behavioral health providers.

The reports presented include partial appointment availability survey data, as survey administration was delayed due to COVID-19. The PNO team elected to bring the reports to the committee to move closer to the pre-COVID review cycle. Reports will be updated once the complete data set is received and analyzed.

Ms. Fadley explained, to identify and monitor access issues, an analysis is conducted on member complaints/appeals and member requests for out of network (OON) services. The goals and results were reviewed, as well as the barriers, opportunities for improvement, and interventions.

It was moved, seconded and the Annual Assessment of Network Adequacy was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Foreman, Paul, Ms. Tomcala
Absent: Dr. Dawood

8. Adjournment

The next regular QIC meeting will be held on December 7, 2021. The meeting was adjourned at 6:45PM.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan

Assessment of Network Adequacy

MY2021

Cal-MediConnect

Prepared by: Karen Fadley, Manager, Provider Data, Credentialing and Reporting

For review and approval by the Quality Improvement Committee
November 16th, 2021

INTRODUCTION

Santa Clara Family Health Plan (SCFHP) covers residents of Santa Clara County, officially the County of Santa Clara, which is California's 6th most populous county, with a population of 1,781,642, as of the 2010 census. The county seat and largest city is San Jose, the 10th most populous city in the United States, California's 3rd most populous city and the most populous city in the San Francisco Bay Area.

Santa Clara County is part of the San Jose-Sunnyvale-Santa Clara, CA Metropolitan Statistical Area as well as the San Jose-San Francisco-Oakland, CA Combined Statistical Area. Located on the southern coast of San Francisco Bay, the urbanized Santa Clara Valley within Santa Clara County is also known as Silicon Valley. Santa Clara is the most populous county in the San Francisco Bay Area and in Northern California.

Counties which border with Santa Clara County are, clockwise, Alameda County, San Joaquin (within a few hundred feet at Mount Boardman), Stanislaus, Merced, San Benito, Santa Cruz, and San Mateo County.

Santa Clara Family Health Plan (SCFHP) administers Cal MediConnect (CMC); a dual eligible plan for members who qualify for both Medicare and Medi-Cal. CMC enrollees receives Medicare and Medi-Cal benefits from one plan, such as, medical care, prescription medications, mental/behavioral health care, long-term services and supports (LTSS), and connection to social services. Other important benefits include vision care, transportation and hearing tests and aids.

SCFHP's goal is to maintain a sufficient number of in-network primary care, specialists and behavioral health providers and to meet the Plan's access performance standards and thresholds by at least 90%.

I. Assessment of Network Adequacy

Santa Clara Family Health Plan (SCFHP) conducts annual assessments to identify gaps in its network by assessing:

- Cultural, ethnic, racial and linguistic needs of its members.
- Performance against the standards for the geographic distribution of primary care, high volume/impact specialists and high volume behavioral health providers.
- Performance against the number of primary care, high volume/impact specialists and high volume behavioral health providers.
- Performance against its standards for access to urgent care, regular/routine appointments and after-hours care (non-behavioral health).
- Performance against its standards for access to non-life threatening emergency, urgent care, routine and follow-up routine appointments and after-hours care (behavioral health).
- Member experience with network adequacy for non-behavioral and behavioral health providers from ME7 Elements C-E.
- Non-behavioral health and behavioral health out-of-network requests by Providers and Members.

II. **Results – Availability and Accessibility:**

As reported in the NET 1A assessment, SCFHP believes that cultural competency is a best practice for valuing diversity, practicing inclusion and creating health equity. SCFHP continues to support developmental processes to ensure awareness of cultural, ethnic/racial differences.

The assessment revealed that there are no significant disparities in meeting member cultural, ethnic/racial and linguistic needs and preferences. While SCFHP did not identify disparities to meet language or cultural needs of its members, the Plan will continue to seek available providers with diverse backgrounds and language skills to ensure member needs continue to be met. SCFHP will also continue to evaluate the needs of its members to ensure they receive the care and services they need in a culturally sensitive manner and in their preferred language.

As reported in the NET 1B assessment, SCFHP was able to demonstrate that provider to member ratios were met against its performance goals on all provider types included in the assessment at 100%. SCFHP was also able to demonstrate that maximum time and distance standards were met across all provider types included in the assessment. The maximum time and distance performance goals were exceeded at 91.4% (lowest) and 100% (highest).

SCFHP further examined access detail reports and maps to identify the top 3 cities/zips where MTD standards were not met. The sample review included the provider types from each category (PCP, HVS, HIS and HVBH) with the highest number of members without access within MTD standards. The sample assessment identified 5 cities where MTD is not met on the provider types with the highest number of members without access within MTD standards. The assessment indicated that Gilroy had the most members without access at 42%, followed by Morgan Hill at 41%, San Jose at 12%, San Martin at 5% and Coyote at .1%, all of which are situated in rural communities in the southeast area of Santa Clara County with the exception of San Jose located in the southwest area of the county in the corner of San Jose, but also in a rural area.

While SCFHP was able to demonstrate its ability to meet performance goals relevant to provider to member ratios and maximum time and distance across its service area, monitoring contracting opportunities with new providers in the southeast area of rural communities is an on-going effort.

As reported in NET 2, SCFHP has established mechanisms to provide access to appointments for primary care, behavioral health and specialty services. The report included separate analyses of provider availability for non-behavioral and behavioral health care services.

The appointment surveys showed improvement in appointment access across most provider types, however there were potential areas that the Plan may need to address as follows:

- Appointment Access
  - BH appointment access –
    1. Urgent Care
  - SPC appointment access
    1. Gynecology – Urgent Care
    2. Oncology – Urgent Care

Network providers deemed non-compliant with after-hours access/timeliness standards received a corrective

action letter from the Plan, advising the providers that they will be resurveyed within 30-days. Providers that showed continued non-compliance through resurveys are required to complete SCFHP access training and submit an attestation.

After Hours

As reported in NET 2, the networks combined had 21 phone numbers that were non-compliant with access (911 messaging) and 39 phone numbers that showed non-compliance with timeliness (30min call back messaging). The assessment also revealed that the in the past 3-years the networks have made a significant amount of progress to meet after-hours access and timeliness.

Network providers deemed non-compliant with after-hours access/timeliness standards received a corrective action letter from the Plan.

Member Experience

As reported in NET 2, SCFHP conducted the Consumer Assessment of Health Provider and Systems (CAHPS) survey. The Plan was pleased to acknowledge 4 out of 7 measures showed a marked improvement from 2019. Overall results showed that the Plan improved by 7.02 percentage points, which may be attributed to the Plans on-going efforts to improve operational procedures and member/provider communications. One example of SCFHP's initiatives is the recent development of a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. As reported, this program along with other efforts show that SCFHP has taken a more active role working with network providers in support of plan initiatives that are aimed toward meeting regulatory requirements and improving overall access and quality of care. SCFHP's Provider Network Management, Quality Management, Provider Relations, Customer Service and Contracting departments will continue to develop and improve initiatives to meet member needs.

As reported in the ME7 analysis, SCFHP conducts an annual telephonic member satisfaction survey for CMC members who receive behavioral health services. The goal of obtaining greater or equal to 85% of Always and Usually categories was met for all applicable questions with the exception of Q7 – getting an appointment as soon as you wanted (77%), and Q8-"How often did you see someone as soon as you wanted when you needed help right away?" (82%).

The results relevant to Q7 and Q8 were presented to the Timely Access and Availability (TAA) Work Group, which is made up of representatives from Provider Network Operations, Customer Service, Marketing, G&A, Quality, Compliance, Health Services and Claims. The work group requested additional data and analysis to determine if there were specific provider networks, provider types or individual providers associated with the outcome of the survey (Q7 & Q8). The assessment was conducted on the members who replied "sometimes or never" to "access" questions (Q7 & Q8) and it did not show trending against any specific providers or networks. Furthermore, there were no member complaints or appeals filed against the behavioral health provider network. The ME7 analysis also reported that SCFHP Grievance and Appeals (G&A) Department documents, collects, stores and calculates grievance and appeals data which includes behavioral health-related issues. SCFHP's performance goal is to maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and to maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category.

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Table I: Results – Grievances and Appeals

A. Grievances

Member Count = 9069

Grievance Category	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	155	4.85	5.0	Yes	0	.3	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	155	4.85	5.0	Yes	0	.3	5.0	Yes

Quantitative analysis: (Table I A) Compared to 2019**,** access grievances per 1,000 members increased from 2.4 to 4.85 regarding non-behavioral health providers and decreased from .3 to none for behavioral health providers. With the exception of Psychiatry, there were no other member grievances relevant to non-behavioral health or behavioral health providers that did not meet accessibility or availability standards as reported in NET 1 and NET 2.

B. Appeals

Member Count = 9069

Appeals Category	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	334	10.4	5.0	No	0	0	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0		0	0	5.0	Yes
Total	334	10.4	5.0	No	0	0	5.0	Yes

Quantitative analysis: (Table I B) Compared to 2019, access appeals per 1,000 members increased from 1.2 to 10.4 regarding non-behavioral health providers and there is no change relevant to behavioral health providers. There are no billing/financial appeals to report for 2020 and none were reported in 2019.

A. OUT OF NETWORK REQUESTS

The Plan compiles data on member requests for out-of-network services and data on actual out-of-network utilization to identify and monitor issues with access to non-behavioral and behavioral health providers and other services.

Further review is conducted on OON provider types that did not meet availability and/or accessibility standards and provider types with 10 or more OON approvals. In addition, the assessment includes high volume/high impact provider types and provider types with member grievances, regardless of the number of OON approvals identified. The assessment includes all behavioral health OON approvals.

SCFHP goals to review Out of Network utilization are to:

- Describe the process the Plan uses to track and report OON referrals

- Determine if OON referrals are due to network gaps
- Determine what steps (if any) the Plan should take to address OON referrals

Methodology:
The out of network report is generated from the QNXT system, which is where OON encounters are documented and tracked. The IT department generates the OON report and an analysis is conducted by the Provider Network Access Manager. The analysis is to assess and evaluate the reason for OON requests and if they are associated with network gaps or deficiencies relevant to specific provider types/services and geographic areas within the Plans service area. When applicable, further assessments on the following qualifiers are conducted:

Standards and Thresholds:

- **Rate per 1000 Members** = (Total number of out of network requests divided by total members for the reporting period) x 1000

- **Maintain a rate** as shown below for member out of network requests as follows:

Non-Behavioral Health 15.0 OON requests per 1,000 members

A. OON Assessment

Table I: OON Requests/Approvals/Denials Member Count = 9069

Category	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met	
	Non-Behavioral Health				Behavioral Health				
# Requests	300	33.19	135	No	1			Yes	
# Approved	137	15.10	135	No				Yes	
# Denied	154	16.98	135	No	1			NA	

Quantitative analysis: (Table I) SCFHP received a total of 300 non-behavioral health out of network requests and 1 behavioral health out of network request.
The non-behavioral health provider requests were approved at 46% and the behavioral health provider requests were denied at 100%.

Conclusions and Interventions (Non-Behavioral Health):

The combined NET (1, 2, and 3) analyses has shown some gaps in the SCFHP non-behavioral health network. The Availability of Provider Network analysis (NET 1) showed that SCFHP's provider network has a shortage of General Practice providers in the southeast area of Santa Clara County which is in a rural area where there may be limited providers available. However, as stated in the analyses, SCFHP's PCP network includes other provider types (Family Practice and Internal Medicine) and members are assigned to a PCP upon enrollment without incident within SCFHP's entire service area. The member grievance assessment showed 4 incidents of long wait times for PCP's; however, has identified that some of the barriers to meeting the goals were a lack of extended office hours, hours of operation not suiting the patient and providers not aware of appointment access standards

The NET 2 analysis showed the provider types that were surveyed on access standards and did not meet the urgent care and/or non-urgent care/routine appointment standards, which included PCP's, Cardiology,

Gynecology, Ophthalmology and Oncology. There were no out of network requests for PCP's or Gynecology. There were 9 Cardiology, 3 Ophthalmology and 5 Oncology OON requests/approvals; however, they were unrelated to "access" issues and were approved due to continuity of care.

The NET 2 analysis reports that SCFHP conducts an annual Provider Appointment Availability Survey (PASS) to assess provider compliance with access standards and providers who are deemed non-compliant are issued a CAP and are resurveyed. As noted in the "opportunities" section in NET 2 SCFHP will educate providers on timely access, which is in process as follows:

The access resurveys apply to all provider types that are noncompliant with access standards. Each provider is contacted to complete SCFHP's access training program, and must successfully complete within given time frame. SCFHP's goal is to ensure all providers complete the access training program by the end of 2021.

Family Practice and Internal Medicine all of which are in rural areas with limited providers available. SCFHP has conducted provider outreach efforts in Gilroy and San Martin and there are 3 CSW's that are in the process of contracting with SCFHP. SCFHP is in the process of identifying Addiction Medicine providers who might be available to join SCFHP's provider network. SCFHP's process is to resurvey providers who were non-complaint and if the provider shows continued non-compliance, they are required to complete SCFHP's training program. As noted in the "opportunities" section in NET 2, SCFHP planned to update and improve "access" training materials, which has been completed. The NET 2 "opportunities" section also stated that SCFHP would educate BH providers on timely access, which is in process as follows:

The access resurveys are completed within 30-days from the date on the corrective action letters. Providers who show continued non-compliance from the resurveys receive notice from the Plan and are required to complete SCFHP's access training and submit an attestation within 60-days from the date of notice. SCFHP will continue its efforts to educate providers on timely access standards.

A. Behavioral Health Providers-OON "Approval" Breakdown

Provider Type	**Assessment Reason	# of Approvals	Approval: *COC	Approval: Retro-Authorization	Timely Access Issue	Provider is now PAR/or in Process	Other
Marriage/Family Counselor	HVS/Access	0	0	NA	NA	NA	NA
Psychiatrist (HVS)	HVS/Access	0	0	NA	NA	NA	NA
Psychology	Access	0	0	NA	NA	NA	NA
Total	**NA**	**0**	**0**	**0**	**0**	**0**	**NA**

***Denotes Continuity of Care (COC)
****Assessment Reason(s):
HVS: Provider type is a high volume specialist
Access: Provider type did not meet one or more access standards
GA: Grievance and/or appeals were filed against this provider type
TD: Provider type did not meet time or distance standards

Quantitative analysis: (Table II B) The 1 behavioral health provider denied request, Psychiatrist was requested but denied for In Network provider available. As shown in the table the Plan had NO OON requests that were authorized due to continuity of care and retroactive requests.

The Availability of Provider Network (NET 1) and Accessibility of Provider Network (NET 2) analyses included

behavioral health provider types that were identified as having member grievances on file, did not meet time or distance standards, and/or did not meet timely appointment access standards; none of which had any OON requests/approvals.

Conclusion and Interventions (Behavioral Health Providers—Prescribing and Non-Prescribing):

The combined NET (1, 2, and 3) analyses has shown some gaps in the SCFHP behavioral health network; however, it is important to note that SCFHP partners with the County Behavioral Health Services Department (CBHSD). The CBHSD conducts behavioral health screenings and refers SCFHP members to the County Mental Health clinic or a Community Based Organization (CBO) for services. SCFHP members are assisted with care coordination by the SCFHP Behavioral Health (BH) social workers which includes:

- Shared Care Plans, integrating care plan goals
- Assistance with transportation to psychiatric appointments
- Coordinating medical care with primary and specialty care and behavioral health care

Specialty Mental Health services could include psychiatry, therapy and case management. Those identified as mild to moderate are accommodated within a 10-day timeframe in a County clinic or are referred to SCFHP for placement within the health plan's network for services. Psychiatry continues to be provided in the County network due to a lack of capacity in the SCFHP network to provide this service.

In 2021, the Availability of Provider Network analysis (NET 1) showed that SCFHP's provider network has a shortage of Clinical Social Workers and Addiction Medicine providers in the cities of Gilroy, San Martin, and Morgan Hill, all of which are in rural areas with limited providers available. SCFHP has conducted provider outreach efforts in Gilroy and San Martin and there are 3 CSW's that are in the process of contracting with SCFHP. SCFHP is in the process of identifying Addiction Medicine providers who might be available to join SCFHP's provider network. As noted in the "opportunities" section in NET 2, SCFHP planned to update and improve "access" training materials, which has been completed. The NET 2 "opportunities" section also stated that SCFHP would educate BH providers on timely access, which is in process as follows:

The access resurveys are in process and each provider has been contacted to complete SCFHP's access training program, of which providers will have successfully completed the trainings within the time frames indicated, SCFHP's goal is to ensure all providers complete the access training program by the end of 2021.

OPPORTUNITIES:

Barrier	Opportunity	Intervention	Selected for 2021	Date Initiated
Timely access – Urgent appointments within 48-hours, 96-hours	Improve access to urgent care appointments	Following CAP, resurvey non-compliant providers	Yes	In Process
Providers are unaware of appointment access standards	Educate providers on access standards	Require providers who show continued non-compliance through resurveys to complete SCFHP's access matrix via fax blast to network providers	Yes	12/2019 – On going
Appointment Access – Behavioral Health	Increase the number of BH providers within SCFHP's network	Following CAP, resurvey non-compliant providers	Yes	Ongoing
Shortage of BH providers	BH network development	Submit SCFHP's access matrix via fax blast	Yes	12/2019 – On-going
PCP's and Behavioral Health Providers	Improve after-hours access	Following CAP, conduct provider outreach (Training)	Yes	On going
After-Hours Access (return call within 30min or less) – Providers are unaware of – 1. After-hours messaging requirements 2. Calls are required to be returned within 30-minutes	Educate providers on after-hours access	Submit SCFHP's access matrix via fax blast to network providers quarterly	Yes	On going
In-Office wait times exceed 15 minutes	Educate providers on in-office wait times	Submit SCFHP's access matrix via fax blast to network providers	Yes	12/2019 On going

Santa Clara Family Health Plan
Accessibility of Provider Network
MY2021

Cal-MediConnect

Prepared by: Karen Fadley, Manager, Provider Data, Credentialing and Reporting

November 16, 2021

I. INTRODUCTION

Cal MediConnect is a program that integrates medical care, long-term care, mental health and substance use programs and social services under a coordinated care plan for people who are dually eligible for Medicare and Medi-Cal.

Santa Clara Family Health Plan (SCFHP) conducts an annual performance analysis on provider network accessibility against its standards. The Plan's access standards are established by SCFHP, CMS, DMHC, DHCS and NCQA.

SCFHP makes every effort to ensure that at least 90% of its members receive timely access to appointments, medical services and after-hours care. When appointment and after-hours access is not being met, an analysis of findings is conducted and a corrective action plan is required (when applicable). Access reporting monitoring activities are reviewed in the Timely Access & Availability (TAA) Work Group and Quality Improvement Committee (QIC). The Work Group is represented by the following departments: Provider Network Operations, Quality, Utilization Management, Customer Service, Behavioral Health, Compliance, Grievance/Appeals, Contracting, and Marketing. The TAA work group and QIC reviews, evaluates, and makes recommendations as needed.

II. TERMS AND DEFINITIONS

Primary Care Providers PCP(s) are defined as physicians of Family Medicine and Internal Medicine.

High **Volume** Specialists (HVS) are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high volume analysis includes cardiology, ophthalmology and gynecology.

High **Impact** Specialists (HIS) are defined as specialists who treat conditions that have high mortality and morbidity rates and where treatment requires significant resources**.** High impact specialists are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high-impact analysis includes hematology/oncology.

High **Volume** Behavioral Health (HVBH) providers are defined as providers who are located in a high-volume geographic area or in a high-volume specialty (or both), and are likely to provide services to a large segment of members. Behavioral health providers are defined Psychiatry (prescribing) and Psychology (non-prescribing), Licensed Clinical Social Workers and Marriage/Family Therapists. High volume behavioral health providers are identified by analyzing claims and encounter data for a 12-month period.

This report provides an overview and analysis of SCFHP's timely access survey results. SCFHP survey goals, objectives, methodologies and results are included in each reporting section.

The following survey assessments are included in this report:

1. Provider Appointment Availability Survey
2. After Hours Survey
3. CAHPS
4. Provider Satisfaction Survey
5. Member Grievances

The provider types included in this report:

- Primary Care Provider's (PCPs)
- High Volume Specialists (HVS)
- High Impact Specialist (HIP)
- Behavioral Health Providers (BHP) -- prescribers and non-prescribers.

III. Provider Appointment and Availability Survey (PAAS)

A. GOALS

- Ninety percent (90%) of providers will meet appointment access standards established by SCFHP, CMS, and NCQA.

B. OBJECTIVES

- Measure rate of compliance with timely access standards, at least annually.
- Evaluate SCFHP's timely access performance in comparison to goals.
- Identify areas to improve timely appointment access.
- Develop interventions as appropriate/applicable to address deficiencies and/or gaps in timely access to care.

C. METHODOLOGY

The Provider Appointment Availability Survey (PAAS) Methodology is developed by the Department of Managed Health Care (Department), pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS Methodology, published under the authority granted in Section 1367.03 is a regulation in accordance with Government Code section 11342.600. For measurement year 2020 (MY 2020), all reporting health plans must adhere to the PAAS Methodology when administering the PAAS and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2.

The Plan uses the Department's PAAS Templates, which include:

- Contact List Template
- Raw Data Template
- Results Data Template

Each contact list will include the provider types to satisfy the DMHC and NCQA compliance formats and each list is de-duplicated to ensure providers are only surveyed one time.

SCFHP sends outreach communications that inform network providers of the following:

- Who is administering the survey
- Information about the importance of participating in the survey
- What the survey is, why it is being done, how it is administered and the types of questions that will be asked
- The date range during which the survey is likely to occur

SCFHP uses an "all provider network" (census) where sixty percent (50%) of providers are surveyed in the first wave and the 2nd wave starts following the 3-week DMHC mandatory break and covers the remaining forty percent (50%) of providers.

The surveys are initiated by fax and email (email included a personalized URL to take the survey online; the fax directed providers to www.cssresearch.org/Appointment and a unique login code is provided) with a telephone follow-up. Three call attempts are made during business hours (9:00 am – 4:30 pm Pacific Time) and within a 48-hour time period from the first attempt. The timeframe to complete the survey online or by fax is limited to 48 hours from the time of the message.

D. MEASURES

Table I: Appointment Standards

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care
Primary Care Providers (All)	48 hours	10-days	NA	NA
Specialists (All)	96 hours	15-days	NA	NA
BH/MH – (All)	48 hours	10-days	6-hours	30-days

E. Results – Provider Appointment/Availability Survey

Table I: Aggregate PCP Urgent Care Appointment within 48-hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	PCP *(N=159)	77	82	46	59%	90%	No
2020	PCP (N=545)	226	319	161	73%	90%	No
2019	PCP (N=509)	285	224	189	66%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table I)**:** Rate of compliance for PCP's relevant to the urgent care appointment access fell short of goal by 30.9 percentage points at 59.1% for year 2021, 17 percentage points for year 2020 and 24 percentage points for year 2019.

Table II: Aggregate PCP Non-Urgent/Routine Appointment within 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	PCP *(N=165)	73	92	62	84%	90%	No
2020	PCP (N=545)	141	131	128	90%	90%	Yes
2019	PCP (N=509)	326	183	276	85%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table II): Rate of compliance for PCP's relevant to the Non-Urgent/Routine appointment access fell short of goal by 5.8 percentage points at 84.2% for year 2021, goal was met for year 2020 at 90.4% and fell short 5 percentage points for year 2019.

Review on PCPs performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 66%
- Non-Urgent Care: 87%

The analysis also revealed that urgent appointment access remains steady at 64%, 26 percentage points below goal and that non-urgent appointment access is also remaining steady at 87%, 3 percentage points below goal.

Qualitative Analysis: In the past survey cycles the Plan established interventions in an effort to assist provider with improved PCP urgent/non-urgent appointment access and survey participation. It appears that the pandemic had an impact on PCP respondents to the survey; reduction in staff, closed offices, staff turnover, training and the surge of patient care impacted the PCPs survey participation and appointment availability.

SCFHP's Provider Network Access Manager worked directly with compliance officers and/or clinic administrators and issued a corrected action letter to each of them with a report listing each provider that was non-complaint with access standards. All non-compliant providers are resurveyed within 30-days from the date on the corrective action letters. Providers who show continued non-compliance from the resurveys receive notice from the Plan and are required to complete SCFHP's access training and submit an attestation within 60-days from the date of notice.

Specialists - High Impact and High Volume

Below includes tables that shows the number of high volume/impact providers were surveyed, the number that responded and the rate of compliance broken down by each network. The Direct network represents the Plan's individually contracted providers. With the exception of Gynecology, the majority of the Plans specialists included in this report are available through Stanford. While SCFHP is very pleased to have Stanford in its network to serve CMC members, as they are well known for their international reputation for excellence, it is important to point out that Stanford's access survey participation rates have historically been low, therefore meaningful conclusions on appointment access through the PAAS survey has been difficult to achieve. Discussions with this group to improve participation has occurred, and a "manual/electronic extraction" of provider schedules are being explored as a method to increase data collection for measurement year 2021. Also included below are charts that show results against goals and/or benchmarks trended over time.

Table I: - Urgent Care Access – Appointment within 96 Hours
Cardiology, Gynecology, Ophthalmology – High Volume Provider, Oncology – High Impact Provider

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Specialists *(N=73)	31	42	17	54%	90%	No
2020	Specialists (N=308)	103	205	54	56%	90%	No
2019	Specialists (N=300)	102	198	40	48%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table I) Rate of compliance for Specialists on urgent appointment access fell short of goal by 36 percentage points for year 2021, a 34 percentage point decrease short of goal in 2020, and a 42 percentage point decrease from goal in 2019.

Table II: - Non - Urgent/Routine Care Appointment within 15 days
Cardiology, Gynecology, Ophthalmology – High Volume Provider, Oncology – High Impact Provider

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Specialists *(N=74)	30	44	22	71.7%	90%	No
2020	Specialists (N=308)	103	205	82	79%	90%	No
2019	Specialists (N=300)	102	198	58	59%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table II) Rate of compliance for Specialists on Non-Urgent Care appointment access fell short of goal by 18.3 percentage points for year 2021, an 11 percentage point decrease short of goal in 2020, and a 31 percentage point decrease from goal in 2019.

Review on Specialists performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 53%
- Non-urgent Care: 70%

The 3-year (2019-2021) analysis on Specialists urgent appointment access revealed that results remain steady at 53%,37 percentage points below goal; and non-urgent appointment access is trending upward and is currently 70%, 20 percentage points below goal.

Santa Clara Family Health Plan™

Behavioral Health Providers – Prescribers/Non-Prescribers (HVBH)

Psychiatry – Prescribers (High Volume Provider)

Table I: Psychiatrists Urgent Care Appointment 48 hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Psychiatrists *(N=3)	1	2.5	1	33.3%	90%	No
2020	Psychiatrists (N=104)	15	89	7	54%	90%	No
2019	Psychiatrists (N=82)	14	68	4	33%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table I) Rate of compliance for Psychiatrists Urgent Care Appointment fell short of goal by 56.7 percentage points for year 2021, 36 percentage points decrease short of goal in 2020, and 57 percentage points for year 2019.

Table II: Psychiatrists Non-Urgent/ Routine Care Appointment within 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Psychiatrists *(N=3)	1	2	2	66.7%	90%	No
2020	Psychiatrists (N=104)	15	89	10	67%	90%	No
2019	Psychiatrists (N=82)	14	68	8	58%	90%	No

*Provider Appointment/Availability Survey 2021 50% of providers surveyed results

Quantitative Analysis (Table II) Rate of compliance for Psychiatrists Non-Urgent/Routine Care appointment fell short of goal by 23.3 percentage points for year 2021, 23 percentage points for year 2021, and 32 percentage points for year 2019.

Review on Psychiatrists performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care 48 hours: 40%
- Non-urgent Care: 64%

It appears that meeting appointment access with initial and routine visits is trending upward, therefore the Plan is confident that access to timely routine care is improving results have remained steady for the past 3-years.

Table I: Non-Physician Mental Health – Non-Prescribers Urgent Appointment 48 hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Non-Physician Mental Health*(N=3)	2	1	1.5%	75%	90%	No
2020	Non-Physician Mental Health (N=79)	14	64	11	79%	90%	No
2019	Non-Physician Mental Health (N=83)	19	64	11	61%	90%	No

Quantitative Analysis (Table I): Rate of compliance for Non Physician Mental Health Providers Urgent Appointment fell short of goal by 15 percentage points for year 2021, 11 percentage points for year 2021, and 29 percentage points for year 2019.

Table II: Non-Physician Mental Health – Non-Prescribers Non-Urgent/ Routine Appointment 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Non-Physician Mental Health*(N=3)	2	1	1.5%	75%	90%	No
2020	Non-Physician Mental Health (N=79)	15	64	14	93%	90%	Yes

2019	Non-Physician Mental Health (N=83)	19	64	12	63%	90%	No

Quantitative Analysis (Table II) Rate of compliance for Non-Physician Mental Health provider's Non-Urgent/routine Appointment fell short of goal by 15 percentage points for year 2021, 2020 the Plan Met performance standards, and fell short by 27 percentage points for year 2019.

Review on performance by Non-Physician Mental Health Providers relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 72%
- Non-Urgent: 77%

Given that the 3-year analysis indicates that the behavioral health network collectively is holding steady further review within this review cycle to identify barriers was conducted as follows:

- Member Complaints: None were filed against the Behavioral Health network.
- Open for New Referrals: 100%.
- Out of Network Requests: None

In conjunction with the reviews bulleted above and other components included in this analysis, such as the assessments on time/distance and provider to member ratios, all of which were met for behavioral health, this may indicate that there is not an access issue. The barriers to consider are as follows:

- Appointment access survey participation has been historically low across the BH network, which may skew access results. Provider feedback concerning lack of participation is mostly due to practice operations where solo practitioners do not staff front desk or schedulers, thus while in session with patients, survey calls are not captured.

SCFHP educates its providers by submitting the timely access grid bi-annually via fax blast to network behavioral health providers which advises them to include the following message on automated systems, office, or exchange/answering services to:

"Hang up and dial **911** or go to the nearest emergency room or call Santa Clara County Behavioral Health at **1-800-704-0900**."

The same information is included in the Plan's access training offered on-line or via webinar. This action item by the Plan and its BH network ensures that patients needing non-life threatening and/or urgent care are directed to the Santa Clara County BH system, where access to triage/screening and referrals for care are established as needed are available. The Santa Clara County BH system is available to SCFHP members 24hrs a day/7-days a week.

F. AFTER HOURS SURVEY

Santa Clara Family Health Plan (SCFHP) conducts an annual After-Hours survey to ensure that telephone triage or screening services are provided in a timely manner. The survey also identifies if emergency 911 instructions are provided. The provider types included in the survey are:

- Primary Care Providers
- Behavioral/Mental Health Providers

A. GOAL

To ensure that Plan network providers meet after-hours access and timeliness standards at 90%.

B. METHODOLOGY

The after-hours survey was administrated by CSS survey vendor. The survey was conducted during non-business hours Pacific Standard Time (6:00 pm - 8:00 am on weekdays, and all day on weekends). The survey sample included all contracted primary care providers. SCFHP provided CSS a provider contact list, which was de-duplicated to ensure each provider was surveyed once. Providers who share the same phone numbers are combined into one group and survey results are attributed to all the providers.

When a live person (provider or answering service) is reached, the surveyor announces that they are calling on behalf of SCFHP to conduct a survey and the respondents are asked the same questions from the after-hours survey tool, and if the call is answered by an automated recording, the interviewer collects the response based on the message. If the automated recording provides an option to connect to a live person (by pressing a button or staying on the line), the interviewer selects that option and records the answers the person provides. The interviewer does not leave a voice message during any telephone attempts.

C. MEASURES

Table I: After Hours Standards

Provider Type	After-Hours Care
PCP (All)	24-hours / 7-days a week
BH/MH - Prescribers	24-hours / 7-days a week
BH/MH – Non-Prescribers	24-hours / 7-days a week

Table II: After Hours Access and Timeliness Standards

Service	Standard access requirement
Automated systems, office, or exchange/answering services	Must inform the patient that the provider will call back within 30 minutes.
Life-threatening situation	Automated systems must provide emergency 911 instructions, such as: • "Hang up and dial **911** or go to the nearest emergency room." Behavioral health providers should include the number to the Santa Clara County Behavioral Health: • "Hang up and dial **911** or go to the nearest emergency room or call Santa Clara County Behavioral Health at **1-800-704-0900**."
Urgent need to speak with a provider	Automated systems, office, or exchange/answering services must connect the patient with an on-call provider or should direct the patient on how to contact a provider after hours.

D. Aggregate After-Hours Data Results

Table I: Primary Care Providers

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2021	Met
Access	786	679	286	10	94.7%	Yes
Timeliness				17	71.7%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	640	601	141	29	91%	Yes
Timeliness				57	42%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2019	Met
Access	505	455	183	22	80%	No
Timeliness				18	40%	No

*Access = 911 messaging
*Timeliness = 30min call back messaging

Aggregate access results:
- 2021: 94.7%
- 2020: 91%
- 2019: 80%

Aggregate timeliness results:
* 2021: 71.7%
* 2020: 42%
* 2019: 40%

Aggregate results for PCP's rate of compliance increased by 3.7 percentage points on access and 29.7 percentage points on timeliness for year 2021, increased 11 percentage points on access and 2

percentage points on timeliness for year 2020. There is a total of 1 phone number that were non-complaint with after-hours messaging on access and 1 phone number on timeliness which shows a significant decrease in SCFHP conducted an after-hours review of each network as follows -

--Aggregate results for **Behavioral Health Providers**:

Table I: Behavioral Health Providers

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2021	Met
Access	335	279	235	11	95.7%	Yes
Timeliness				22	82.6%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	350	316	52	26	89%	No
Timeliness				41	36%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2019	Met
Access	329	300	83	30	78%	No
Timeliness				65	33%	No

*Access = 911 messaging
*Timeliness = 30min call back messaging

Aggregate access results:
- 2021: 95.7%
- 2020: 89%
- 2019: 78%

Aggregate timeliness results:
* 2021: 82.6%
* 2020: 36%
* 2019: 33%

Aggregate results for Behavioral Health Provider's rate of compliance increased by 6.7 percentage points on access and 46.6 percentage points on timeliness in year 2021, 11 percentage points on access and 3 percentage points on timeliness in year 2020. There are a total of 11 phone numbers that were non-complaint with after-hours messaging on access and 22 phone numbers on timeliness.

Analysis (Tables I &X)

The PCP network showed an increase in compliance with access and timeliness in 2021. The PCP network also showed a total of 10 phone numbers that were non-compliant with after-hours messaging on access and 17 phone numbers for timeliness.

The BH network showed an increase in compliance with access and timeliness in 2021. The BH network also showed a total of 11 phone numbers that were non-compliant with after-hours messaging on access and 22 phone numbers for timeliness.

The Plan believes that the efforts made in partnership with the providers through notifications of non-compliance and access training increased awareness on after-hours standards, thus both PCP's and BH providers showed improved results on access (911) and showed improved timeliness (30min). The Plan also believes that monitoring after-hours timeliness (30min call back messaging) can be a challenge because the surveyors do not follow through with prompts to contact the after-hours provider to avoid interference with patient care, thus if the message does not state that the provider will call back or get on the line within 30minutes or less, the provider is marked non-compliant. Following receipt of corrective action letters, several providers contact the Plan each year to report that they meet after-hours timeliness requirements by calling patients back with 30mintues or less.

The Plan and Providers are working to ensure front line messaging states that the provider will call back within 30 minutes or less. Monitoring member complaints is another avenue used by the Plan to identity issues with after-hours access

PCPs and Behavioral Health providers that were deemed non-complaint as a result of the 2021 survey, received a corrective action letter, and or the networks (PMG, PC, VHP, PAMF) received a corrective action letter and a report highlighting all phone numbers that were deemed non-compliant on access and/or timeliness.

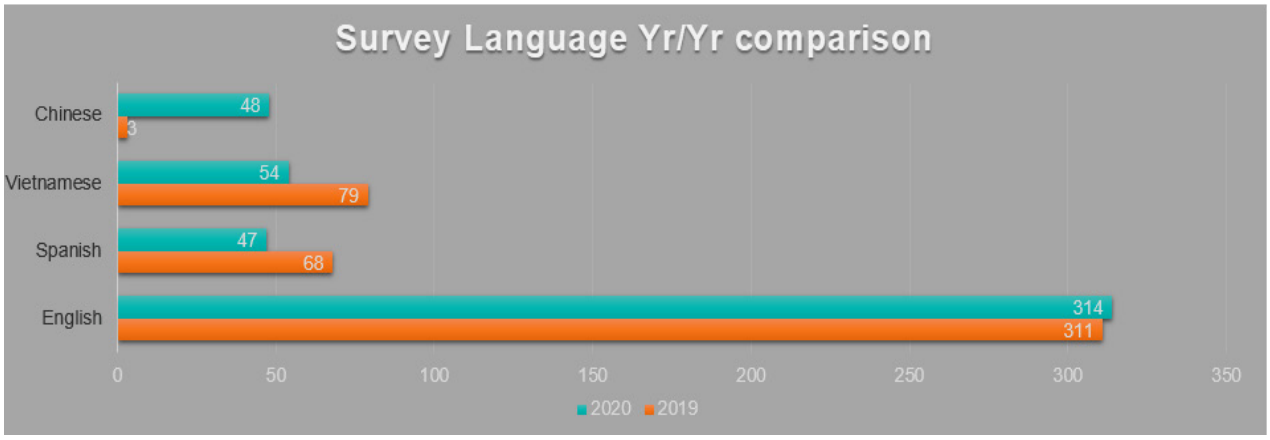
Conclusions:

- The PCPs and Behavioral Health providers combined have 21 phone numbers that show non-compliance with access (911 messaging) and 39 phone numbers that showed non-compliance with timeliness (30min call back messaging).
- Providers deemed non-compliant with after-hours access/timeliness standards receive a corrective action letter from the Plan, and are expected to submit a corrective action plan within 30-days.
- Overall Providers have made a significant amount of progress in trending upward in meeting after-hours access and timeliness in the past 3-years.

G. MEMBER EXPERIENCE SURVEY (CAHPS)

METHODOLOGY

- CAHPS is a consumer satisfaction survey that the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS)
- SCFHP contracts with a vendor-SPH Analytics to conduct the survey
- Respondents were given the option of completing the survey in a language other than English. Survey Language 2020/2019 comparisons are as follows:



- Due to COVID-19, changes were made to the methodology and no follow up phone calls to non-respondents were made in 2020.

Data Collection:

Survey Protocol	Date
SCFHP postcard notification #1	1/31/2020
SCFHP postcard notification #2	2/28/2020
Pre-notification letter mailed	3/5/2020
First survey mailed	3/11/2020
Second survey mailed	4/11/2020
Last day to accept completed surveys	6/14/2020

Note: CMS recommended to cease telephone outreach due to COVID-19

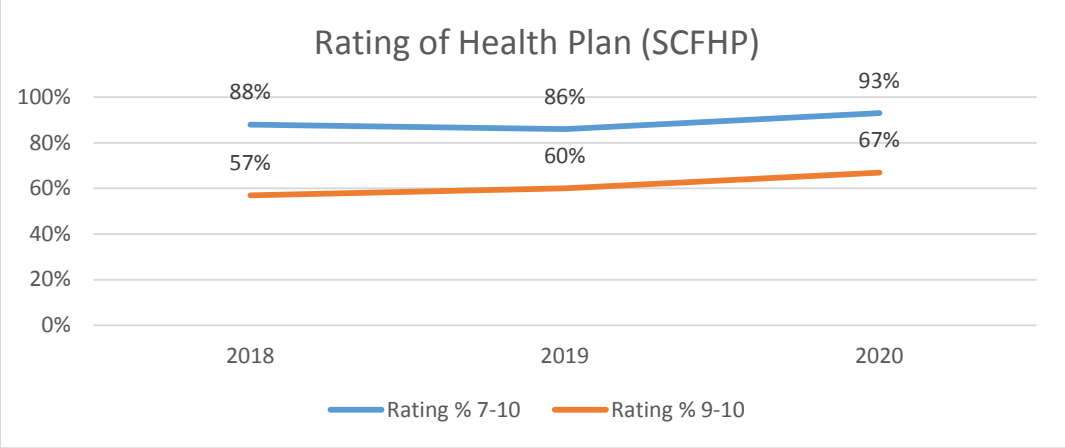
Item	Volume
Total mailed	1600
Ineligibles	11
Total completed surveys	463
Mail completes	461
Phone completes	2

RESULTS

Table I: 2020 Medicare CAHPS Survey

Composite Rating & Questions	# of Respondents	Goal	Goal Met	Always and Usually (2020)	Always and Usually (2019)	PY Change
Rating of Health Plan (Q38)	375	90%	Y	93%	86%	+6
Getting tests results when needed (Q21)	318	90%	N	82%	83%	-1
Getting appointments with specialists (Q29)	246	90%	N	75%	75%	-.4
Getting needed care, tests or treatment (Q10)	445	90%	N	83%	80%	+3
Getting care needed right away (Q4)	134	90%	N	81%	82%	-.7
Getting appointments (Q6)	338	90%	N	73%	76%	-3
Getting seen within 15min of your appt (Q8)	335	90%	N	58%	54%	-4

Chart I: Rating of Health Plan



Quantitative Analysis (Tables I)**:**
Table I shows that 3 out of 7 measures indicate a marked improvement from 2019. While Getting seen within 15min of your appointment" did not meet goal, 2020 ratings showed a marked improvement by 4 percentage points. In 2020, overall "access" results showed the Plan's performance improved by 7.66 percentage points, also improved from 2019's 7.02 percentage points.

Chart 1 shows that approximately 7 in 10 (67.10%) gave the Plan a rating of 9 or 10, which an improvement from the past two years. On a 0 to 10 scale about 9 in 10 (92.90%) gave the Plan a rating of 7, 8, 9 or 10 which is a continuous improvement from the past two years.

The response rate in “Always” and “Usually” is combined to compare the member/enrollee satisfaction in timely appointment access and rating of health plan measures between 2019 and 2020. As shown in the Table I above, the goal was not met for any measures; however, member satisfaction improved in 4 out of 7 measures, which is a marked improvement from 2019. The measure most improved was “getting care needed right away” (Q4) with an increase of 7.78 percentage points from 2019. The measure for “getting seen within 15min of your appointment” (Q8), showed the greatest decrease in satisfaction by 6.41 percentage points from 2019.

As shown in Table II, SCFHP performed similar to last year on the rating of the health plan and performed similar to two years ago. About 9 in 10 (84.41%) gave their health plan a rating of 7, 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from two years ago. About six in 10 (59.91%) gave a rating of 9 or 10, which is not significantly different from last year and not significantly different from two years ago.

Qualitative analysis: Overall results showed no significant improvements compared to 2019; however, there was a significant improvement compared to two years ago on the composite score relevant to Customer Service. SCFHP performed similar to last year on the rating of the health plan and performed similar to two years ago. About 9 in 10 (84.41%) gave their health plan a rating of 7, 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from two years ago. About six in 10 (59.91%) gave a rating of 9 or 10, which is not significantly different from last year and not significantly different from two years ago.

SCFHP recognizes that “getting care needed right away” (Q4) has a relatively high impact on members and is pleased that satisfaction ratings showed an improvement of 7.78 percentage points in 2020. The assessment on member grievances showed that 34% of complaints were associated with timely appointments; therefore, survey results combined has helped SCFHP identify factors that may affect member satisfaction, such as:

- Providers do not have an adequate understanding of regulatory requirements for timely access to care.
- Longer wait times for urgent and non-urgent/routine care could be due to inefficient scheduling procedures.
- Provider offices are not communicating in office wait times with members at check in or contacting them ahead of time to allow member to come in at a later time.

Conclusion - CAHPS:
SCFHP is pleased to acknowledge 4 out of 7 measures showed a marked improvement from 2019. Overall results showed that the Plan improved by 7.02 percentage points, which may be attributed to the Plans on-going efforts to improve operational procedures and member/provider communications. One example of SCFHP’s initiatives is the recent development of a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. This program along with other efforts show that SCFHP has taken a more active role working with network providers in support of

plan initiatives that are aimed toward meeting regulatory requirements and improving overall access and quality of care. SCFHP's Provider Network Management, Quality Management, Provider Relations, Customer Service and Contracting departments will continue to develop and improve initiatives to meet member needs.

H. PROVIDER SATISFACTION SURVEY

Santa Clara Family Health Plan (SCFHP) conducts an annual Provider Satisfaction Survey (PSS) to assess provider satisfaction with specific areas of services.

GOALS AND OBJECTIVES

A. Goals:

- To ensure that SCFHP providers have a positive experience with health plan services.

B. Objectives:

- Measure provider experience (satisfaction) at least annually.
- Evaluate provider's satisfaction with performance measures.
- Identify any areas for improving contracted provider's experience with the health plan.
- Develop interventions as appropriate to address gaps in service.

C. Performance Standards for Provider Satisfaction:

- Eighty percent (80%) of provider's will be satisfied (Q1-8 & 10)
- One hundred percent (100%) of provider's will be satisfied (Q9)

METHODOLOGY

A. Sample

SCFHP provided CSS with lists of 1,726 providers to be surveyed using a fax-only methodology. CSS drew a sample of all unique fax numbers (N=486) associated with providers in SCFHP's network. This was done to reduce the burden on offices where multiple providers share a single fax number, especially since it is often office staff who complete these surveys, not the provider to whom the survey is addressed. Each fax number was assigned a unique 8-digit identification number to track responses.

B. Survey Instrument

In 2021, one version of the survey instrument was used to help SCFHP assess provider satisfaction with services delegated to provider networks as well as those provided directly by the plan. The measures (27) were included in the version of the survey.

C. Timeline

The entire sample was included in the first wave of fax outreach.

D. Data Capture

Returned surveys were captured using manual data entry with double key verification. Each returned survey was identified by the original tracking ID and the date the survey was received. Returned surveys with missing responses for every question were eliminated. Thus, any survey with a valid response to at least one question was retained. If two completed surveys with the same tracking ID were received, the most complete survey (based on the total number of questions appropriately answered) was retained. In the event of a tie, the survey with the earliest return date was retained.

E. Sample

The original sample was comprised of 486 unique fax numbers. Of the original sample, 34 fax numbers were undeliverable or determined to be ineligible and were removed from the final sample size in following exhibits.

A total of 83 responses were received at the close of data collection resulting in an overall response rate of 17.1%. This was down from MY2020, when 18.3% of fax numbers resulted in a returned survey. Responses for a fax number were attributed to all providers in the sample associated with that fax number. Therefore, collected fax responses were associated with 196 out of 1,513 eligible providers (13.0%).

IV: Rate of Response

Table A: Responses by Provider Types

Provider Type	# Surveyed	Response #	2021	2020	2019
PCP	721	126	18%	20%	27%
SPC	477	57	12%	8%	7%
BH	308	10	3%	11%	12%
Total	1,508	193	13%	11%	10%

- Provider participation increased in 2021 by 2 percentage point.

V. Provider Satisfaction Results

Survey results that are calculated based on sample data and compared to a benchmark score (such as the plan's prior-year rate), the question is whether the observed difference is real or due to chance. A test of statistical significance uses the difference in scores as well as the number of respondents in both groups (in this case, the number of current-year and prior-year respondents) to determine the likelihood that the observed difference is real.

Scores marked with an asterisk are statistically significant at a 95% confidence level, meaning there is a 95% probability that the observed difference is not due to chance. Questions with larger changes in scores and a larger number of respondents are more likely to be statistically significant.

The following tables reflect the responses to the survey on access categories:

Table I: Patient Timely Access to Appointments (Q5a)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Urgent Care	86.7%	-11.6%	100.0%	15.4%	100.0%	0.0%	94.4%	-2.7%	80%	YES
MY2020										
Urgent Care	98.0%	-4.0%	85.0%	-4.0%	100.0%	0.0%	97.0%	2.0%	80%	Yes

Goal: Met - 2021

- Urgent Care:
  - ❑ All provider networks rated satisfaction above goal – VHP and Premier Care rated the highest at 100%,
    followed by Direct at 94.4%, and PMG at 86.7%.
  - ❑ PMG had a decrease in satisfaction from 2020 by -11.6 percentage points and Direct showed a decrease in satisfaction from 2020 by -2.7 percentage points.

Table II: Timely Access to Appointments (Q5b)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Primary Care	96.3%	-3.7%	100.0%	15.4%	100.0%	0.0%	90.0%	-6.9%	80%	YES
MY2020										
Non-Urgent Primary Care	100.0%	0.0%	85.0%	-6.0%	100.0%	0.0%	97.0%	-1.0%	80%	Yes

Goal: Met - 2021

- Non-urgent primary care:
  - ❑ All provider networks rated satisfaction above goal – Premier Care and VHP rated the highest at 100%, followed by PMG at 96.3% and Direct at 90.0%
  - ❑ PMG showed a decrease in satisfaction from 2020 by 3.7 percentage points and Direct showed a decrease of 6.9 percentage points.

Table III: Timely Access to Appointments (Q5c)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Specialists Care	89.3%	-7.8%	100.0%	21.4%	100.0%	21.9%	92.9%	-0.8%	80%	Yes
MY2020										
Non-Urgent Specialists Care	97.0%	-2.0%	79.0%	-8.0%	59.0%	0.0%	94.0%	1.0%	80%	No

Goal: Met - 2021

- Non-urgent specialists care:
  - Premier Care and VHP rated satisfaction above goal – 100%, followed by Direct at 92.9 and PMG at 89.3 percentage points.
  - PMG rated satisfaction at 89.3% and showed a decrease in satisfaction from 2020 by -7.8 percentage points a Direct showed a decrease in satisfaction by .8 percentage points.

Table VIII: Timely Access to Appointments (Q5d)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Ancillary diagnostic and treatment services	100.0%	0.0%	100.0%	14.3%	72.7%	4.0%	92.2%	-4.0%	80%	No
MY2020										
Non-Urgent Ancillary diagnostic and treatment services	100.0%	2.0%	86.0%	-4.0%	69.0%	0.0%	96.0%	8.0%	80%	No

Goal: Not met - 2021

- Non-urgent ancillary diagnostic and treatment services:
  - ❑ PMG, PC and Direct rated satisfaction above goal – PMG and Premier Care rated the highest at 100%,followed by Direct at 92.2%
  - ❑ VHP rated satisfaction at 72.7% - goal was not met by 7.3 percentage points.

Table IV: Timely Access to Appointments (Q5e)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Behavioral Health Care	76.9%	-4.7%	88.9%	8.9%	81.3%	4.6%	83.7%	28.9%	80%	No
MY2020										
Non-Urgent Behavioral Health Care	82.0%	-13.0%	80.0%	-9.0%	77.0%	0.0%	55.0%	-8.0%	80%	No

Goal: Not met.

- Non-urgent behavioral health care:

- ❑ VHP, Direct and PC rated satisfaction above goal – Premier Care rated the highest with 88.9 percentage points, followed by Direct with 83.7 percentage points, and VHP with 81.3 percentage points. PMG rated the lowest with 76.9 percentage points.

Table V: Customer Service Staff (Q6a-c)

MY 2021										
Customer Service Staff	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Ability to answer calls promptly	96.6%	3.6%	84.6%	-15.4%	83.3%	-16.7%	92.2%	-2.7%	80.0%	Yes
Ability to resolve my concerns/issues	96.6%	6.3%	92.3%	4.8%	100.0%	0.0%	92.1%	-0.6%	80.0%	Yes
Friendliness and helpfulness	96.6%	3.7%	92.3%	-7.7%	100.0%	3.7%	95.1%	1.5%	80.0%	Yes
MY 2020										
Ability to answer calls promptly	93.0%	2.0%	100.0%	0.0%	100.0%	0.0%	95.0%	0.0%	80.0%	Yes
Ability to resolve my concerns/issues	90.0%	-3.0%	88.0%	-4.0%	100.0%	0.0%	93.0%	0.0%	80.0%	Yes
Friendliness and helpfulness	93.0%	-3.0%	100.0%	4.0%	96.0%	0.0%	94.0%	-2.0%	80.0%	Yes

Goal: Met across all metrics -2021

- "Ability to answer calls promptly" – PMG showed an increase from 2020 of 3.6 percentage points and the other networks showed decreases with VHP having the largest decrease -16.7 percentage points, followed by PC with -15.4 percentage points and Direct with -2.7 percentage points.
- "Ability to resolve my concerns/issues" – PMG and PC showed an increase in satisfaction from 2020 by 6.3 and 4.8 percentage points. VHP had no change in 2021 while Direct had a slight decrease of .6 percentage points.
- "Friendliness/helpfulness" – PMG, VHP and Direct network showed an increase in satisfaction by 3 – 2 percentage points. PC rated satisfaction at 92.3 percentage points with a decrease of -7.7 percentage points from 2020.

Table VI: Provider Relations Staff (Q7a-c)

MY 2021										
Provider Relations Staff	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Ability to answer calls promptly	100.0%	7.0%	69.2%	-19.0%	83.3%	-5.1%	94.1%	1.6%	80.0%	No
Ability to resolve my concerns/issues	100.0%	9.3%	69.2%	-19.0%	83.3%	-5.1%	94.1%	2.2%	80.0%	No
Friendliness and helpfulness	96.4%	3.5%	76.9%	-10.6%	100.0%	11.5%	95.1%	0.8%	80.0%	No
MY 2020										
Ability to answer calls promptly	93.0%	-3.0%	88.0%	-8.0%	88.0%	0.0%	92.0%	-4.0%	80.0%	Yes
Ability to resolve my concerns/issues	91.0%	-3.0%	88.0%	-3.0%	88.0%	0.0%	93.0%	-1.0%	80.0%	Yes
Friendliness and helpfulness	93.0%	-4.0%	87.0%	-12.0%	88.0%	0.0%	94.0%	1.0%	80.0%	Yes

Goal: Not Met - 2021

- "Ability to answer calls promptly" – PMG rated the highest with 100 percentage points and a 7 percentage point increase, while Direct also showed an increase of 1.6 percentage points from year 2020.VHP and PC showed a decrease in satisfaction from 2020. PC fell below the satisfaction rate of 80% with a 69.2 percentage point and the largest decrease of 19 percentage points.
- "Ability to resolve my concerns/issues" – PMG rated the highest with 100 percentage points and a 9.3 percentage point increase. VHP, Direct and PC showed a decrease in satisfaction from 2020. PC fell below the satisfaction rate of 80% with a 69.2 percentage point and the largest decrease of 19 percentage points.
    - "Friendliness/helpfulness" – PMG, VHP and Direct rated above goal for year 2021, while PC rated below goal with 76.9% and the largest decrease of -10.6 percentage points.

Table VII: Provider Network (Q8a-c)

MY 2021										
Provider Network	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Quality of Provider Network	82.1%	-12.9%	92.3%	12.3%	100.0%	17.2%	93.4%	10.5%	80.0%	Yes
Availability of Medical Health Providers	74.1%	-22.1%	91.7%	-1.7%	72.7%	0.3%	93.0	-2.3%	80.0%	No
Availability of Behavioral Health Providers	57.1%	-22.5%	63.6%	-9.7%	72.7%	0.3%	48.9%	-19.7%	80.0%	No
MY 2020										
Quality of Provider Network	95.0%	-2.0%	80.0%	-16.0%	83.0%	0.0%	83.0%	-6.0%	80.0%	Yes
Availability of Medical Health Providers	96.0%	-4.0%	93.0%	-2.0%	72.0%	0.0%	95.0%	7.0%	80.0%	No
Availability of Behavioral Health Providers	80.0%	-13.0%	73.0%	-13.0%	72.0%	0.0%	67.0%	3.0%	80.0%	No

Goal: Q8a met. Q8b-c not met.

- "Quality of provider network" – PMG, showed a decrease in satisfaction of -12.9 percentage points from 2020 but maintained goal along with PC, VHP and Direct met the satisfaction goal of 80%.

- "Availability of medical health providers" – PMG showed the largest decrease in satisfaction overall with a -22.1 percentage point, followed by PC showed a decrease in satisfaction from 2020 of 1.7 percentage points, VHP fell below the goal of 80% with a 72.7 percentage points and Direct showed a decrease in satisfaction of 2.3 percentage points...

- "Availability of behavioral health providers" –

- Direct rate the lowest with a 48.9%, followed by PMG at 57.1%, PC rated satisfaction at 63.6% And VHP rated below the goal at 72.7 percentage points.

Table XIII: SCFHP's Language Assistance Program (Q9a-c)

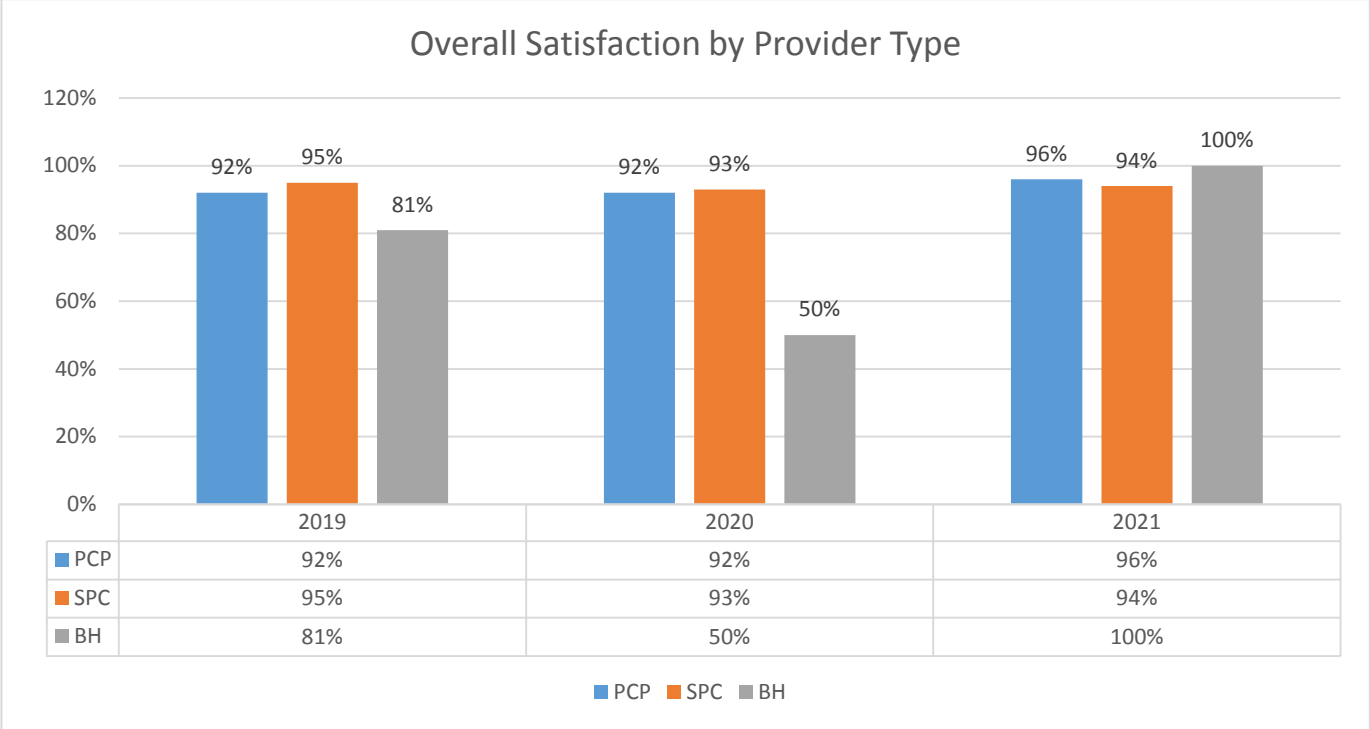
MY 2021										
SCFHP's Language Assistance Program	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Coordination of Appointments with an interpreter	100.0%	8.3%	100.0%	0.0%	100.0%	0.0%	94.7%	-1.9%	80.0%	Yes
Availability of an appropriate range of interpreters	100.0%	8.3%	100.0%	0.0%	100.0%	0.0%	94.6%	-2.1%	80.0%	Yes
Training and competency of interpreters	100.0%	8.6%	100.0%	0.0%	100.0%	0.0%	94.6%	-1.9%	80.0%	Yes
MY 2020										
Coordination of Appointments with an interpreter	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-1.0%	80.0%	Yes
Availability of an appropriate range of interpreters	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-2.0%	80.0%	Yes
Training and competency of interpreters	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-1.0%	80.0%	Yes

Goal: Met - 2021

- PMG, PC and VHP rated satisfaction at 100% across all metrics, while Direct rated 94.7 and 94.6 with a decrease of -2.1 percentage points and -1.9 percentage points.

A. Overall Provider Satisfaction with SCFHP (Q10)

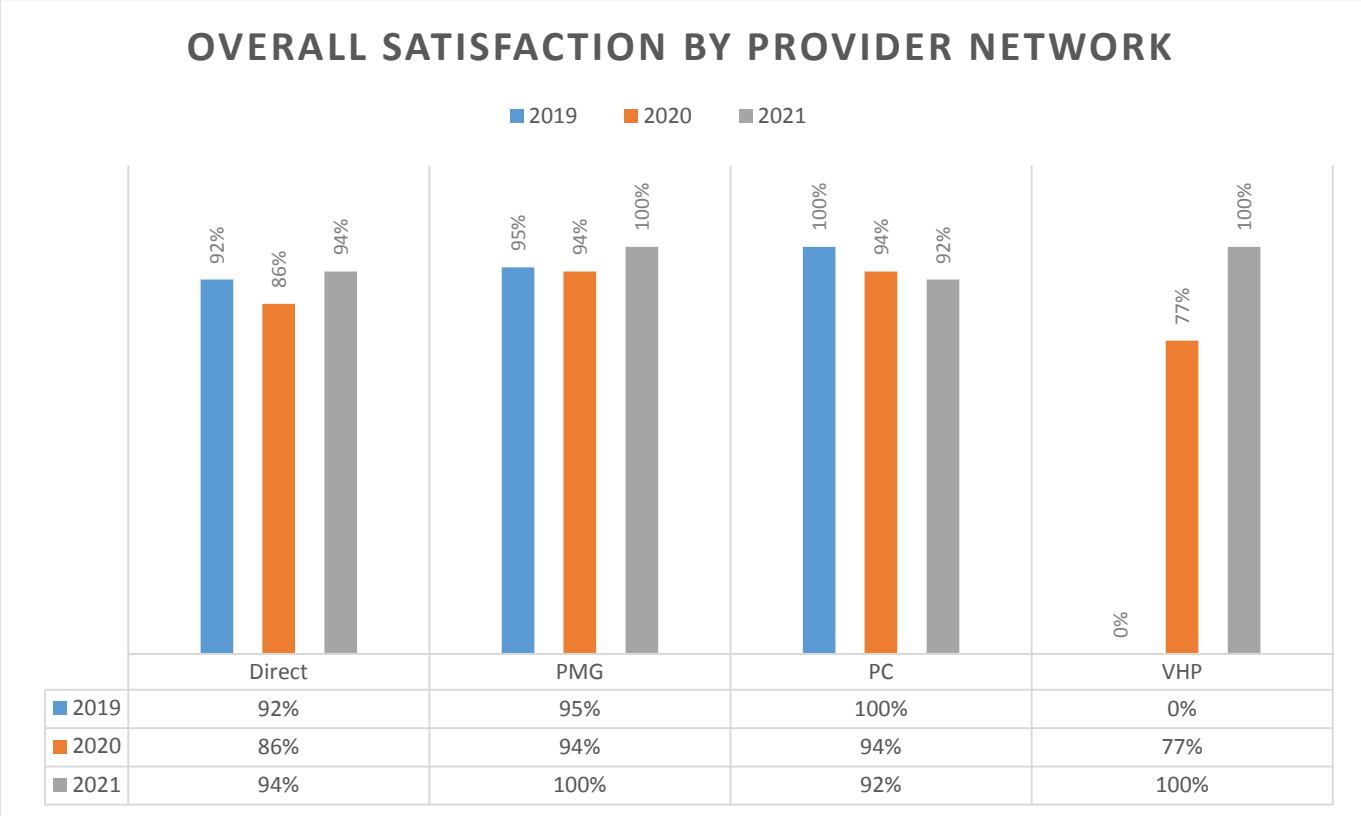
Chart A: Overall Satisfaction by Provider Type



- BH providers rated satisfaction the highest at 100% - a 50 point increase from 2020, and 11 point increase from 2019.
- PCP providers rated satisfaction at 96% - an increase of 4 points from 2020 and from 2019.

- Specialist providers rated satisfaction the lowest at 94% - 1 point increase from 2020, and 1 point decrease from 2019.

Chart B: Overall Satisfaction by Provider Network



	Direct	PMG	PC	VHP
2019	92%	95%	100%	0%
2020	86%	94%	94%	77%
2021	94%	100%	92%	100%

- Direct rated satisfaction at 94% 2021- a 6 point increase from 2020.
- PMG rated satisfaction at 100% 2021 - a 6 point increase from 2020.
- PC rated satisfaction at 92% 2021 - a 2 point drop from 2020.
- VHP rated satisfaction at 100% 2021 - 13 points increase from 2020.

.

B. Conclusion:

While the Plan is pleased that most measures met the Plan's performance goals, and overall results indicate strengths in most operational areas, SCFHP business units will collaborate internally on specific areas, and if operational issues are identified, a correction plan will be established.

SCFHP values its network providers and will continue to improve operations to satisfy and meet provider needs and expectations.

I. MEMBER ACCESS GRIEVANCES

Table I: Access Complaint Record

Jan 2020 – Dec 2020

Provider/Service Type	Totals	Resolved In Favor of Member	Resolved In Favor of Plan	Withdrawn
Interpreter Services	2	2		
Office Wait Time	4	4		
Physical Access to Facility	1	1		
Provider Directory Error	1	1		
Provider Not Accepting New Patients	5	2	3	
Provider Telephone Access	30	25		5
SCFHP Telephone Access	1	1		
Specialist Telephone Access	2	1		1
Timely Access to Non-Medical Transportation	3	2	1	

Timely Access to Primary Care Provider	35	30	1	4
Timely Access to Specialist	26	23		3
Totals	**110**	**92**	**5**	**13**

Quantitative Analysis (Table I): As shown in the table, there were a total of 110 member complaints relevant to access. The three highest percentage of member complaints was at 32% relevant to Timely Access to Primary Care Provider, followed by Provider Telephone Access at 27%, and Timely Access to Specialist 24%.

Provider Network Operations department is currently monitoring complaints and is working directly with specific transportation vendors to ensure that member complaints are addressed.

Qualitative Analysis: The review showed that member complaints are resolved expeditiously and no barriers appear to be present in resolving member access complaints. No trending or concerns with specific provider types and/or geographic areas were identified in the member complaint assessment. As noted, the increase in transportation complaints initiated an action plan to closely monitor complaints and to work directly with transportation vendors specifically to improve services and decrease member complaints.

Conclusion

Overall member complaints were within normal limits.

Overall Conclusions:

- Appointment surveys showed improvement in access across most provider types. However, there are potential areas that may need to be addressed.

  Potential focus area(s):

  - BH appointment access –

    1. Urgent Care

  - SPC appointment access

    1. Gynecology – Urgent Care
    2. Oncology – Urgent Care

- After-hours survey – PCP and BH providers exceeded goal on “access” (911 messaging) and fell short of goal on “timeliness”.

Potential focus area(s):

- Messaging on timeliness (call back within 30min or less)

- Member experience survey (CAHPS) showed marked improvements in several areas, specifically the rating of the Plan, which increased by 6 percentage points in 2020.

Potential focus area(s):

- Getting seen within 15min of appointment

- Provider experience survey indicated a reasonable overall satisfaction rating in 2021.

Potential focus area(s):

- Specialist Providers – Overall satisfaction rating with SCFHP is 94%.
- Timely appointment access to non-urgent behavioral health care.

The assessments in this report revealed potential barriers in access, therefore the Plan established opportunities and interventions for 2020/2021 as outlined in the grid below --

OPPORTUNITIES

Barrier	Opportunity	Intervention	Selected for 2020/2021	Date Initiated
Timely appointment access	• Notify providers of non-compliance.	• Submit a CAP to non-compliant providers and require an action plan within 30-days.	Yes	11/2020
After-hours timeliness (call back within 30min)	• Notify providers of non-compliance.	• Submit a CAP to non-compliant providers and require them to submit an action plan within 30-days. • CAP to include non-compliant phone numbers.	Yes Yes	11/2020 11/2020
In-office wait times not to exceed 15-minutes.	• Educate providers on in-office wait times.	• Submit SCFHP's access matrix to the entire provider network via fax blast.	Yes	03/2021

Santa Clara Family Health Plan™

Quality Improvement Committee

Q3 2021 Grievance & Appeals Data

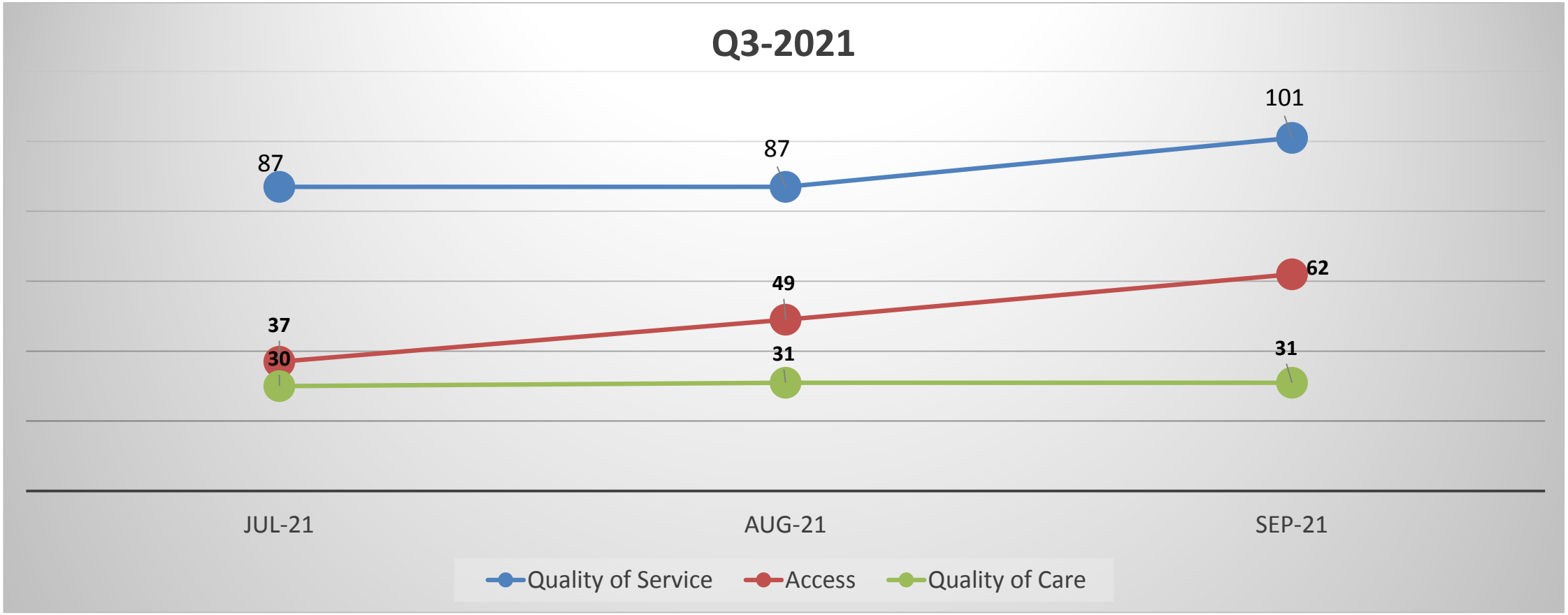
Total Grievances & Appeals

(*Rate per 1000 Members*)

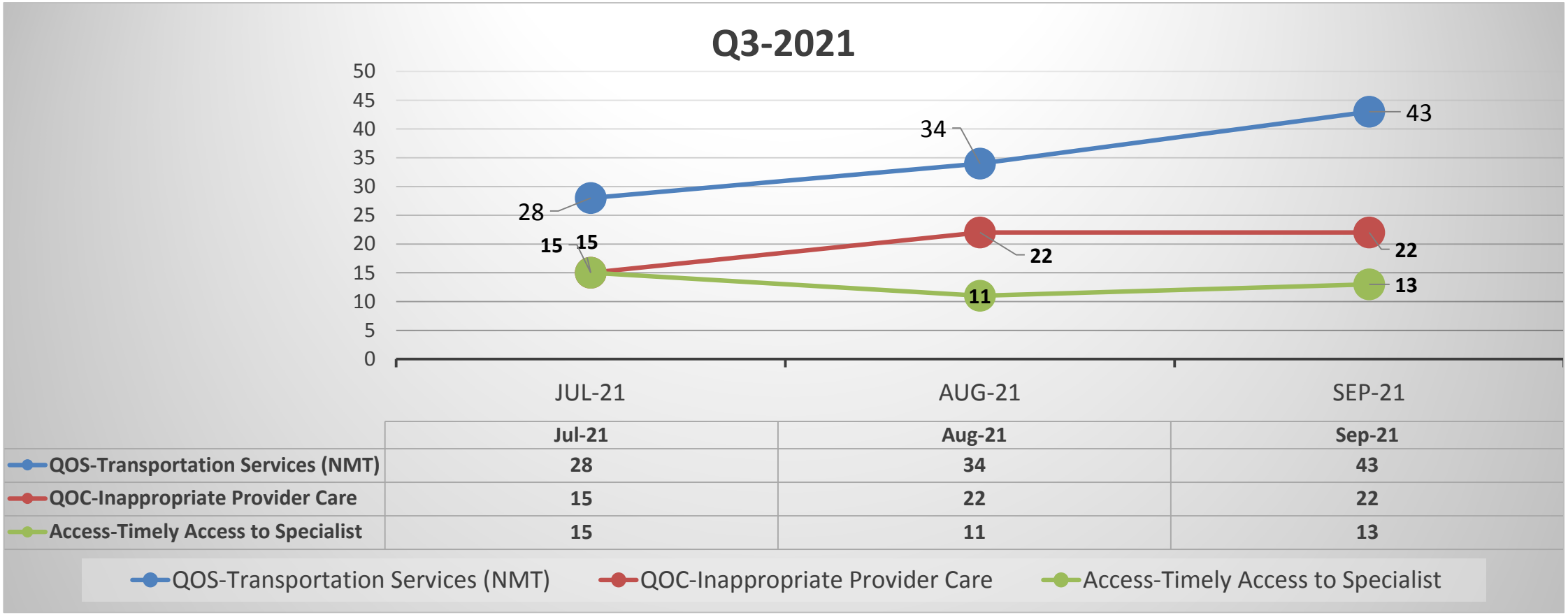
	Jul-20	Aug-20	Sep-20	Jul-21	Aug-21	Sep-21
Total Appeals	**45**	**53**	**53**	**45**	**41**	**36**
CMC Total Membership				**10,148**	**10,245**	**10,325**
Rate per 1,000				8.96816	5.80639	5.95238
Total Grievances	**104**	**94**	**95**	**106**	**102**	**127**
CMC Total Membership				**10,148**	**10,245**	**10,325**
Rate per 1,000				12.8980	10.1111	9.82143

	Jul-20	Aug-20	Sep-20	Jul-21	Aug-21	Sep-21
Total Appeals	86	77	83	85	79	98
MC Total Membership				**274,030**	**275,227**	**276,227**
Rate per 1,000				0.34195	0.32074	0.45490
Total Grievances	126	133	156	174	187	211
MC Total Membership				**269,043**	**275,227**	**276,227**
Rate per 1,000				0.73966	0.54194	0.71903

Q3 2021:Top 3 Medi-Cal Grievance Categories

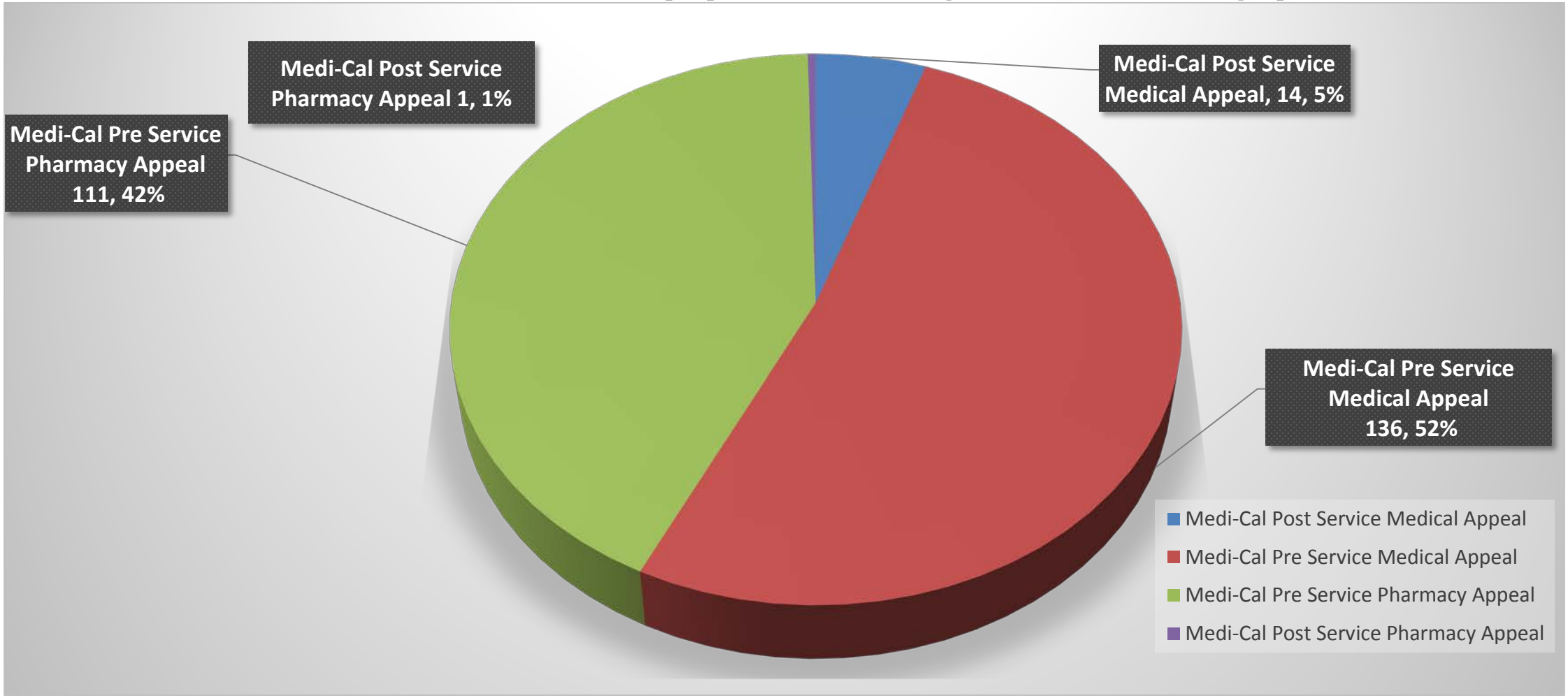


Q3 2021:Top 3 Medi-Cal Grievance Subcategories

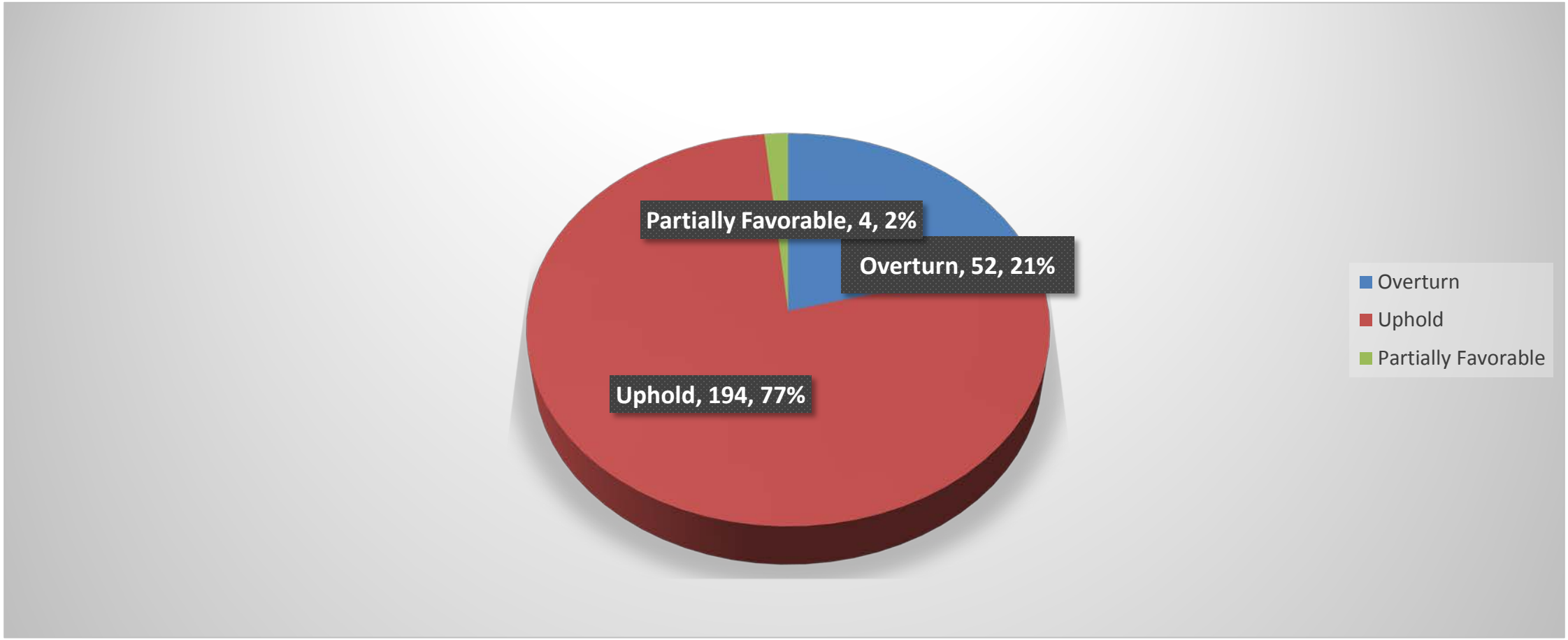


	Jul-21	Aug-21	Sep-21
QOS-Transportation Services (NMT)	28	34	43
QOC-Inappropriate Provider Care	15	22	22
Access-Timely Access to Specialist	15	11	13

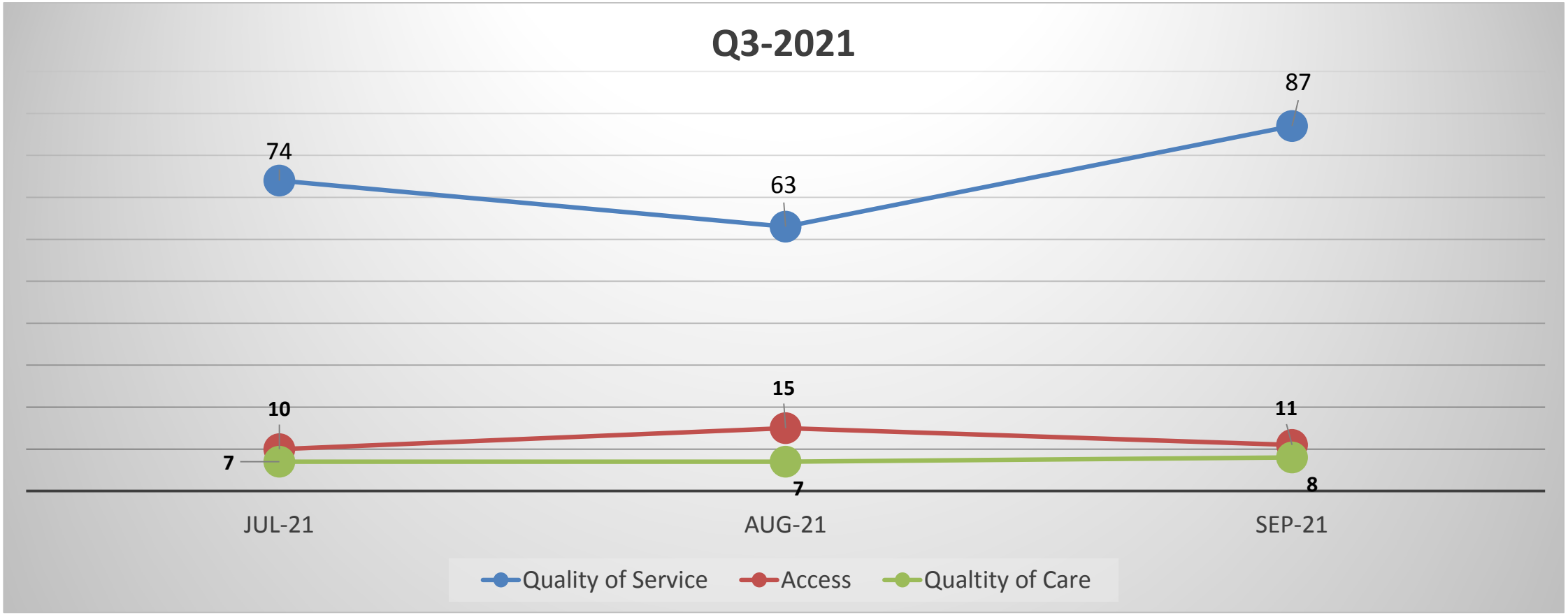
Q3 2021 Medi-Cal Appeals by Case Type



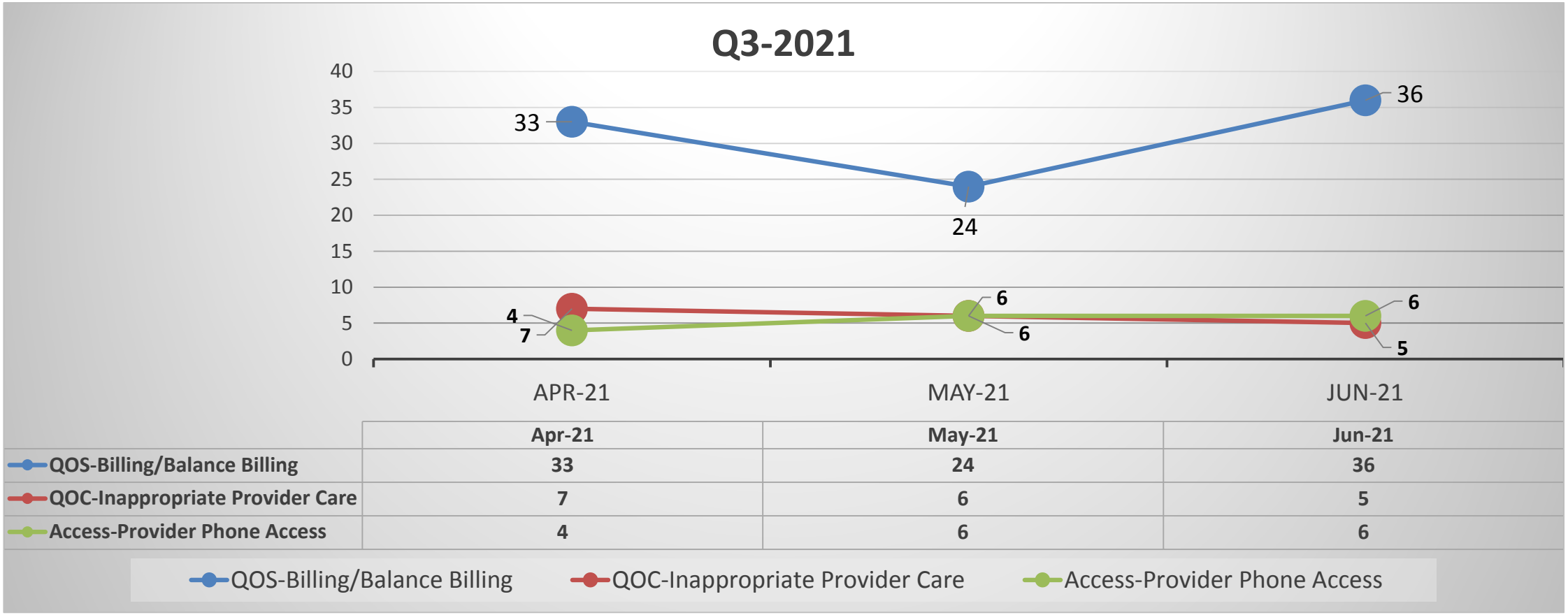
Q3 2021 MC Appeals by Disposition



Q3 2021:Top 3 Cal MediConnect Grievance Categories

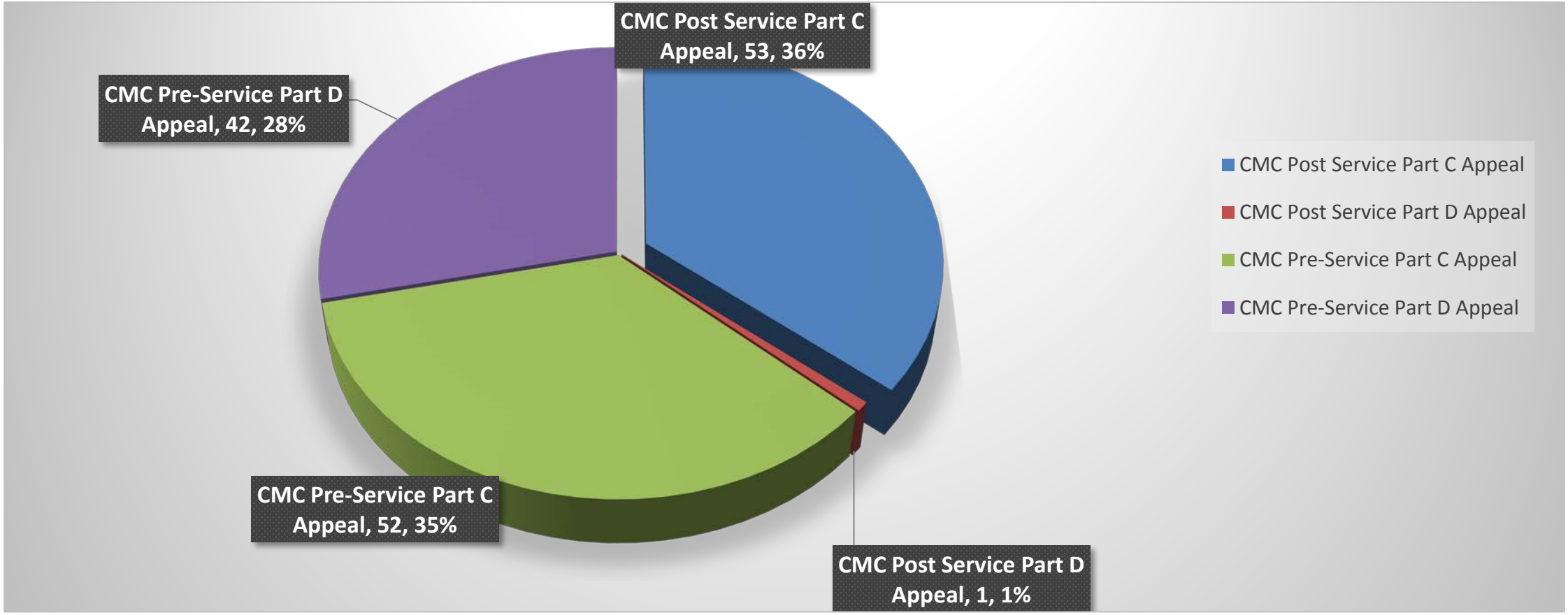


Q3 2021:Top 3 Cal MediConnect Grievance Subcategories

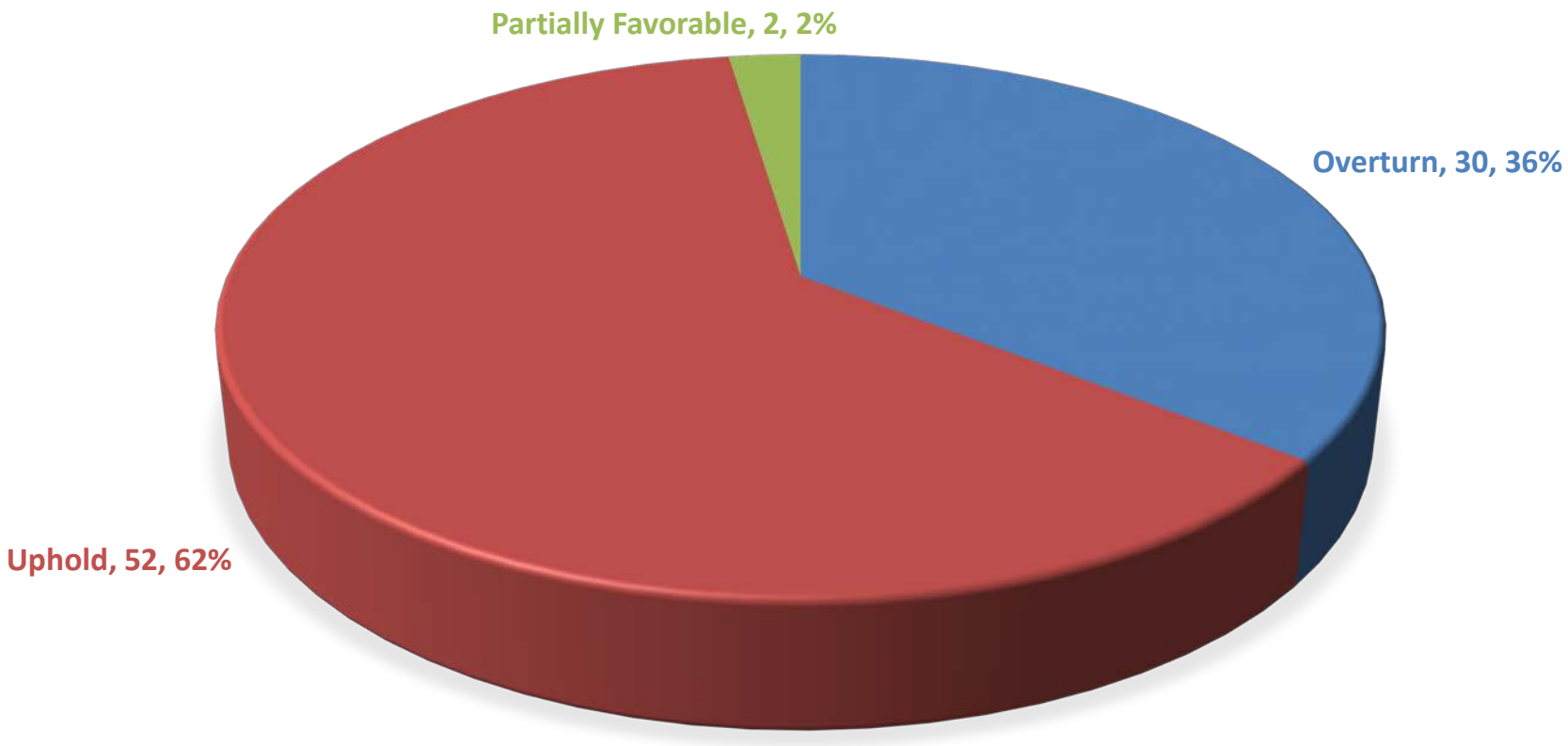


	Apr-21	May-21	Jun-21
QOS-Billing/Balance Billing	33	24	36
QOC-Inappropriate Provider Care	7	6	5
Access-Provider Phone Access	4	6	6

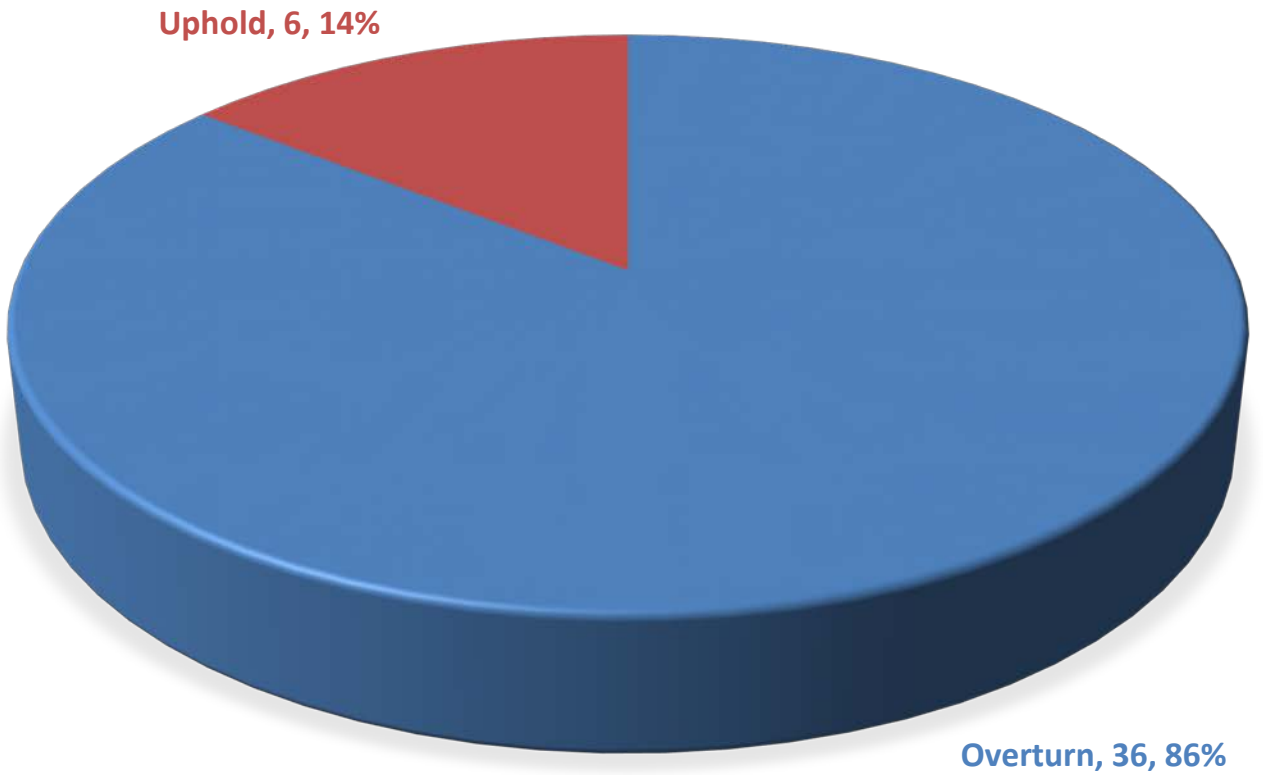
Q3 2021 CMC Appeals by Case Type



Q2 2021 CMC Pre-Service Appeals by Disposition



Q2 2021 CMC Post-Service Appeals by Disposition



Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, October 20, 2021 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Ngon Hoang Dinh, OB/GYN
Laurie Nakahira, D.O., Chief Medical Officer
Habib Tobbagi, PCP, Nephrology
Indira Vemuri, Pediatric Specialist

Members Absent
Dung Van Cai, D.O., Head & Neck

Staff Present
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Hoang Mai Vu, Utilization Management & Discharge Planning Nurse
Amy O'Brien, Administrative Assistant

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:08 p.m. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The minutes of the July 21, 2021 Utilization Management Committee (UMC) meeting were reviewed.

   It was moved, seconded, and the minutes of the July 21, 2021 UMC meeting were **unanimously approved.**

   Motion: Dr. Tobbagi
   Seconded: Dr. Alkoraishi
   Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi, Dr. Vemuri
   Absent: Dr. Cai, Dr. Dinh

4. **Chief Executive Officer Update**

   This item was addressed during the Chief Medical Officer update.

5. **Chief Medical Officer Update**

   a. **General Update**

   Dr. Laurie Nakahira, Chief Medical Officer, gave the Chief Executive Officer update. The CalAIM Enhanced Case Management (ECM) and In-Lieu-of Services (ILOS) programs will roll-out on January 1, 2022. The Medi-Cal Rx carve-out will also begin on January 1, 2022. The Blanca Alvarado Community Resource Center (CRC) held a soft Grand Opening in September and there are virtual classes and services available. The

pop-up vaccination clinics will continue at the CRC. SCFHP is continuing to develop the programming and anticipating a formal Grand Opening with in-person classes, programs, and services.

Dr. Nakahira continued with the Chief Medical Officer update, and she discussed the COVID vaccine disparity project. There is a 20% gap between residents of the County of Santa Clara, with an almost 90% vaccination rate, and SCFHP plan membership, with a 20% lower vaccination rate. The COVID vaccine disparity project will work to close this gap. Dr. Lin remarked that he does not see his patients in person unless they are fully vaccinated. Dr. Nakahira agreed, and the Plan is encouraging members to either attend a drive-through vaccination clinic, or to get a vaccination at their pharmacy when they pick up their regular medications.

b. Cal MediConnect NCQA Audit Timeline

Dr. Nakahira advised the committee that the Plan is currently preparing for the National Committee for Quality Assurance (NCQA) resurvey audit for our Cal MediConnect (CMC) line of business. The onsite portion of the audit runs from January 31, 2022 through February 1, 2022.

6. Old Business/Follow-Up Items

a. General Old Business

There was no general old business to discuss this evening.

b. Plan All-Cause Readmissions Rates Due to COVID-19

Hoang Mai Vu, Utilization Management and Discharge Planning Nurse, gave an overview of the impact of COVID on the CY2020 Plan All-Cause Readmissions (PCR) rates. Ms. Vu explained that the majority of COVID admissions for our CMC members occurred at O'Conner Hospital and Regional Medical Center. These indicators represent approximately 10.50% of the total PCR rates for the year 2020. The majority of COVID admissions for our Medi-Cal (MC) members occurred at Regional Medical Center and Valley Medical Center. These indicators represent approximately 9.55% of the total PCR rates for the year 2020.

Dr. Lin asked about the number of deaths due to COVID. Ms. Vu responded that she does not have this information available at this time. She will research this information and provide the details to Dr. Lin in a follow-up email.

7. Summary of DMHC Final Report - 2020

Ms. Vu summarized the findings of the DMHC Final Report for Routine Survey of 2020. Ms. Vu explained that two deficiencies were found. Deficiency #1 found that the Plan did not conduct adequate oversight of its delegates to ensure compliance with UM denial letter requirements. This deficiency was corrected as of August 2021. Deficiency #2 found that the Plan did not provide evidence that post-stabilization medical care is deemed authorized if the request is not approved within 30 minutes. Ms. Vu highlighted the processes and procedures that were put in place to correct these deficiencies.

8. UM Delegate Oversight Matrix Dashboard

Ms. Vu presented the results of the UM department's Prior Authorization (PA) delegation oversight from March through September of 2021. Ms. Vu explained that these results were impacted by COVID, as well as by staff attrition. One deficiency noted was that templates for members' threshold languages were not correctly used, as there was no criteria listed as the basis for a decision. Another common deficiency was the lack of direct phone numbers for peer-to-peer reviews. Ms. Vu advised that, going forward, there should be more consistent results by the time of our January 2022 meeting.

9. Inter-Rater Reliability (IRR) BH Report - 2021

Natalie McKelvey, Manager, Behavioral Health (BH), presented the results of the BH IRR testing conducted in September 2021. Ms. McKelvey explained that all staff members passed the tests. As of September 2021, the Plan's 2 medical directors and the Chief Medical Officer were also included in the testing process.

10. Medical Covered Services Prior Authorization (PA) Grid

Ms. Vu highlighted the minor change to the Medical Covered Services PA Grid. Ms. Vu explained that under the category of 'Outpatient Services and Procedures', endoscopy has been updated to include 'All types of endoscopy except colonoscopy and nasal endoscopy'.

Dr. Lin asked how many of our members requested gender reassignment, and how the Plan compares to private sector plans such as Blue Cross and Blue Shield. Ms. Vu and Dr. Nakahira responded that it is a relatively small number of our members that request gender reassignment. Dr. Nakahira will work with Dr. Boris to research this topic and discuss their findings at our January 19, 2022 meeting.

It was moved, seconded, and the Medical Covered Services PA Grid was **unanimously approved.**

Motion: Dr. Alkoraishi
Seconded: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi, Dr. Vemuri
Absent: Dr. Cai, Dr. Dinh

11. Reports

a. Membership

Dr. Nakahira gave a brief summary of the Membership Report from October 2020 through October 2021. Our CMC membership continues to grow with 10,368 members as of October 2021. This is largely due to the pause on MC redeterminations due to COVID-19. The Plan is waiting for the Department of Healthcare Services (DHCS) to advise when they will resume the MC redeterminations process. Dr. Nakahira explained that there is an error in the total number of MC members as of October 2021. Our total MC membership is not 554,334. The Plan's total MC membership is 277,130 members, an increase of approximately 1,000 members from September 2021, and approximately 20,000 members from October 2020.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Nakahira presented the Committee with the UM objectives and goals. Dr. Nakahira advised that these metrics cover the period from December 1, 2020 through September 30, 2021. Dr. Nakahira gave a summary of the data for the Plan's MC SPD line of business. The number of discharges per thousand is 13.50, with an average length of stay of 5.43 days. Dr. Lin asked if these numbers are comparable to other counties, such as Los Angeles county. Dr. Nakahira replied that these numbers are used as a benchmark of where the Plan stands at this time. The UM department will research this information in comparison to other counties, and present it during the January 19, 2022 meeting. Dr. Nakahira continued with a summary of the data for the Plan's MC non-SPD line of business. The number of discharges per thousand is 3.78, with an average length of stay of 4.30 days.

Dr. Nakahira then gave a summary of the data for the Plan's CMC line of business. The number of discharges per thousand is 18.20, with an average length of stay of 5.71 days. This line of business includes a more high risk population.

Dr. Nakahira continued with a comparison of the inpatient utilization rates for the Plan's MC non-SPD and SPD populations. Dr. Nakahira also summarized the inpatient readmissions rates for the MC lines of business. The 10.47% increase in the readmission rate may have been impacted by COVID-19. The UM department has a plan in place to decrease the admissions and readmissions rates. Dr. Lin asked what the goal is, and Dr. Nakahira responded that the goal is actually 7%. This has been a real challenge, as the number of preventive care visits was impacted by COVID. Dr. Nakahira continued her summarization with a discussion of inpatient readmissions rates for the Plan's CMC line of business. This data does not cover a full year.

Dr. Nakahira concluded with an overview of the ADHD MC BH metrics. The UM department hopes to continue to increase these rankings through increased telehealth, primary care, and behavioral health care visits. The antidepressant medication management measures are on track for 2021. It has been a challenge

to meet the rankings for the cardiovascular measures. Dr. Lin asked for a definition of the 10th percentile, and Dr. Nakahira explained how the rankings are determined and what they mean.

Dr. Alkoraishi asked why these measures do not include schizophrenia, schizoaffective disorder, and bipolar 1 disorder. Dr. Nakahira responded that these measurements are driven by NCQA criteria. Ms. McKelvey added that, for this particular Healthcare Effectiveness Data and Information Set (HEDIS) health metric, the Plan looked only at schizophrenia during the first year. Thereafter, the Plan did open it up to all schizophrenia types, not including bi-polar disorder. In order to meet NCQA requirements, the Plan is trying interventions to help increase these scores; however, HEDIS is specific to the schizophrenia diagnosis. Dr. Lin asked if the Plan will be able to capture prescription data for anti-depressant medication, and Ms. McKelvey responded that the Plan will have access to pharmacy data.

c. Dashboard Metrics

- Turn-Around Time – Q3 2021

Mr. Perez summarized the CMC Turn-Around Time metrics for Q3 2021. The turn-around times in all categories are compliant at 98.7% or better, with many categories at 100%. Dr. Lin asked for clarification of the Part C categories. Mr. Perez replied that those are outpatient services and procedures. Mr. Perez confirmed for Dr. Lin that Part B means Medicare Part B drugs. Mr. Perez next summarized the MC Turn-Around Time metrics for Q3 2021. The turn-around times in the majority of MC categories are compliant at 98.3% or better. In the category of Provider Notification of UM decisions within 24 hours, August fell slightly short at 96.8%, which brought Q3 down to 97.9%. Mr. Perez explained this last category includes the work that occurs at the end of the authorization process, and the Plan's goal is to achieve 100% in all categories each quarter.

Dr. Dinh joined the meeting at 6:48 p.m.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q3 2021

Ms. Vu summarized the data from the Q3 2021 CMC Quarterly Referral Tracking report for the Committee. This report covers the period from July 1, 2021 through September 30, 2021. Ms. Vu explained that, for Q3 2021, the Plan approved 800 more services than Q2 2021. The Plan is 7% higher than last quarter for remaining unclaimed services.

Ms. Vu continued and summarized the data from the Q3 2021 MC Quarterly Referral Tracking report. Ms. Vu explained that there were a significant number of unclaimed hospital services. Dr. Lin asked why this number is so high. Ms. Vu explained that it is likely these were elective procedures. The Plan approves elective procedures for a period of 3 months. It is possible these procedures have not yet occurred. In Q3 2021, the Plan approved 1,300 more services than Q2 2021. The Plan is 8% higher than last quarter for remaining unclaimed services.

Dr. Lin asked if the Plan uses auto-approval or if staff individually approves these. Ms. Vu clarified that the Plan does not do auto-approvals. Care coordinators, nurses, or medical directors review and approve services. Ms. Vu also clarified that the grand total represents all services combined.

Dr. Tobaggi asked how many times the Plan errs on the side of approval to avoid problems if services are denied. Dr. Nakahira explained that medical directors review approvals, and disapprovals, on a regular basis. Only the medical directors can deny services. Staff members are not incentivized to issue approvals for services. Dr. Nakahira emphasized that, regardless of the service, all medical criteria must be met as per the standards of care guidelines.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q3 2021

Ms. Vu presented the results of the Q3 2021 Quality Monitoring of Plan Authorizations and Denial Letters from July 1, 2021 through September 30, 2021. Ms. Vu reported that the UM department received a 100% score in all categories. All findings are reviewed on a quarterly basis, with oversight by the Plan's medical directors.

f. Behavioral Health (BH) UM

Ms. Natalie McKelvey, Manager, BH, gave an overview of the BHT program for the committee. Ms. McKelvey highlighted the screenings that the BH team completed. She also highlighted the number of CMC psychiatric admissions in 2021. Ms. McKelvey pointed out that the 408 BH claims are not only limited to those members who fall into the mild-to-moderate category, but also includes members who need specialty BH services. Medicare does not make a distinction, so she is unable to separate specialty services. Ms. McKelvey continued with the number of CMC unique members who received services. She expected this number to be higher in 2021, and this might be due to the number of in person office visits versus telehealth care.

Kaiser Permanente and VHP are delegated for their BHT services. Kaiser has the highest number of ABA members in treatment, per 1,000 members. The Plan has oversight of the utilization guidelines and criteria for those networks that are not delegated to ensure all kids receive the appropriate treatment and services. Dr. Lin commented that it is good the Plan gives our members plenty of BH support.

12. Adjournment

The meeting adjourned at 7:17 p.m. The next meeting of the Utilization Management Commitment is on January 19, 2022 at 6:00 p.m.

_____ _____

Jimmy Lin, M.D, Chair
Utilization Management Committee

Date

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Monitoring or Meeting Period:

Credentialing Committee 10/06/2021

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	15	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	22	
Number practitioners recredentialed within 36-month timeline	22	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 09/30/2021	634	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1346	1036	755	812	403	456

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Regular Meeting of the

Santa Clara County Health Authority1
Provider Advisory Council (PAC)

Wednesday, November 10, 2021, 12:15 – 1:45 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Committee Members Present
Thad Padua, MD, Chair
Clara Adams, LCSW
Dolly Goel, MD
Bridget Harrison, MD
Jimmy Lin, MD
David Mineta
Peter L. Nguyen, DO
Sherri Sager
Meg Tabaka, MD

Committee Members Absent
Michael Griffis, MD
Pedro Alvarez, MD

Additional Attendees
Jack Pollack, MD, Guest

Staff Present
Christine Tomcala, Chief Executive Officer
Dang Huynh, PharmD, Director, Pharmacy & Utilization Management
Janet Gambatese, Director, Provider Network Operations
Johanna Liu, PharmD, Director, Quality & Process Improvement
Brandon Engelbert, Manager, Provider Network Operations
Robyn Esparza, Administrative Assistant

Staff Absent
Laurie Nakahira, DO, Chief Medical Officer

Additional Staff
Jessica Bautista, Manager, Community Based Case Management
Nicole Bell, Manager, Home & Community Based Services Program Manager
Karen Fadley, Manager, Provider Data, Credentialing and Reporting
Stephanie Vielma, Manager, Provider Performance Program

1. **Roll Call/Establish Quorum**

   Thad Padua, MD, Chair, called the meeting to order at 12:20 pm. Roll call was taken and a quorum was established.

   Dr. Padua introduced Dr. Jack Pollack and welcomed him as a new member of the Provider Advisory Council (PAC).

   Dr. Padua noted that new member Dr. Ghislaine Guez could not attend today's meeting. She will be in attendance at the next meeting on February 9, 2022, and will be officially welcomed to the council then..

2. **Public Comment**

   There was no public comment.

3. Meeting Minutes

The minutes of the August 11, 2021, Provider Advisory Council (PAC) meeting were reviewed.

It was moved, seconded, and the August 11, 2021, Provider Advisory Council (PAC) minutes were **unanimously approved.**

Motion: Dr. Peter Nguyen
Second: Mr. David Mineta
Ayes: Ms. Adams, Dr. Goel, Dr. Harrison, Dr. Lin, Mr. Mineta, Dr. Nguyen, Dr. Padua, Ms. Sager, Dr. Tabaka

4. Chief Executive Officer Update

Ms. Christine Tomcala, CEO, presented the November 2021 Enrollment Summary, noting a total enrollment of 289,288, with 10,415 members in Cal MediConnect (CMC) and 278,873 members in Medi-Cal(MC).

Ms. Tomcala noted COVID continues to be the focus of the Plan. She noted the Plan would like to narrow, if not close, the gap between the vaccine percentages of our Medi-Cal members compared to the county as a whole. In most counties around the state, it runs about a 20% difference. To help close the gap, the Plan has held some vaccine clinics at our new Blanco Alvarado Community Resource Center in collaboration with the county's vaccination efforts.

Ms. Tomcala noted the Plan is also in the process of sponsoring other community-based organization events to encourage the remaining population to get vaccinated. The Plan is offering a $50 incentive for members ages 12 and up, who have not yet been vaccinated to get a vaccine.

Dr. Bridget Harrison asked if the $50 is automatically sent to members. Ms. Tomcala confirmed incentives would automatically be sent to members. She noted the member does not have to take any action and that it is based on claims information received by the Plan.

Dr. Harrison inquired about the difference between the local vaccination rate and our membership vaccination rate. Ms. Tomcala noted the difference is roughly about 20%, and in general, the Plan is the second-highest health plan in the state for Medi-Cal membership vaccination rates. Even though the Plan is still lagging 20 percentage points, our county does so well that our population is more vaccinated than any other population, other than San Francisco, which might be a touch more than us. She noted we are doing very well from that perspective, but we still have that 20% gap as many of the counties do.

5. Pharmacy

a. Review and Discuss the Current Drug Reports

Dr. Dang Huynh, Director, Pharmacy and Utilization Management, presented the drug utilization reports for the '2021 Q3 Top 10 Drugs by Total Cost' and 'Top 10 Drug Classes by Prior Authorization Volume' for the reporting period of July 1, 2021 – September 30, 2021.

For MC, Dr. Huynh noted cost were related to diabetes, cancer, and biologics for psoriasis and rheumatoid arthritis. Claims have increased to about 15,000 claims with an increase of about a million dollars quarter over quarter.

For CMC, same drug mix as the previous quarter, which includes diabetes and HIV. Eliquis, a drug used to treat atrial fibrillation to prevent clotting, came in tenth. Overall, there was an increase of roughly 3,000 claims and about half a million dollars versus last quarter.

Medi-Cal Prior Authorization (PA) volume were similar to the previous quarter. The volume decreased roughly to about 100 for our MC and 76 for our CMC. CMC Pas volume remains low. Therefore, any increases of a couple PAs may cause the drug to be on the list. Prolia, which is used to treat bone health, had a slight increase in requests. It was previously ranked at 268 and is now ranked 3rd.

b. Pharmacy Updates

Medi-Cal RX

Dr. Huynh provided an update on the Medi-Cal RX, state wide pharmacy benefit FFS carve for MC. The 60-day member notice has gone out. The plan is currently working on updating a provider communication. There will be internal training again as well. The Plan was previously prepared for all this before the multiple delays from the State. Plan is on track for the transition with training and communication. Dr. Huynh also noted that DHCS and Magellan has computer-based training on the Medi-Cal Rx portal. The Plan is still working with DHCS to finalize some recommendations for scope of medical vs pharmacy billing. The state is still working on closing the gap in terms of drugs and items typically covered by managed care plans, but not on the State's contracted drug list. The state has announced they will allow alcohol pads to be billable under Medi-Cal Rx.

Dr. Huynh provided an update that therapeutic continuous glucose monitors (CGMs) for Type 1 diabetes will be a Medi-Cal benefit and may be billed through the pharmacy effective 1/1/2022.

COVID Vaccinations

Dr. Huynh noted the plan is working with our local independent pharmacies to close the gap on COVID-19 vaccinations. We have reached out to all the independent pharmacies in the county. Those independent pharmacies are reaching out to our members to provide education and answer any questions on any hesitancy regarding the vaccination. These independent sites are covered sites and we are happy that they are willing to collaborate with us on this matter.

Regarding the COVID-19 vaccination costs as well as the administration fee, all the pharmacies are billing to Medicare FFS for right now. Starting 1/1/22, the financial responsibility will land on the Plan.

6. Utilization Management

a. UM Updates

Dr. Dang Huynh, Director, Pharmacy and Utilization Management, provided an update to the council regarding the Spanish-speaking blood glucose meter. He noted the Quality team identified that there were about 200 Hispanic-speaking or Hispanic members that may benefit from the meters. Letters have been sent to both members and providers about the meters. He noted that, as of today, we have about 25 members that are on the meter and we are trying to capture how their A1C is doing. The outreach has only been via letter communication. A Clinical Pharmacist has been hired to do clinical programs. One of the programs they will be doing is to manage diabetes. Initially, the pharmacist will be reaching out to DM members with an A1C greater than 9 in addition to reaching out to the doctors to collaborate and help the physicians manage prescription regimens, coordinate A1C orders and labs, for the member. They will also be speaking with the members to identify any barriers surrounding their diabetes (i.e., diet, medication adherence, transportation). They will also be contacting the remainder of 175 members that have not received the Spanish-speaking meters. In the future, they will be expanding to members with hypertension, hyperlipidemia, CHF, and osteoporosis.

b. Discuss the New Major Organ Transplant (MOT) Carve-in Benefit

Dr. Huynh updated the council that for the MC line of business major organ transplants will be the Plan's plan responsibility, effective January 1, 2022. The plan already does have criteria and processes in place as the plan already has prior authorization processes for the CMC line of business.

7. Quality

Cal MediConnect CAHPS Survey Results 2021

Dr. Johanna Liu presented on the "Cal MediConnect CAHPS Survey Results 2021" and reviewed the findings in detail. CAHPS is a consumer satisfaction survey that the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS). She noted that SCFHP contracts with SPH Analytics to conduct the survey. Results impact NCQA accreditation and health plan star ratings. COVID-19 has had a significant impact on the CAHPS survey methodology and reporting for 2021.

The health plan achieved a 33.5% response rate, which is the highest response rate since CAHPS started in 2016. CAHPS language was integrated into the Customer Service post-call survey and social media platform implemented on March 15, 2021. Dr. Liu reviewed the survey findings outlined in the presentation in detail on the following areas: 'SCFHP's Overall Performance based on SPH Benchmark and CMS National benchmark', 'Overall Performance of Providers', 'Overall Performance of SCFHP', 'Overall CAHPHS Performance from 2019 to 2021', 'Findings by Demographic', 'Estimated NCQA Health insurance Plan Ratings', 'Estimated 2021 CMS Medicare Star Ratings', 'Flowchart - Understanding Relative Performance', 'Successful CAHPS Improvement Projects', and 'Opportunities for Improvement, and Next Steps for CAHPS 2022 Work Plan and Strategies'.

8. Provider Network Operations

a. Discuss the Quality Provider Bonus

Ms. Janet Gambatese, Director, Provider Network Operations (PNO), briefed the council on the Provider Bonus for CY2021. She noted that we recently communicated to our providers about the bonus. We're providing a last-minute quality care gap closure bonus from now until December 31, 2021. We report, these measures to CMS and NCQA to show our health plan quality performance, and hope this end of the year push will help our performance as well as support our providers with an incentive.

She noted this is a one-time bonus for MC and CMC lines of business. The eligible providers are SCFHP PCPs and the target members are those members assigned to each PCP panel. The service timeframe is related to care gaps closed between October 1 and December 31, 2021. The provider memos for MC and CMC are included in the meeting packet, and includes all of the details: the measures, the services to be completed, strategies for gap closures, the provider bonus, and the member incentive.

b. Discuss SCFHP's Objective Regarding Provider Satisfaction

Each year, SCFHP does a survey to providers to rate their satisfaction with Santa Clara County Health Plan (SCFHP). This year, in addition to this regular annual survey we do for regulatory purposes, we are going to conduct an enhanced provider/delegate satisfaction survey, as we have created a plan objective around provider satisfaction. We want to use other tactics such as focus groups, or interviews to gain additional insights into provider and delegate satisfaction, which we will use to establish action plans to increase provider satisfaction. We brought this to PAC to get the council's input as to how we can successfully get providers and delegates to participate in this endeavor, for example, should we do small focus groups, one-on-one meetings, interviews, or any other ideas?

Suggestions from the council included:

- An online survey, such as Survey Monkey, with questions and a field for additional comments.
- Focus groups or one-on-one for small group practitioners.
- Break down the survey into multiple surveys, rather than one long survey.
- Be aware of the timing of the survey, such as do not survey providers at the end of the year, when providers are busier.

9. Old Business

There was no old business discussed.

10. New Business

a. Discuss the 2022 Meeting Calendar

Ms. Gambatese, Director, Provider Network Operations, presented the PAC Meeting Calendar for 2022.

The council will revert to holding all meetings on the second Wednesday of the month, quarterly. The meeting dates are as follows: Wednesday, February 9th, May 11th, August 10th, and November 9th.

b. Discuss Enhanced Care Management (ECM)/Community Support (CS)

The purpose of our presentation is to provide updated information on the CalAim implementation and give the Provider Advisory Council a high level overview of the new Enhanced Care Management benefit and complimentary Community Supports that will launch on January 1, 2022. The overview includes a brief explanation of the benefit and services being offered and how to refer members.

Ms. Jessica Bautista, Manager, Community Based Case Management, provided a detailed presentation on ECM.

Ms. Nicole Bell, Manager, Home & Community Based Services Program Manager, provided a detailed presentation on Community Supports.

11. Discussion / Recommendations

There were no further discussions and/or recommendations.

12. Adjournment

The meeting adjourned at 1:55 p.m. The next meeting is scheduled for Wednesday, February 9, 2022.

_____ _____

Thad Padua, Chair Date

Santa Clara County Health Authority
Updates to Pay Schedule
December 16, 2021

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Accounts Payable Specialist	Annually	51,145	62,652	74,160
Behavioral Health Program Manager	Annually	94,585	120,596	146,607
Copy Writer and Content Strategist	Annually	83,893	104,866	125,840
Director, Community Engagement	Annually	130,587	166,498	202,409
Director, Marketing and Communications	Annually	150,489	195,635	240,782
Director, Medicare Outreach	Annually	150,489	195,635	240,782
Fraud, Waste, and Abuse Program Manager	Annually	94,585	120,596	146,607
Manager, Case Management (Clinical)	Annually	111,138	141,701	172,263
Manager, Case Management (Non-Clinical)	Annually	94,585	120,596	146,607
Manager, Community Outreach	Annually	94,585	120,596	146,607
Manager, Enrollment and Eligibility	Annually	111,138	141,701	172,263
Manager, Provider Performance Program	Annually	94,585	120,596	146,607
Supervisor, Case Management (Non-clinical)	Annually	83,893	104,866	125,840
Supervisor, Production Services	Annually	83,893	104,866	125,840
Supervisor, IT System Support	Annually	94,585	120,596	146,607
Vice President, Marketing, Communication, and Outreach	Annually	216,704	281,715	346,726

Santa Clara County Health Authority
Job Titles <u>Removed</u> from Pay Schedule
December 16, 2021

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Director, Marketing, Communications and Outreach	Annually	150,489	195,635	240,782
Manager, Case Management	Annually	111,138	141,701	172,263

Santa Clara Family Health Plan
Quarterly Investment Compliance Report
For The Quarter Ended September 30, 2021

OVERVIEW

Previous quarterly reports were prepared by Sperry Capital, which is no longer providing these services. The Plan is seeking a replacement firm for Sperry Capital. This report was prepared by the CFO and retains the format used by Sperry Capital.

The California Government Code (the Code), Section 53646, which governs Santa Clara Family Health Plan's (the Plan's) investment policy (the Policy), states that the Chief Financial Officer may render a quarterly report on the status of investment portfolio and cash to the Governing Board.

This quarterly report includes the following:

1. A statement of compliance with the investment policy.
2. A summary of investments & cash held at quarter-end.
3. A statement of SCFHP's ability to meet its expenditure requirements for the next six months.
4. Statements of diversification compliance with investment policies from the County of Santa Clara & Wells Fargo Bank.
5. Details of investment diversification.
6. Analysis of, and commentary on, investment yield.
7. Reports & other reference materials

1. COMPLIANCE WITH THE INVESTMENT POLICY

The Plan's Investments and Cash & Equivalent accounts include the following:

1. Investments
    a. County of Santa Clara Comingled Investment Pool (County Investment Pool)
    b. Wells Fargo Investment Management Portfolio (Portfolio Investments)

2. Cash & Equivalents
    a. Wells Fargo Stagecoach Money Market Fund (Sweep Account)
    b. Bank of the West Money Market Account (Money Market Account)
    c. Chase Bank account (Lockbox account)

Following review of the quarterly investment reports of the above-listed accounts, all investments made by Santa Clara County and Wells Fargo Asset Management were compliant with Santa Clara Family Health Plan's 2021 Investment Policy (adopted at the Executive/Finance Committee meeting of April 22, 2021, attached to this report) and with the California Government Code.

2. PORTFOLIO SUMMARY

The quarter-end value of the Investments and Cash & Equivalents accounts were as follows:

CHART #1: PORTFOLIO SUMMARY	
Investments:	
County Comingled Investment Pool (County Investment Pool)	$182,649,335
Wells Fargo Asset Management Portfolio (Portfolio Investments)	$241,732,401
	$424,381,736
Cash & Equivalents:	
Wells Fargo Stagecoach Money Market Fund (Sweep Account)	$24,796,885
Bank of the West Money Market (Money Market Account)	$174,425
Chase Bank (Lockbox)	$58,486
	$25,029,796
Quarter-End Balance of Investments and Cash & Equivalents	**$449,411,532**

Commentary on Investment Composition

At quarter-end, the Wells Fargo balance included $23 million of hospital directed payments, funds were required to be distributed within 30 days of receipt and therefore kept liquid.

3. SIX MONTH CASH SUFFICIENCY

The Plan has sufficient cash on-hand, plus projected revenues, to meet its operating expenditure requirements for at least the next six months.

4. DIVERSIFICATION COMPLIANCE

The published Quarterly Investment Report for the Santa Clara County Commingled Investment Pool indicates compliance with the County Treasurer's Investment Policy and Diversification parameters. The Plan's investment policy specifies no maximum percentage or investment in the Commingled Investment Pool.

Wells Fargo has provided a report of compliance with the Plan's investment policy, attached to this report.

5. ACTUAL VS. DIVERSIFICATION REQUIREMENTS

CHART #2: DIVERSIFICATION SUMMARY

Investment Type	Maximum Maturity	Maxium % of Portfolio	Quality Requirements	Quarter-End Balance	Percent	Compliant?
Comingled Investment Pool	N/A	None	None	**$182,649,335**	40.6%	Yes
Wells Fargo Investments & Cash:						
U.S. Treasury Obligations	450 days	None	None	$64,348,940	14.3%	Yes
U.S. Agency Obligations	450 days	None	None	$84,839,555	18.9%	Yes
CA & Local Agency Obligations	450 days	None	None	$11,236,062	2.5%	Yes
Supranationals	450 Days	30%	"AA rating or better"	$7,070,795	1.6%	Yes
Commerical Paper	270 days	40% of Investible funds	Highest rating by national rating agency	$35,000,992	7.8%	Yes
Medium-Term Notes	450 days	30% (not more than 20% in any 1 institution)	"A" rating or better	$44,488,799	9.9%	Yes
Money Market Mutual Funds	N/A	20%	**	$25,157,559	5.6%	Yes
Cash	None	None	None	($5,380,505)	-1.2%	Yes
				$266,762,197	59.4%	
Quarter-End Balance of Investments and Cash & Equivalents				**$449,411,532**	100.0%	

***A money market mutual fund must receive the highest ranking by not less than two nationally recognized statistical rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investing in money market instruments with assets under management in excess of $500 million.*

6. INVESTMENT PERFORMANCE

CHART #3: INVESTMENT PERFORMANCE

Santa Clara County Comingled Investment Trust

Annualized Yield = 0.75%
Weighted Average Life = 1.84 years (670 days)

Wells Fargo Asset Managed Portfolio

Annualized Yield = 0.01% (0.00% net of fees)
Benchmark: 3-Month T-Bill Rate: 0.04%
Average Duration: 0.249 years
Average Effective Maturity 0.233 years

Wells Fargo Stagecoach Sweep Account (Wells Money Market Mutual Fund)

Annualized Yield = 0.01%
Benchmark: Fidelity Class 1 (FIGXX) Money Market Fund = 0.03%

Commentary on Investment Performance:

Overall investment yield is lower than budget 0.38% actual vs. 1.4% budgetd) due to market conditions. Addiitonally, investment performance at Wells Fargo has trailed benchmarks. As a result, funds were reallocated to the County Investment Trust which, due to a longer investment horizon, has a higher yield. As noted above, the Wells Fargo balance at quarter-end reflected hospital directed payments of $23 million, which were distributed within 30 days of receipt. Additionally, the Plan is moving its banking relationship, including investments, from Wells Fargo to City National Bank during the fourth quarter of 2021.

7. REFERENCE/ATTACHMENTS

a. 2021 SCFHP Investment Policy
b. Link to County Investment Trust Report:
https://controller.sccgov.org/sites/g/files/exjcpb511/files/report/Quarterly-Investment-Report-20210930.pdf
c. Portfolio listing of the Wells Fargo Asset Managed Portfolio
d. Wells Fargo Compliance Report

POLICY

Policy Title:	**Investment Policy**	**Policy No.:**	**FA.07 v3**
Replaces Policy Title (if applicable):	NA	**Replaces Policy No. (if applicable):**	NA
Issuing Department:	Finance	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☐ Medi-Cal	☐ CMC	

I. PURPOSE

This investment policy sets for the investment guidelines and structure for the investment of short- term operating funds not required for the immediate needs on and after April22, 2021 of the Santa Clara Family Health Plan (SCFHP or the Plan) which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

Investments may only be made as authorized by this Annual Investment Policy. SCFHP is required to invest its funds in accordance with the California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox- Keene Act of 1975 as well as the prudent investment standard:

> The Prudent Investor Standard: When investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of SCFHP, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code Section 53600.3).

II. OBJECTIVES

i. **Safety**: the primary objective of this policy is the preservation of principal; avoiding capital losses by minimizing credit risk and interest rate or market risk.
ii. **Liquidity:** maintain sufficient liquidity to meet the operating requirements for six months.
iii. **Yield:** achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
iv. **Diversification:** provide diversification of the portfolio securities to avoid incurring unreasonable market and credit risks.

Santa Clara Family Health Plan™

POLICY

III. INVESTMENT STRATEGY

The Plan will adhere to the investment goal of holding investments to maturity. From time to time, the portfolio may go out of alignment. The Chief Financial Officer may choose to rebalance the portfolio earlier to bring it back into compliance if the portfolio will not suffer any losses for selling the investment prior to maturity.

IV. ETHICS AND CONFLICTS OF INTEREST

SCFHP's officers, employees and Governing Board members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. SCFHP's officers and employees involved in the investment process are not permitted to have any material financial interests in financial interests in financial institutions, including state or federal credit unions, that conduct business with SCFHP, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of SCFHP's investments.

V. DELEGATION OF AUTHORITY

A. County of Santa Clara Commingled Investment Pool

The Governing Board is responsible for the management and oversight of SCFHP's investment program. The Board has directed that available excess funds not required for immediate operational cash flow purposes be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

(1) All of the evidence of indebtedness of the County, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.

(2) The County has cash or cash equivalents in an amount equal to fifty million dollars or more, based on its audited financial statements for the immediately preceding fiscal year.

(3) The day-to-day managing, reporting, and oversight of the investment contractual obligations between the County and SCFHP shall be the responsibility of SCFHP's Chief Financial Officer.

B. Depository (Financial) Institutions

All SCFHP money shall be deposited in financial institutions that meet the requirements as set forth in Section 53635.2 and authorized by the Board. The financial institution shall have received an overall rating of not less than "satisfactory" in its most recent evaluation by its appropriate federal financial supervisory agency. In addition, the depository financial institution shall maintain a rating of its senior long-term debt obligations, deposit rating or claims-paying ability rating, or is guaranteed by an entity whose obligations are rated not lower than "AA- by S&P, AA- by Fitch or "Aa3" by Moody's or its equivalent from another nationally recognized rating agency.

(1) All depository institutions shall provide SCFHP with notification of any downgrades in long-term ratings or any unsatisfactory rating by their appropriate federal financial supervisory agency within 10 days of such downgrade.

(2) Any downgrade in ratings of a financial institution holding SCFHP funds, shall be provided to the Board by the Chief Financial Officer.

(3) The day-to-day managing, reporting, and oversight of the depository and investment contractual obligations for SCFHP shall be the responsibility of SCFHP's Chief Financial Officer.

(4) The Board of Directors may renew the delegation of authority to enter into depository and investment relationships annually.

(5) Funds not required to compensate for transaction costs shall be invested in and earn a market rate of return in the depository institution's highest rated money market mutual fund as permitted by the California Government Code, Section 53600 et seq.

C. Portfolio Investment Manager

The Governing Board may grant authority to a qualified investment manager to direct investments of excess funds in accordance with the AIP and be subject to periodic review for compliance to the AIP. The qualified investment manager must meet all requirements established by federal and California law. Any Board-approved changes in Permitted Investments and the AIP shall be communicated to the investment manager upon approval.

D. Exceptions to this Policy

The Governing Board may grant express written authority to make a one-time investment not permitted by this Policy however, the investment must be permitted by the CA Government code. The Board of Directors may also make amendments to the AIP at any quarterly meeting as needed.

VI. AUTHORIZED INVESTMENTS

A. Authorized Investment Types: SCFHP shall invest only in instruments as permitted by the CA Government Code, subject to the limitations of this AIP.

POLICY

1. Permitted investments in the managed portfolio shall be considered short-term operating funds and are subject to a maximum stated term of four hundred fifty (450) days.

2. The Governing Board may designate a reserve fund for excess funds not required for operational cash flow for which permitted investments are subject to a maximum term of five years pursuant to the Code.

INVESTMENT TYPE	MAXIMUM REMAINING MATURITY	MAXIMUM SPECIFIED % OF PORTFOLIO	MINIMUM QUALITY REQUIREMENTS
U.S. Treasury Obligations	5 years	None	None. May invest in securities that could result in zero or negative interest accrual if held to maturity, in the event of a period of negative market interest rates.
U.S. Agency Obligations	5 years	None	None
State Obligations: CA and Others	5 years	None	None for CA; AA or better for other States
CA Local Agency Obligations	5 years	None	AA rated
Commercial Paper: Non-Pooled Funds (minimum $100,000,000 of investments)	270 days or less	40% of Plan's investible funds	Highest letter and number rating by an NRSRO[1,5]
Placement Service Certificates of Deposit	2 years	$250,000 per deposit per institution	FDIC insured at all times
Repurchase Agreements	1 year	None	U.S. Treasury and Agency Obligations
Medium-term Notes	5 years or less	30% (with not more than 10 % in any one institution)	"A" rating category or better
Mutual Funds and Money Market Mutual Funds	N/A	20% (no more than 10% invested in any one mutual fund; limitation does not apply to money market mutual funds)	Multiple[2]
Collateralized Bank Deposits	5 years	None	If investments require collateral, collateral must be placed in institution not affiliated with the issuer of the obligation.

Mortgage Pass-through and Asset Backed Securities	5 years or less	20%	"AA" rating category or its equivalent or better[4]
County Pooled Investment Funds-Santa Clara County Pool	N/A	None	A or better
Joint Powers Authority Pool (CAMP, CalTrust)	N/A	None	Multiple[3]
Local Agency Investment Fund (LAIF)	N/A	None	None
Supranational Obligations	5 years or less	30%	"AA" rating or better
Public Bank Obligations	5 years	None	Section 57600 (b) [6]

1Issuing corporation must be organized and operating within the U.S., have assets in excess of $500 million, and debt other than commercial paper must be in a rating category of "A" or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized statistical rating agency (NSRO).

2A money market mutual fund must receive the highest ranking by not less than two nationally recognized rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investment in money market instruments with assets under management in excess of $500 million.

3A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years' experience investment in instruments authorized by Section 53601, subdivisions (a) to (o).

4Any investments in asset-backed securities (mortgage pass-through securities, collateralized mortgage obligations, mortgage-backed or other pay-through bonds, equipment lease-backed certificates, consumer receivable pass-through certificates, or consumer receivable-backed bonds) are required to have a maximum remaining maturity of five years or less. While the Legislature removed the requirement that the securities' issuer be rated "A" or its equivalent or better for the issuer's debts in accordance with a nationally recognized statistical rating organization (NRSRO), the Plan retains this requirement.

[5] In 2021, Section 53601 (h) amended to allow local agencies that have one hundred million dollars or more of investment assets under management to invest no more than 40% of their moneys in eligible commercial paper. Further amendment to Section 53601 limits local agencies to invest no more than 10% of their total investment assets in commercial paper and medium- term notes of any single issuer.

[6] Public Bank means a corporation organized under the Nonprofit Mutual benefit corporation Law for the purpose of engaging in the commercial banking business or industrial banking business that is wholly owned by a local agency, local agencies or a joint powers authority that is composed only of local agencies. A local agency may invest in commercial paper, debt securities, or other obligations of a public bank.

B. Prohibited Investment Types: CA Government Code Section 53601.6 prohibits local agencies from investing in inverse floaters, range notes, or mortgage-derived, interest-only strips, and any security which could result in zero interest accrual if held to maturity. In addition, the Plan does not authorize investment in the following:

i. Bankers' Acceptances
ii. Commercial Paper: Pooled Funds (pertains only to Managed Portfolio)
iii. Negotiable Certificates of Deposit
iv. Non-negotiable Certificates of Deposit
v. Reverse Repurchase Agreements and Securities Lending Agreements
vi. Voluntary Investment Program Fund

VII. REPORTING REQUIREMENTS

The following documents and reports will be periodically provided to support the investment procedures, oversight and reporting requirements:

A. County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits

B. County of Santa Clara Treasury Investment Policy

C. County of Santa Clara Treasury Quarterly Report

D. SAP Balance and Interest Earnings Report of SCFHP Invested Funds

E. Depository Institution – daily transaction and monthly activity report

F. Managed Portfolio - Month-end and quarter-end portfolio performance summary, income, ending balance sheet, trading activity, transaction detail and portfolio diversification report. The listing must include issuer names, dates of maturity, par amounts, dollar amount, market values as of month-end and comparable published index as to diversification and duration that most closely tracks the performance of the portfolio.

G. Investment Oversight Quarterly Report – provides independent review of all invested funds for tracking of AIP, diversification requirements and performance review. Minimum reporting requirements includes a listing of the types of investment, issuer names, dates of maturity, par amounts, dollar amount, market values, descriptions of the programs under the management of contracted parties, a statement of compliance with the investment policy, and a statement of the ability to meet cash flow needs for six months. Any irregularities shall be noted and included in the report.

Santa Clara Family Health Plan™

POLICY

VIII. REVIEW OF INVESTMENT POLICY

At least annually and more frequently as needed, the Governing Board will review this investment policy at a regular meeting of the Board. Any recommended changes to the Policy, including modifications to current investment strategy, oversight procedures including internal controls will be first be brought to the Executive/FinanceCommittee by the CFO for review and approval prior to presentation to the Board. The Executive Committee and Board of Directors will be supported in this work by the CFO, investment advisors and legal counsel for financial and legal issues, respectively.

Any modifications to this Investment Policy, including withdrawal from the County of Santa Clara Commingled Investment Pool, will be made in accordance with California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox Keene Act of 1975 as well as the prudent investment standard.

IX. Approval/Revision History

First Level Approval	Second Level Approval
Barbara Granieri, Controller April 22, 2021 Date	Neal Jarecki Chief Financial Officer April 22, 2021 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Exec/Finance	Approved 04/26/18	Approved 06/28/18
V1	Original (no changes)	Exec/Finance	Approved 05/01/19	Approved 06/27/19
V2	Revised	Exec/Finance	Approved 04/23/20	Approved 06/25/20
V3	Revised	Exec/Finance	Approved 04/22/21	Approved 6/24/21

Portfolio Holdings

US Dollar

As of 30 September 2021

WC-Santa Clara Family HealthPl

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Cash

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
CCYUSD Cash	0.32 0.32	0.00 AAA	09/30/2021 09/30/2021	0.32	1.0000 0.00	0.00 0.00	0.32 0.32
CCYUSD Payable	-5,439,010.00 -5,439,010.00	0.00 AAA	09/30/2021 09/30/2021	-5,439,010.00	1.0000 0.00	0.00 0.00	-5,439,010.00 -5,439,010.00
CCYUSD Receivable	19.06 19.06	0.00 AAA	09/30/2021 09/30/2021	19.06	1.0000 0.00	0.00 0.00	19.06 19.06
CCYUSD ---	**-5,438,990.62 -5,438,990.62**	**0.00 AAA**	**09/30/2021 09/30/2021**	**-5,438,990.62**	**1.0000 0.00**	**0.00 0.00**	**-5,438,990.62 -5,438,990.62**

MMFund

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
94975P405 WELLSFARGO:GOVT MM I	186,247.87 186,247.87	0.01 AAA	09/30/2021 09/30/2021	186,247.87	1.0000 0.01	0.00 0.00	186,247.87 186,247.87
94975P405 WELLSFARGO:GOVT MM I	**186,247.87 186,247.87**	**0.01 AAA**	**09/30/2021 09/30/2021**	**186,247.87**	**1.0000 0.01**	**0.00 0.00**	**186,247.87 186,247.87**

Fixed Income

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
010392FQ6 ALABAMA POWER CO	2,000,000.00 2,000,000.00	2.45 A+	03/30/2022 02/28/2022	2,018,777.20	100.8987 0.26	136.11 -803.20	2,017,974.00 2,018,110.11
037833DL1 APPLE INC	2,468,000.00 2,468,000.00	1.70 AA+	09/11/2022 09/11/2022	2,503,222.58	101.3570 0.26	2,330.89 -1,731.82	2,501,490.76 2,503,821.65
04821UB92 Atlantic Asset Securitization Corp.	3,500,000.00 3,500,000.00	0.00 A-1	02/09/2022 02/09/2022	3,498,216.94	99.9509 0.13	0.00 63.40	3,498,280.35 3,498,280.35
04821TYJ8 Atlantic Asset Securitization Corp.	1,050,000.00 1,050,000.00	0.00 A-1	11/18/2021 11/18/2021	1,049,874.00	99.9860 0.10	0.00 -21.20	1,049,852.80 1,049,852.80
06051GEM7 BANK OF AMERICA CORP	3,000,000.00 3,000,000.00	5.70 A	01/24/2022 01/24/2022	3,050,760.00	101.6829 0.38	33,250.00 -273.00	3,050,487.00 3,083,737.00
06051GFY0 BANK OF AMERICA CORP	547,000.00 547,000.00	1.31 A	10/21/2022 10/21/2021	547,345.29	100.0578 0.32	1,437.79 -29.13	547,316.17 548,753.96
06406RAK3 BANK OF NEW YORK MELLON CORP	2,000,000.00 2,000,000.00	1.95 A+	08/23/2022 08/23/2022	2,032,544.99	101.5993 0.17	4,116.67 -558.99	2,031,986.00 2,036,102.67
130658QX8 CALIFORNIA ST DEPT VET AFFAIRS HOME PUR REV	1,500,000.00 1,500,000.00	0.21 AA-	06/01/2022 06/01/2022	1,500,000.00	100.0530 0.14	436.92 795.00	1,500,795.00 1,501,231.92
14913Q3A5 CATERPILLAR FINANCIAL SERVICES CORP	1,345,000.00 1,345,000.00	1.90 A	09/06/2022 09/06/2022	1,366,649.02	101.6607 0.12	1,774.65 687.40	1,367,336.42 1,369,111.07

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Portfolio Holdings

US Dollar

As of 30 September 2021

WC-Santa Clara Family HealthPl

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
14913Q3D9 CATERPILLAR FINANCIAL SERVICES CORP	1,285,000.00 1,285,000.00	0.32 A	11/12/2021 11/12/2021	1,285,323.82	100.0290 0.42	576.02 48.83	1,285,372.65 1,285,948.67
166764AT7 CHEVRON CORP	2,655,000.00 2,655,000.00	2.41 AA-	03/03/2022 01/03/2022	2,670,483.96	100.5483 0.29	4,978.72 -926.60	2,669,557.37 2,674,536.08
21969AAA0 CORONA CALIF PENSION OBLIG	1,500,000.00 1,500,000.00	0.25 AA+	05/01/2022 05/01/2022	1,500,000.00	99.9990 0.23	0.00 -15.00	1,499,985.00 1,499,985.00
223047AA9 COVINA CALIF PENSION OBLIG	600,000.00 600,000.00	0.30 AA	08/01/2022 08/01/2022	600,000.00	99.9970 0.30	313.95 -18.00	599,982.00 600,295.95
21687BBA8 Coöperatieve Rabobank U.A., New York Branch	3,000,000.00 3,000,000.00	0.00 A-1+	02/10/2022 02/10/2022	2,998,570.00	99.9653 0.09	0.00 388.16	2,998,958.16 2,998,958.16
22550UAA9 CREDIT SUISSE AG (NEW YORK BRANCH)	1,250,000.00 1,250,000.00	0.50 A+	02/04/2022 02/04/2022	1,251,391.68	100.1247 0.15	1,006.94 167.07	1,251,558.75 1,252,565.69
22550L2B6 CREDIT SUISSE AG (NEW YORK BRANCH)	800,000.00 800,000.00	2.80 A+	04/08/2022 04/08/2022	810,563.16	101.3463 0.22	10,702.22 207.24	810,770.40 821,472.62
244199BE4 DEERE & CO	500,000.00 500,000.00	2.60 A	06/08/2022 03/08/2022	505,350.97	101.0444 0.22	4,080.56 -128.97	505,222.00 509,302.56
26442CAW4 DUKE ENERGY CAROLINAS LLC	1,000,000.00 1,000,000.00	3.35 A	05/15/2022 05/15/2022	1,019,939.87	101.8983 0.31	12,655.56 -956.87	1,018,983.00 1,031,638.56
284035AA0 EL SEGUNDO CALIF PENSION OBLIG	500,000.00 500,000.00	0.19 AA+	07/01/2022 07/01/2022	500,000.00	99.9800 0.22	297.11 -100.00	499,900.00 500,197.11
30231GAJ1 EXXON MOBIL CORP	2,500,000.00 2,500,000.00	2.40 AA-	03/06/2022 01/06/2022	2,514,520.23	100.5661 0.27	4,161.46 -367.73	2,514,152.50 2,518,313.96
313313XH6 FEDERAL FARM CREDIT BANKS FUNDING CORP	4,000,000.00 4,000,000.00	0.00 A-1+	05/27/2022 05/27/2022	3,998,413.29	99.9608 0.06	0.00 18.70	3,998,432.00 3,998,432.00
313313SE9 FEDERAL FARM CREDIT BANKS FUNDING CORP	5,000,000.00 5,000,000.00	0.00 A-1+	01/24/2022 01/24/2022	4,999,361.10	99.9872 0.03	0.00 -1.10	4,999,360.00 4,999,360.00
313385MZ6 FEDERAL HOME LOAN BANKS	811,000.00 811,000.00	0.00 A-1+	10/15/2021 10/15/2021	810,988.96	99.9992 0.02	0.00 4.55	810,993.51 810,993.51
313385NP7 FEDERAL HOME LOAN BANKS	40,000,000.00 40,000,000.00	0.00 A-1+	10/29/2021 10/29/2021	39,998,949.99	99.9984 0.02	0.00 410.01	39,999,360.00 39,999,360.00
313385NG7 FEDERAL HOME LOAN BANKS	3,133,000.00 3,133,000.00	0.00 A-1+	10/22/2021 10/22/2021	3,132,936.03	99.9988 0.02	0.00 26.37	3,132,962.40 3,132,962.40
313385MY9 FEDERAL HOME LOAN BANKS	1,900,000.00 1,900,000.00	0.00 A-1+	10/14/2021 10/14/2021	1,899,975.98	99.9993 0.00	0.00 10.72	1,899,986.70 1,899,986.70
313385QM1 FEDERAL HOME LOAN BANKS	10,000,000.00 10,000,000.00	0.00 A-1+	12/14/2021 12/14/2021	9,999,177.77	99.9918 0.05	0.00 2.23	9,999,180.00 9,999,180.00
313385NT9 FEDERAL HOME LOAN BANKS	20,000,000.00 20,000,000.00	0.00 A-1+	11/02/2021 11/02/2021	19,999,466.66	99.9964 0.00	0.00 -186.66	19,999,280.00 19,999,280.00
38346LXS0 Gotham Funding Corporation	3,950,000.00 3,950,000.00	0.00 A-1	10/26/2021 10/26/2021	3,949,752.78	99.9930 0.10	0.00 -29.52	3,949,723.26 3,949,723.26
38346LYF7 Gotham Funding Corporation	1,500,000.00 1,500,000.00	0.00 A-1	11/15/2021 11/15/2021	1,499,850.00	99.9858 0.11	0.00 -62.74	1,499,787.25 1,499,787.25
419792F68 HAWAII ST	855,000.00 855,000.00	0.25 AA	08/01/2022 08/01/2022	855,000.00	99.9870 0.25	0.00 -111.15	854,888.85 854,888.85

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Portfolio Holdings

US Dollar

As of 30 September 2021

WC-Santa Clara Family HealthPl

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
438516CC8 HONEYWELL INTERNATIONAL INC	1,510,000.00 1,510,000.00	0.48 A	08/19/2022 10/10/2021	1,510,000.00	100.0115 0.06	850.88 173.65	1,510,173.65 1,511,024.53
4581X0CW6 INTER-AMERICAN DEVELOPMENT BANK	5,000,000.00 5,000,000.00	2.13 AAA	01/18/2022 01/18/2022	5,030,436.86	100.5742 0.21	21,545.14 -1,726.86	5,028,710.00 5,050,255.14
459058GF4 INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPM	2,000,000.00 2,000,000.00	2.13 AAA	12/13/2021 12/13/2021	2,008,215.95	100.3895 0.20	12,750.00 -425.95	2,007,790.00 2,020,540.00
46625HJE1 JPMORGAN CHASE & CO	2,000,000.00 2,000,000.00	3.25 A	09/23/2022 09/23/2022	2,060,120.41	102.9273 0.26	1,444.44 -1,574.41	2,058,546.00 2,059,990.44
4820P2Y41 Jupiter Securitization Company LLC	5,000,000.00 5,000,000.00	0.00 A-1+	11/04/2021 11/04/2021	4,999,575.00	99.9903 0.10	0.00 -61.10	4,999,513.90 4,999,513.90
5445872P2 LOS ANGELES CALIF MUN IMPT CORP LEASE REV	1,385,000.00 1,385,000.00	0.27 AA-	11/01/2021 11/01/2021	1,385,000.00	100.0050 0.21	2,142.25 69.25	1,385,069.25 1,387,211.50
612574EP4 MONTEREY PENINSULA CALIF CMNTY COLLEGE DIST	800,000.00 800,000.00	0.18 AA	08/01/2022 08/01/2022	800,000.00	99.9990 0.18	145.60 -8.00	799,992.00 800,137.60
63743HEQ1 NATIONAL RURAL UTILITIES COOPERATIVE FINANCE CORP	2,450,000.00 2,450,000.00	2.30 A	09/15/2022 08/15/2022	2,495,362.91	101.8509 0.18	2,504.44 -15.86	2,495,347.05 2,497,851.49
63873KB30 Natixis, New York Branch	4,000,000.00 4,000,000.00	0.00 A-1	02/03/2022 02/03/2022	3,998,055.55	99.9615 0.11	0.00 404.45	3,998,460.00 3,998,460.00
67983TY34 Old Line Funding, LLC	3,000,000.00 3,000,000.00	0.00 A-1+	11/03/2021 11/03/2021	2,999,587.50	99.9915 0.09	0.00 157.50	2,999,745.00 2,999,745.00
67983TYF7 Old Line Funding, LLC	3,508,000.00 3,508,000.00	0.00 A-1+	11/15/2021 11/15/2021	3,507,693.05	99.9884 0.09	0.00 -100.96	3,507,592.09 3,507,592.09
67983TXT8 Old Line Funding, LLC	1,000,000.00 1,000,000.00	0.00 A-1+	10/27/2021 10/27/2021	999,942.22	99.9934 0.09	0.00 -8.22	999,934.00 999,934.00
69371RN77 PACCAR FINANCIAL CORP	2,250,000.00 2,250,000.00	2.30 A+	08/10/2022 08/10/2022	2,290,906.54	101.7431 0.27	7,331.25 -1,686.79	2,289,219.75 2,296,551.00
69371RQ33 PACCAR FINANCIAL CORP	780,000.00 780,000.00	2.00 A+	09/26/2022 09/26/2022	794,199.67	101.8355 0.14	216.67 117.23	794,316.90 794,533.57
69353RFB9 PNC BANK NA	2,000,000.00 2,000,000.00	2.63 A	02/17/2022 01/17/2022	2,014,399.86	100.6965 0.28	6,416.67 -469.86	2,013,930.00 2,020,346.67
693476BN2 PNC FINANCIAL SERVICES GROUP INC	1,335,000.00 1,335,000.00	3.30 A-	03/08/2022 02/06/2022	1,349,376.17	101.0774 0.22	2,814.63 7.12	1,349,383.29 1,352,197.92
742718EU9 PROCTER & GAMBLE CO	1,325,000.00 1,325,000.00	2.15 AA-	08/11/2022 08/11/2022	1,347,901.13	101.7173 0.16	3,956.60 -146.91	1,347,754.23 1,351,710.82
796720NX4 SAN BERNARDINO CALIF CMNTY COLLEGE DIST	475,000.00 475,000.00	0.23 AA+	08/01/2022 08/01/2022	475,000.00	100.0430 0.17	166.25 204.25	475,204.25 475,370.50
80182AAA7 SANTA CRUZ CNTY CALIF PENSION OBLIG	600,000.00 600,000.00	0.16 AAA	06/01/2022 06/01/2022	600,000.00	99.9670 0.21	27.17 -198.00	599,802.00 599,829.17
88602TYF4 Thunder Bay Funding, LLC	4,000,000.00 4,000,000.00	0.00 A-1+	11/15/2021 11/15/2021	3,999,450.00	99.9896 0.08	0.00 136.00	3,999,586.00 3,999,586.00
88602UA67 Thunder Bay Funding, LLC	1,500,000.00 1,500,000.00	0.00 A-1+	01/06/2022 01/06/2022	1,499,474.58	99.9706 0.11	0.00 84.42	1,499,559.00 1,499,559.00

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Portfolio Holdings

US Dollar

As of 30 September 2021

WC-Santa Clara Family HealthPl

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS FARGO Asset Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
86787EAT4 TRUIST BANK	1,000,000.00 1,000,000.00	2.45 A	08/01/2022 07/01/2022	1,017,164.91	101.6791 0.22	4,083.33 -373.91	1,016,791.00 1,020,874.33
05531FBG7 TRUIST FINANCIAL CORP	1,715,000.00 1,715,000.00	3.05 A-	06/20/2022 05/20/2022	1,746,210.96	101.7961 0.23	14,675.16 -407.84	1,745,803.11 1,760,478.27
912796M30 UNITED STATES TREASURY	46,550,000.00 46,550,000.00	0.00 A-1+	10/12/2021 10/12/2021	46,549,502.17	99.9991 0.03	0.00 78.88	46,549,581.05 46,549,581.05
912796M48 UNITED STATES TREASURY	17,800,000.00 17,800,000.00	0.00 A-1+	10/19/2021 10/19/2021	17,799,639.55	99.9964 0.07	0.00 -280.35	17,799,359.20 17,799,359.20
91324PDD1 UNITEDHEALTH GROUP INC	3,000,000.00 3,000,000.00	2.38 A	10/15/2022 10/15/2022	3,066,772.82	102.2510 0.21	32,854.17 757.18	3,067,530.00 3,100,384.17
91412HJH7 UNIVERSITY CALIF REVS	1,515,000.00 1,515,000.00	0.16 AA	05/15/2022 05/15/2022	1,515,000.00	100.0190 0.13	1,378.78 287.85	1,515,287.85 1,516,666.63
90331HPC1 US BANK NA	3,000,000.00 3,000,000.00	2.65 AA-	05/23/2022 04/23/2022	3,041,845.65	101.3725 0.21	28,266.67 -670.65	3,041,175.00 3,069,441.67
9523474S8 WEST CONTRA COSTA CALIF UNI SCH DIST	1,000,000.00 1,000,000.00	0.21 AA-	08/01/2022 08/01/2022	1,000,000.00	99.9780 0.23	343.33 -220.00	999,780.00 1,000,123.33
966770AA7 WHITTIER CALIF PENSION OBLIG	500,000.00 500,000.00	0.21 AA	06/01/2022 06/01/2022	500,000.00	99.9990 0.21	129.56 -5.00	499,995.00 500,124.56
--- **---**	**246,147,000.00** **246,147,000.00**	**0.52** **AA+**	**12/28/2021** **12/22/2021**	**246,768,239.78**	**100.2532** **0.09**	**226,298.53** **-9,394.92**	**246,758,844.87** **246,985,143.40**

Summary

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
--- **---**	**240,894,257.25** **240,894,257.25**	**0.53** **AA+**	**12/30/2021** **12/24/2021**	**241,515,497.03**	**102.4099** **0.09**	**226,298.53** **-9,394.92**	**241,506,102.12** **241,732,400.65**

* Grouped by: Asset Class. * Groups Sorted by: Asset Class. * Weighted by: Base Market Value + Accrued. * Holdings Displayed by: Position.

Santa Clara Family Health Plan - Compliance Report
September 30, 2021

Allowable Instruments	**Maximum % of Portfolio**	**Actual % of Portfolio**	**Market Value**	**Maximum Stated Term Per Security**	**Actual Maximum Maturity Per Security**		**Minimum Stated Quality Per Security**	**Actual Minimum Credit Per Security**
U.S. Treasuries	100	26.62%	64,348,940.25	450 Days	19	10/19/21	TSY	TSY
Federal Agencies	100	35.10%	84,839,554.62	450 Days	239	5/27/22	AGY	AGY
State of CA & Other Municipal Obligations	100	4.65%	11,236,062.11	450 Days	305	8/1/22	A3/A-	AA-
Supranationals	30	2.93%	7,070,795.14	450 Days	110	1/18/22	AA-	AAA
Bankers Acceptances	40			180 Days			A-1/P-1	
Commercial Paper	25	14.48%	35,000,991.81	270 Days	133	2/10/22	A-1/P-1	A-1
Negotiable Certificates of Deposit	30			450 Days			A-1/P-1	
Repurchase Agreements	100			1 Year			A-	
Medium Term Notes & Depository Notes	30	18.40%	44,488,799.47	450 Days	380	10/15/22	A3/A-	A-
Money Market Mutual Funds	20	0.08%	186,247.87	NA			AAA	AAA
Asset Backed Securities	20			450 Days			AA-	
Cash		-2.25%	(5,438,990.62)					
		100.00%	**241,732,400.65**					

Diversification Guidelines

Maximum per Corporate Issuer	**1.50%**

Santa Clara Family Health Plan.

2022

JANUARY

S	M	T	W	T	F	S
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23	24	25	26	27	28	29
30	31					

FEBRUARY

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APRIL

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MAY

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JUNE

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JULY

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31						

AUGUST

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28	29	30	31			

SEPTEMBER

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OCTOBER

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30	31					

NOVEMBER

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27	28	29	30			

DECEMBER

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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Governing Board 12:00pm – 2:30pm	Quality Improvement Committee 6:00pm – 8:00pm
March 24	February 8
June 23	April 12
September 22	June 14
December 15	August 9
Executive/Finance Committee 10:30am – 12:30pm	October 11
	December 13
	Utilization Management Committee 6:00pm – 8:00pm
January 27	
February 24	
April 28	January 19
May 26	April 20
July 28	July 20
August 25	October 19
October 27	Credentialing Committee 12:15pm – 1:30pm
November 17	
Compliance Committee 1:30pm – 2:00pm	February 2
	April 6
February 24	June 1
May 26	August 3
August 25	October 5
November 17	December 7
Provider Advisory Council 12:15pm – 1:45pm	Pharmacy & Therapeutics Committee 6:00pm – 8:00pm
February 9	March 17
May 11	June 16
August 10	September 15
November 9	December 15
Consumer Advisory Committee (Medi-Cal) 6:00pm – 7:00pm	Consumer Advisory Board (CAB) 11:30am – 1:00pm
March 8	March 3
June 7	June 2
September 13	September 1
December 13	December 1

Santa Clara County Health Authority

(dba Santa Clara Family Health Plan)

Conflict of Interest Code

RESOLUTION OF
THE SANTA CLARA COUNTY HEALTH AUTHORITY
TO ADOPT AN AMENDED
CONFLICT OF INTEREST CODE

WHEREAS, the Political Reform Act (Government Code Section 81000, *et seq.)* requires state and local government agencies to adopt and promulgate conflict of interest codes; and

WHEREAS, the Fair Political Practices Commission ("FPPC") has adopted a regulation (2 Cal. Code of Regs. 18730) which contains the terms of a standard conflict of interest code and following public notice and hearing it may be amended by the Fair Political Practices Commission to conform to Amendments in the Political Reform Act; and

WHEREAS, the Santa Clara County Heath Authority ("the Health Authority") has recently reviewed its conflict of interest code, its positions, and the duties of each position, and has determined that changes to the current conflict of interest code are necessary; and

WHEREAS, any earlier resolution and/or appendices containing the Health Authority's conflict of interest code shall be rescinded and superseded by this resolution and Appendix;

NOW, THEREFORE BE IT RESOLVED THAT, the terms of 2 California Code of Regulations Section 18730 (available at http://www.fppc.ca.gov/content/dam/fppc/NS-Documents/LegalDiv/Regulations/Index/Chapter7/Article2/18730.pdf) and any amendments to it duly adopted by the FPPC are hereby incorporated by reference and this regulation and the Appendices, attached hereto and incorporated herein, designating officials and employees, and establishing disclosure categories, shall constitute the Conflict of Interest Code of the Health Authority.

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IT IS **FURTHER RESOLVED THAT,** designated employees shall file their Statements of Economic Interests with the Health Authority's filing official. If a statement is received in signed paper format, the Health Authority's filing official shall make and retain a copy and forward the original of this statement to the filing officer, the County of Santa Clara Clerk of the Board of Supervisors. If a statement is electronically filed using the County of Santa Clara's Form 700 e-fling system, both the Health Authority's filing official and the County of Santa Clara Clerk of the Board of Supervisors will receive access to the e-filed statement simultaneously. The Health Authority shall make a copy of the statements available for public inspection and reproduction in accordance with Government Code section 81008.

PASSED AND ADOPTED by the Santa Clara County Health Authority of the County of Santa Clara, State of California on December ~~17~~16, ~~2020~~ 2021 by the following vote:

AYES:
NOES:
ABSENT:

Signed: _____
Robert Brownstein, Chair

Attest: _____
Susan G. Murphy, Secretary

Attachments to this Resolution:
Appendix A - Positions Required to File
Appendix B – Disclosure Categories

Appendix A – Amended
Santa Clara County Health Authority
Conflict of Interest Code
POSITIONS REQUIRED TO FILE

The following is a list of those positions that are required to submit Statements of Economic Interests (Form 700) pursuant to the Political Reform Act of 1974, as amended:

Required to File Form 700:

Position	Disclosure Category Number
Health Authority Board Member	1
Chief Executive Officer	1
Chief Financial Officer	1
Chief Operating Officer	1
Chief Medical Officer	8
Chief Information Officer	8
Chief Compliance Officer	8
Vice President, Strategies and Analytics	8
~~Vice President, Marketing and Enrollment~~	~~8~~
Vice President, Marketing, Communications & Outreach	8
Director, Community Engagement	8
Director, Facilities	8
Director, Provider Network Operations	8
Director, Infrastructure and System Support	8
Director, Long Term Services and Supports	8
Director, Operations	8
Director, Pharmacy and Utilization Management	8
Director, Quality and Process Improvement	8
Medical Director	8
Consultant	7

*Newly Created Positions

A newly created position that makes or participates in the making of decisions that may foreseeably have a material effect on any financial interest of the position-holder, and which specific position title is not yet listed in the Health Authority 's conflict of

interest code is included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation: The Chief Executive Officer may determine in writing that a particular newly created position, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the broadest disclosure requirements, but instead must comply with more tailored disclosure requirements specific to that newly created position. Such written determination shall include a description of the newly created position's duties and, based upon that description, a statement of the extent of disclosure requirements. The Health Authority's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

As soon as the Health Authority has a newly created position that must file statements of economic interests, the Health Authority filing official shall contact the County of Santa Clara Clerk of the Board of Supervisors Form 700 division to notify it of the new position title to be added in the County's electronic Form 700 record management system, known as eDisclosure. Upon this notification, the Clerk's office shall enter the actual position title of the newly created position into eDisclosure and the Health Authority filing official shall ensure that the name of any individual(s) holding the newly created position is entered under that position title in eDisclosure.

Additionally, within 90 days of the creation of a newly created position that must file statements of economic interests, the Health Authority shall update this conflict-of-interest code to add the actual position title in its list of designated positions, and submit the amended conflict of interest code to the County of Santa Clara Office of the County Counsel for code-reviewing body approval by the County Board of Supervisors. (Gov. Code Sec. 87306.)

Appendix B - Amended
Santa Clara County Health Authority
Conflict of Interest Code
DISCLOSURE CATEGORIES

Category 1. Persons in this category shall disclose (1) all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority; and (2) all investments, business positions, and income, including gifts, loans and travel payments, from all sources.

Category 2. Persons in this category shall disclose all investments, business positions, and income, including gifts, loans and travel payments, from all sources.

Category 3. Persons in this category shall disclose all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority.

Category 4. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority.

Category 5. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that either contract to provide education or training required by the Authority to qualify for or maintain a license, or that provide education or training services which courses or curricula are approved by the Authority.

Category 6. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from (1) all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority, and (2) all sources that are of the type to receive grants or other monies from or through the Authority, including, but not limited to, nonprofit organizations.

Category 7. Each Consultant, as defined for purposes of the Political Reform Act, shall disclose pursuant to the broadest disclosure category in the conflict of interest code subject to the following limitation: The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements of the broadest disclosure category, but instead must comply with more tailored disclosure requirements specific to that consultant. Such a determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. All such determinations are public records and shall be retained for public inspection along with this conflict of interest code.

DISCLOSURE CATEGORIES (cont.)

Category 8. Persons in this category shall disclose all investments in, business positions in, and income (including gifts, loans and travel payments) from (1) all sources that provide leased facilities, goods, equipment, vehicles, machinery, or services, including training or consulting services, of the type utilized by the Authority, and (2) all sources that are potential or current members or providers of the Authority; and (3) all sources that are of the type to receive grants or other monies from or through the Authority, including, but not limited to, nonprofit organizations, and (4) sources that receive referrals to provide assessments and/or treatments that are required or recommended by the Authority.

TO: Santa Clara County Board of Supervisors

FROM: Santa Clara County Health Authority Governing Board

DATE: December 2021

SUBJECT: Annual Report

Santa Clara County Health Authority, doing business as Santa Clara Family Health Plan (SCFHP), serves more than 289,000 low-income residents of Santa Clara County through the Medi-Cal and Cal MediConnect programs. Medi-Cal enrollment continues to reflect an increase due to the suspension of eligibility redeterminations related to the public health emergency. SCFHP experienced an 11.3% increase in membership during the fiscal year, while maintaining a consistent 78% Medi-Cal market share. We are working in partnership with the State to prepare for the disenrollment of ineligible enrollees following the resumption of Medi-Cal redeterminations once the public health emergency declaration is ended. Attached is a summary of SCFHP 2020-2021 Financial Highlights.

Responding to the COVID-19 pandemic continues to be a top priority, with a cumulative total of 191 SCFHP members losing their lives and 1,845 hospitalized. This year, we focused heavily on getting our members vaccinated, hosting County vaccination clinics, outreaching to members, and offering them financial incentives to get vaccinated. As of the end of November, 60.6% of eligible SCFHP members (ages five and up) had received at least one dose, the second highest rate among California's Medi-Cal managed care plans.

SCFHP continued to bolster its quality program to meet the expectations of state and federal regulators. To increase member engagement, we enhanced our Wellness Rewards Program and Community Outreach Program. According to recently-released 2020 data (unofficial due to COVID), SCFHP again climbed in the rankings, to 10th out of 56 Medi-Cal managed care plans.

We are thrilled to have opened the SCFHP Blanca Alvarado Community Resource Center in July. Located near the intersection of North Capitol Ave and McKee Road in San Jose, this site will advance the health of SCFHP members and East San José residents by offering community-responsive and culturally competent health and wellness programs, services and resource navigation.

As you know, the State has proposed sweeping changes to the Medi-Cal program via its multi-year CalAIM plan, beginning with the transitions of Health Homes Program and Whole Person Care to new services known as Enhanced Care Management and Community Supports, which take effect January 1, 2022. Implementing these programs and planning for the 2023 implementation of a population health management plan and transition from Cal MediConnect to a new Dual Eligible Special Needs Plan will continue to require a significant investment in human and other resources during and beyond 2022.

Santa Clara Family Health Plan™

Financial Highlights Fiscal Year 2020-2021

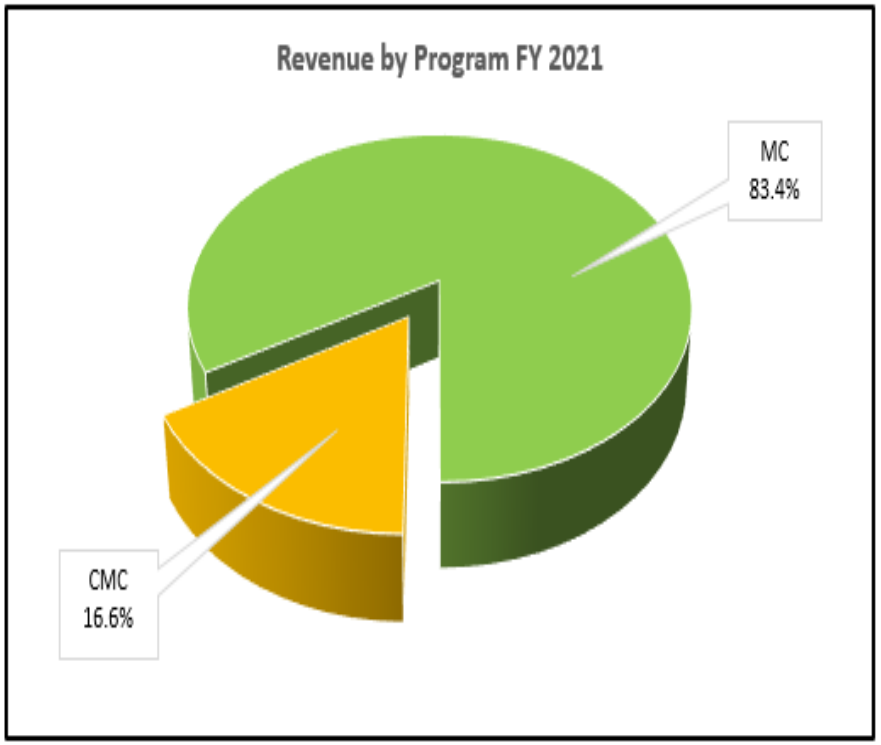
Santa Clara Family Health Plan

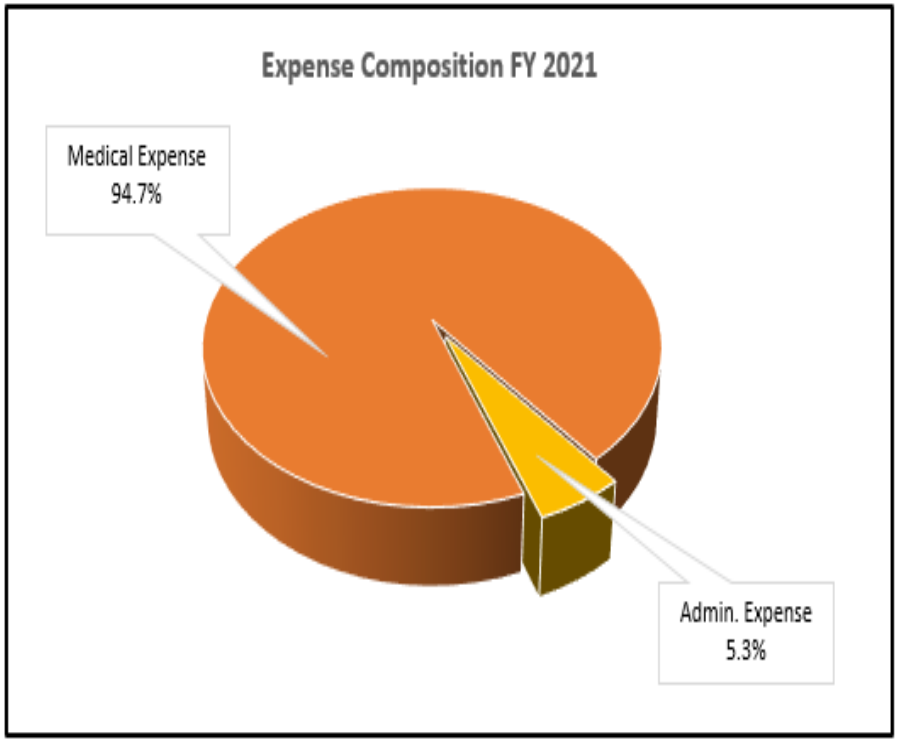
SCFHP Financial Highlights for Fiscal Year 2020-21

- Total enrollment increased 11.3% to 282,670 members at June 30, 2021 from 253,875 members at June 30, 2020.
- Net position increased by $46,209,816 to $254,850,602 for the fiscal year ended June 30, 2021 from $208,640,786 for the fiscal year ended June 30, 2020 due to operating income of $43,357,542 and non-operating income of $2,852,274. Net position represents three months of expenses.
- Total assets and deferred outflows of resources decreased to $963,677,770 as of June 30, 2021 from $1,189,881,233 as of June 30, 2020.
- Total liabilities and deferred inflows of resources decreased to $708,827,168 at June 30, 2021 from $981,240,447 at June 30, 2020.
- The current ratio (current assets divided by current liabilities) of 1.31 as of June 30, 2021 reflected an increase from 1.18 at June 30, 2020.

SCFHP Financial Highlights for Fiscal Year 2020-2021

- Fiscal Year 2020-2021 Revenue and Expense Composition:





- For FY 20-21, of every dollar of expense, SCFHP distributed approximately 95% to providers and retained 5% for administrative expenses.

MEMORANDUM

Date: December 10, 2021

From: Tyler Haskell, Interim Compliance Officer

To: SCFHP Governing Board

Re. AB 361 compliance

Background

Because the Governor's executive order suspending certain Brown Act requirements expired at the end of September, the Legislature passed AB 361, which was signed into law in September. AB 361 amends Government Code §54953 to permit teleconferencing by local agencies during a declared state of emergency without providing public access to each individual teleconference location. In order to do so, a local agency must, within 30 days of its first teleconference meeting following enactment of AB 361 and every 30 days thereafter, make the following findings by majority vote:

- The local agency has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

The Executive/Finance Committee met and made the above findings in October and November. In order for the Governing Board and committees to continue meeting remotely during the ongoing state of emergency, the Governing Board needs again make the required findings.

Recommended Action

Make the following findings and approve continued use of teleconferencing without providing public access to each teleconference location:

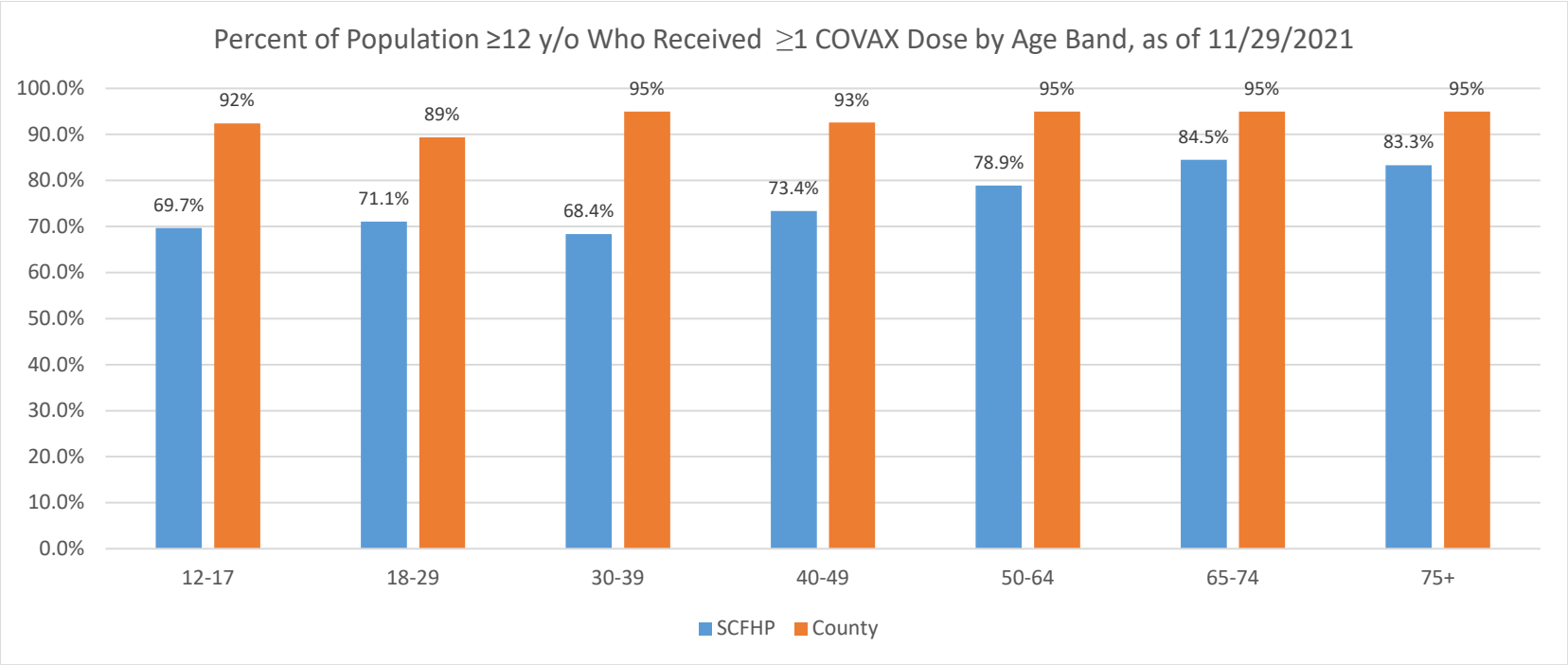
- Santa Clara Family Health Plan has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

SCFHP COVID-19 Summary – December 10, 2021

Group	Focus Area	Activities and Metrics
Members	Statistics	Data as of 12/10/2021 • 6,805 members positive • Cumulatively 1,856 members hospitalized • 192 deceased (101 SNF and 91 non-SNF), representing 11% of County-reported total (total membership equals about 12% of the County population)
	Vaccinations	• 62.3% of Medi-Cal members age 5+ administered at least one dose of a COVID-19 vaccine • Mailed flier cobranded with County Public Health Department to 8,230 non-vaccinated Medi-Cal, non-Kaiser, members age 65+ with information about how to get vaccinated, including how to access transportation • Mailed letter to 16,900 non-vaccinated members age 16-64 with information on how to schedule a vaccine appointment, vaccine safety, and transportation • Held seven vaccine clinics, fully vaccinating a total of 872 individuals • Called 458 non-vaccinated members residing near the CRC to promote the COVAX clinic • Completed robocalls on 5/4 to 2,944 non-vaccinated CMC members to provide vaccine appointment contact info and offer transportation • Completed robocalls on 5/20 to 103,057 non-vaccinated members age 16+ to provide vaccine appointment contact info and offer transportation • Completed second robocall campaign to 11,360 members age 12-15 on 7/12 to provide vaccine appointment contact info and offer transportation • Completed outreach calls to 1,042 members age 21+ (in independent physician network), offering to help schedule appointments for those unvaccinated • Conducted outreach calls to parents and guardians of 780 members age 12 for well care visit reminders and sharing information on where/how to schedule COVID vaccine appointment if member is unvaccinated

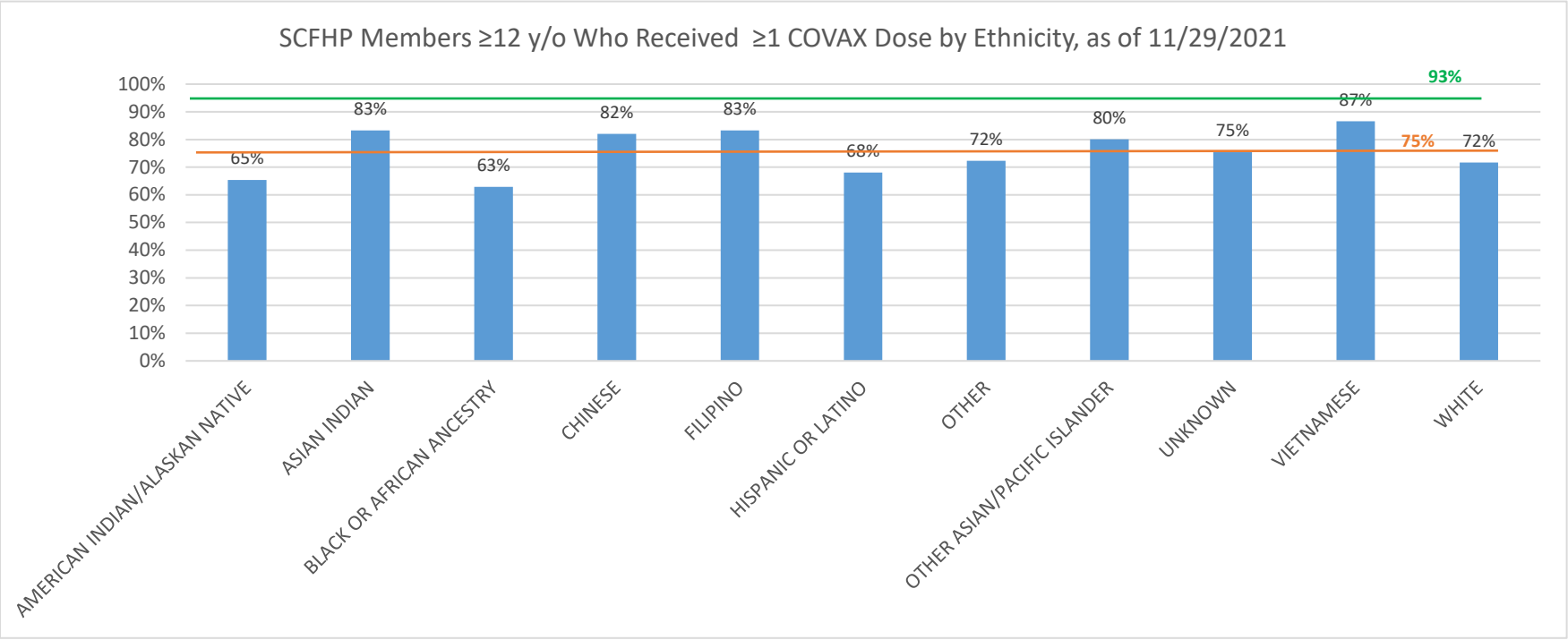
Group	Focus Area	Activities and Metrics
		• Conducted 7,092 Quality outreach calls in August 2021 for Well Child Visits (WCV), Prenatal and Post-Partum Care (PPC), Controlling Blood Pressure (CBP), and Access to Care, while also sharing information on where/how to schedule COVID vaccine appointment, if member is unvaccinated • Submitted COVID Vaccination Response Plan on 9/1/21 to DHCS and obtained approval; developed workplan and meeting weekly with COVID Vaccine Workgroup to define strategy, tasks, and resource requirements for vaccine outreach efforts, incentives, and collaborations • Partnered with 5 high-traffic pharmacies to conduct outreach to 909 unvaccinated members age 12+ who frequent that pharmacy and/or have refills on file. Provide pharmacies with unvaccinated member list & supporting documents for Pharmacists to conduct outreach calls. o Offered $15 for each successful (or at 3 attempts) per member contact/outreach; $50 for gap closure if member comes into the pharmacy for vaccine • Offered $5 gift card incentive to Customer Service staff to encourage COVID vaccine gap closure during inbound phone call with unvaccinated members • Hosted Health Fair at the CRC on 10/2/21; 38 COVID-19 vaccinations administered by the County's Mobile Vaccine Unit • Offered $50 gift card incentive to unvaccinated members age 12+ for first dose from 9/1/21 – 3/6/22 • Explored partnership opportunities with trusted messengers (e.g. CBOs/faith-based organizations/County) to effectively reach target groups with low vaccination rates • Prepared to outreach 591 homebound members and coordinate with County in-home COVID Vaccination Program to schedule appointment • Offered “Ask the Doctor” service at community event on 10/2/21 and 10/16/21 to answer questions regarding COVID and/or the vaccine • Recruited outreach team of 13 temps to conduct outbouund calls to unvaccinated members age 12+ to share information and help schedule COVID vaccine appointment, if requested by member • Createed strategy to create a COVID “one-stop shop” at the CRC; provide information, resources, dedicated 2 Community Health Workers, vaccine clinics • Expanded COVID vaccine ad campaign and social media content • Rolled out initiative for all Nurse Advice Line representatives to ask inbound callers about vaccination status; if caller is unvaccinated, notate to Nurse to talk to patient about COVID vaccination

Santa Clara Family Health Plan



Unvaccinated Numbers			
Age Band	SCFHP	County	Comment
12-17	11,314	10,928	SCFHP is 100% of County
18-29	16,038	33,788	SCFHP is 50% of County
30-39	8,999	12,152	SCFHP is 75% of County
40-49	6,019	20,309	SCFHP is 30% of County
50-64	8,911	909	County denominator error
65-74	3,475	(10,771)	County denominator error
75+	3,764	1,006	County denominator error

Santa Clara Family Health Plan™

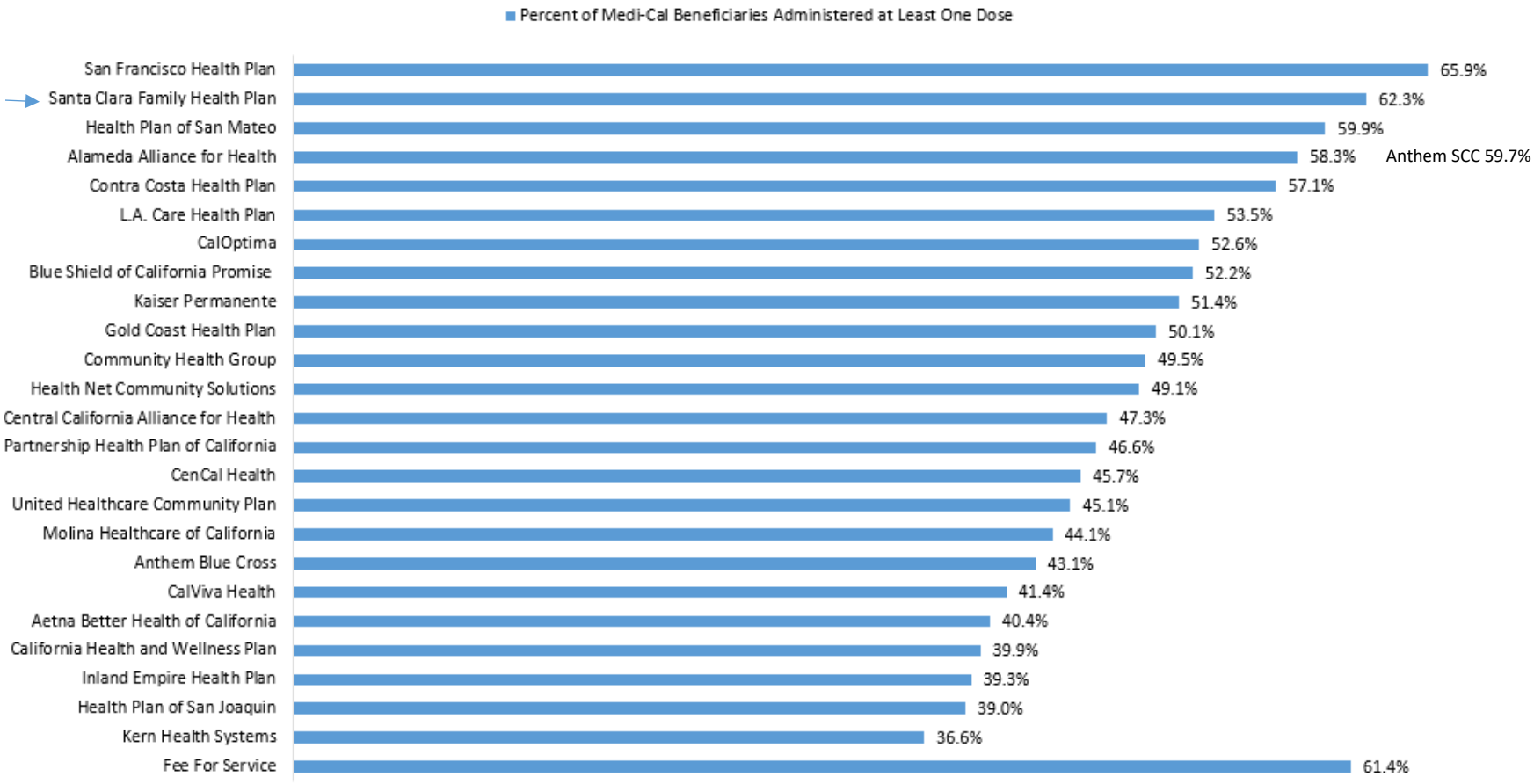


SCFHP's average

County's average, as of 12.10.21

Santa Clara Family Health Plan

Percent of Medi-Cal Beneficiaries age 5 and older Administered at Least One Dose of a COVID-19 Vaccine as of November 2021 Month of Eligibility by Managed Care Parent Plan and FFS



As of Nov. 29, 2021

SCC 85.1%

Board Dashboard Annual Metrics

December 2021

Santa Clara Family Health Plan™

PROVIDER NETWORK

Contracted Providers

SPECIALTY	Medi-Cal	Cal MediConnect
Primary Care Physicians	813	542
Specialists	4,323	3,170
Ancillaries	853	259

SCFHP is contracted with all hospitals in Santa Clara County.

Medi-Cal Network Gaps

SPECIALTY	CY2019	CY2020	CY2021
Adult PCP		X	
Cardiology		X	
Endocrinology		X	X
ENT-Otolaryngology		X	
HIV/AIDS Specialists/Infectious Disease	X	X	X
Neurology	X	X	
Physical Medicine and Rehabilitation	X	X	X
Pulmonology	X	X	

Source: DHCS Annual Network Certification

DHCS definitions: CY2019 and 2020 based on miles and minutes; CY2021 based on miles or minutes.

CY2019 gaps: Gilroy, Morgan Hill

CY2020 gaps: Gilroy, San Martin, and Morgan Hill

CY2021 gaps: Gilroy, San Martin, and Morgan Hill

QUALITY SCORES

Medi_Cal Composite Quality Score

Point Value	Medicaid HEDIS Percentile	CY2018	CY2019	CY2020
4	≥90th	1	5	3
3	75th	3	5	3
2	50th	11	4	7
1	25th	4	3	2
0	< 25th	0	1	1
Total Measures		19	18	16
Average Point Value		2.05	2.56	2.31

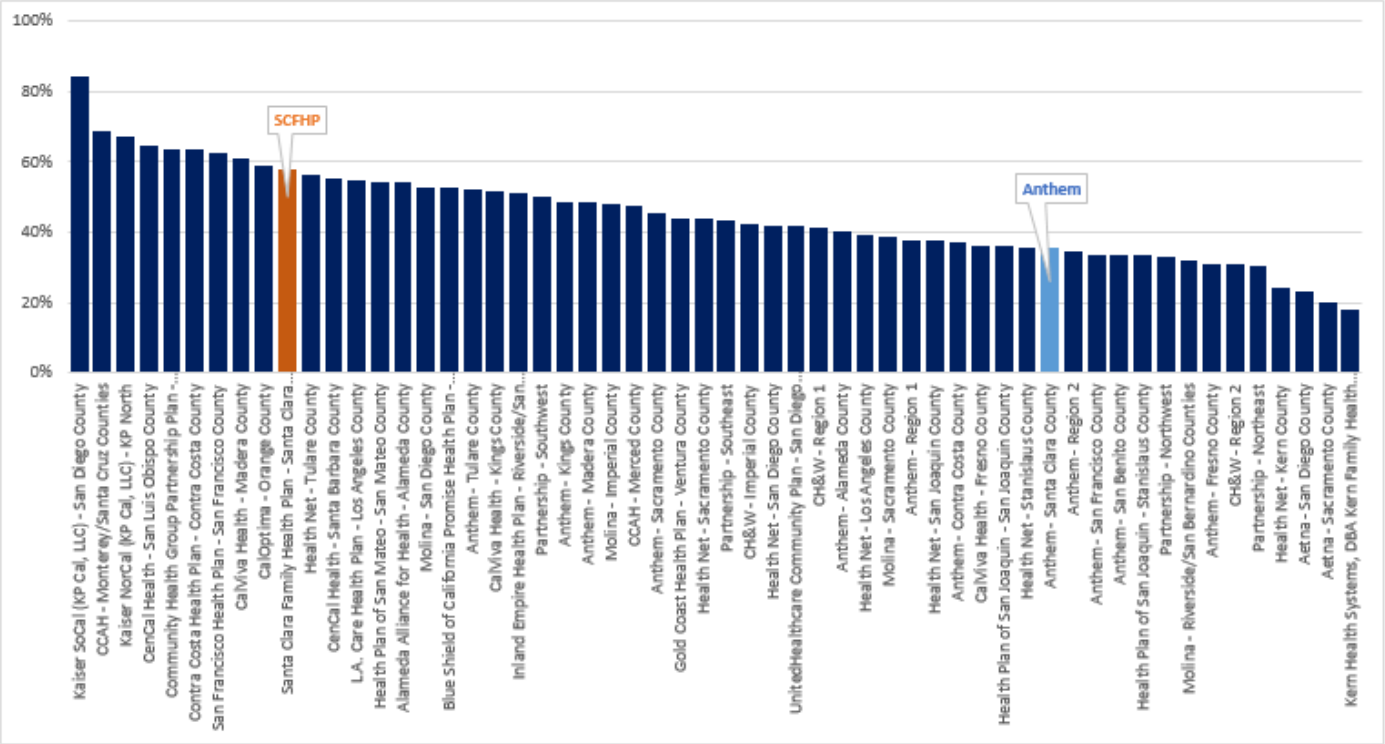
Cal MediConnect Composite Quality Score

Point Value	Medicare Percentile	CY2018	CY2019	CY2020
4	≥90th	2	7	12
3	75th	7	9	2
2	50th	11	10	11
1	25th	13	14	6
0	< 25th	15	11	17
Total Measures		48	51	48
Average Point Value		1.33	1.75	1.71

Board Dashboard Annual Metrics

December 2021

Medi-Cal Aggregated Quality Factor Score (AQFS) by Health Plan CY2020



Rank	CY2017	CY2018	CY2019	CY2020
SCFHP	18	24	12	10
Anthem	23	28	35	43
# Plans	53	53	56	56

MEMBER SATISFACTION SURVEY

Medi-Cal Overall Ratings and Composites

	CY2016	CY2019
Rating of Health Plan	**77.24%**	**70.88%**
Rating of Health Care Quality	**72.37%**	**70.64%**

Cal MediConnect Overall Ratings and Composites

	CY2019	CY2020	CY2021
Rating of Health Plan	**80.00%**	**85.40%**	**82.40%**
Rating of Health Care Quality	**70.80%**	**76.39%**	**72.83%**
Rating of Drug Plan	**81.30%**	**87.24%**	**82.35%**

Source: Consumer Assessment of Healthcare Providers and Systems (CAPHS)
Scale rating 1-10; data reflects ratings 8-10

Board Dashboard Annual Metrics

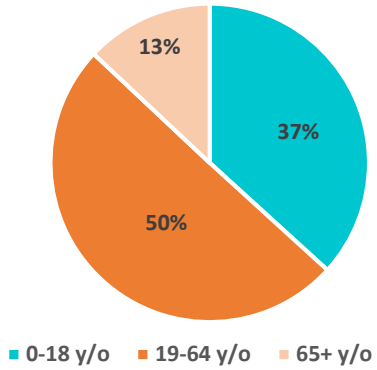
December 2021

Santa Clara Family Health Plan™

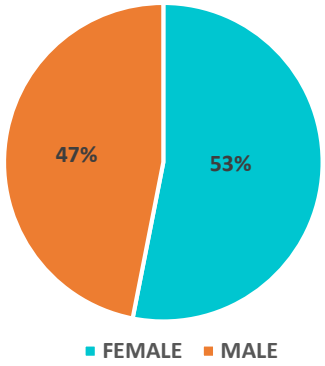
MEMBER DEMOGRAPHICS

Medi-Cal as of 12/2021

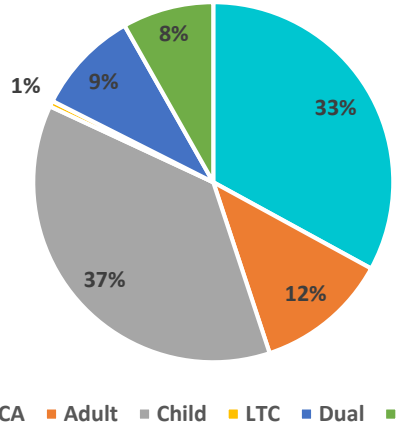
Membership by Age



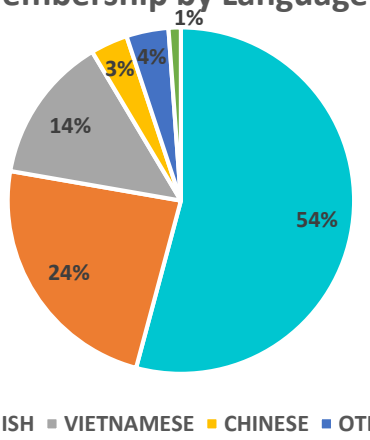
Membership by Gender



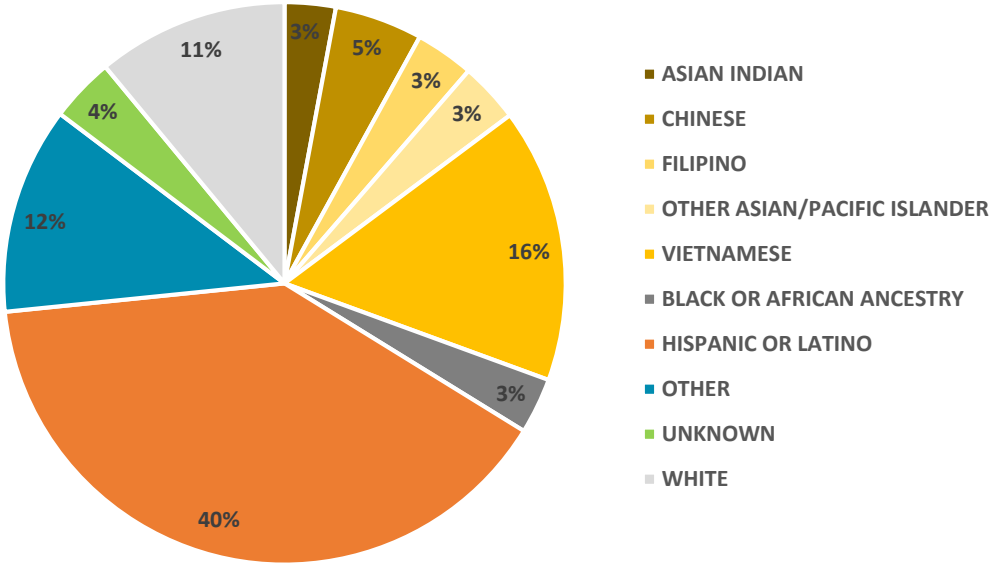
Membership by Category of Aid



Membership by Language



Membership by Ethnicity



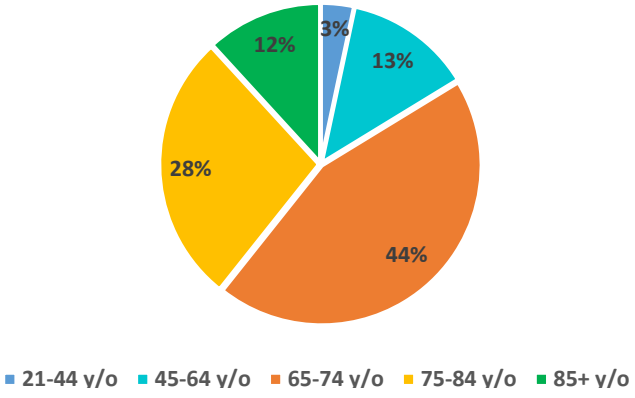
Board Dashboard Annual Metrics

December 2021

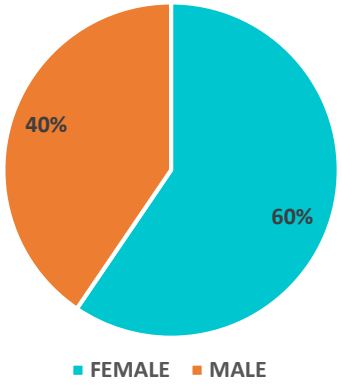
Santa Clara Family Health Plan™

Cal MediConnect as 12/2021

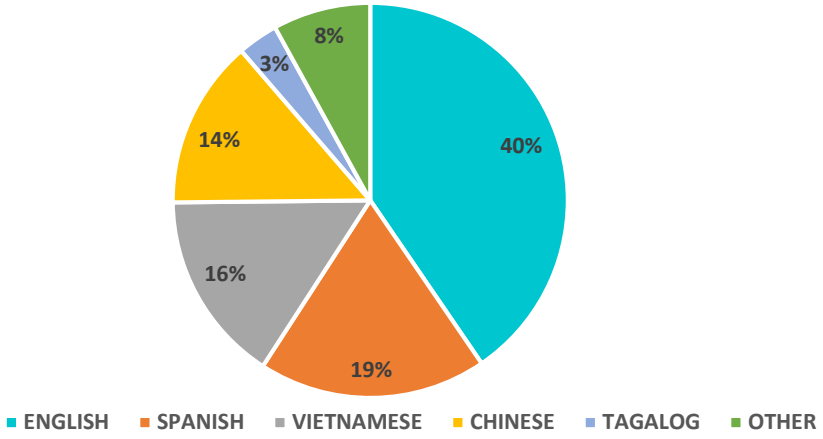
Membership by Age



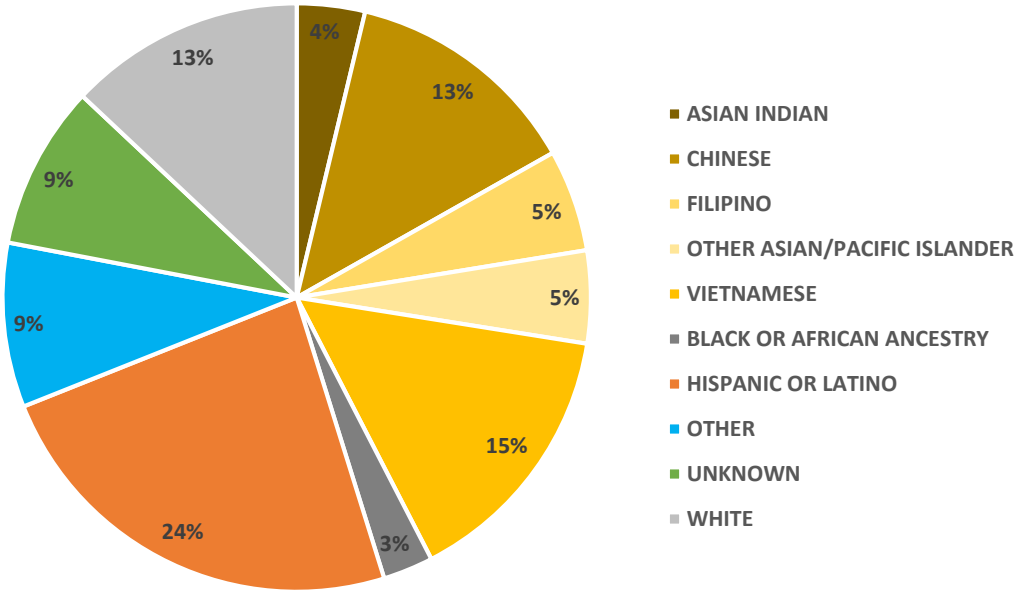
Membership by Gender



Membership by Language

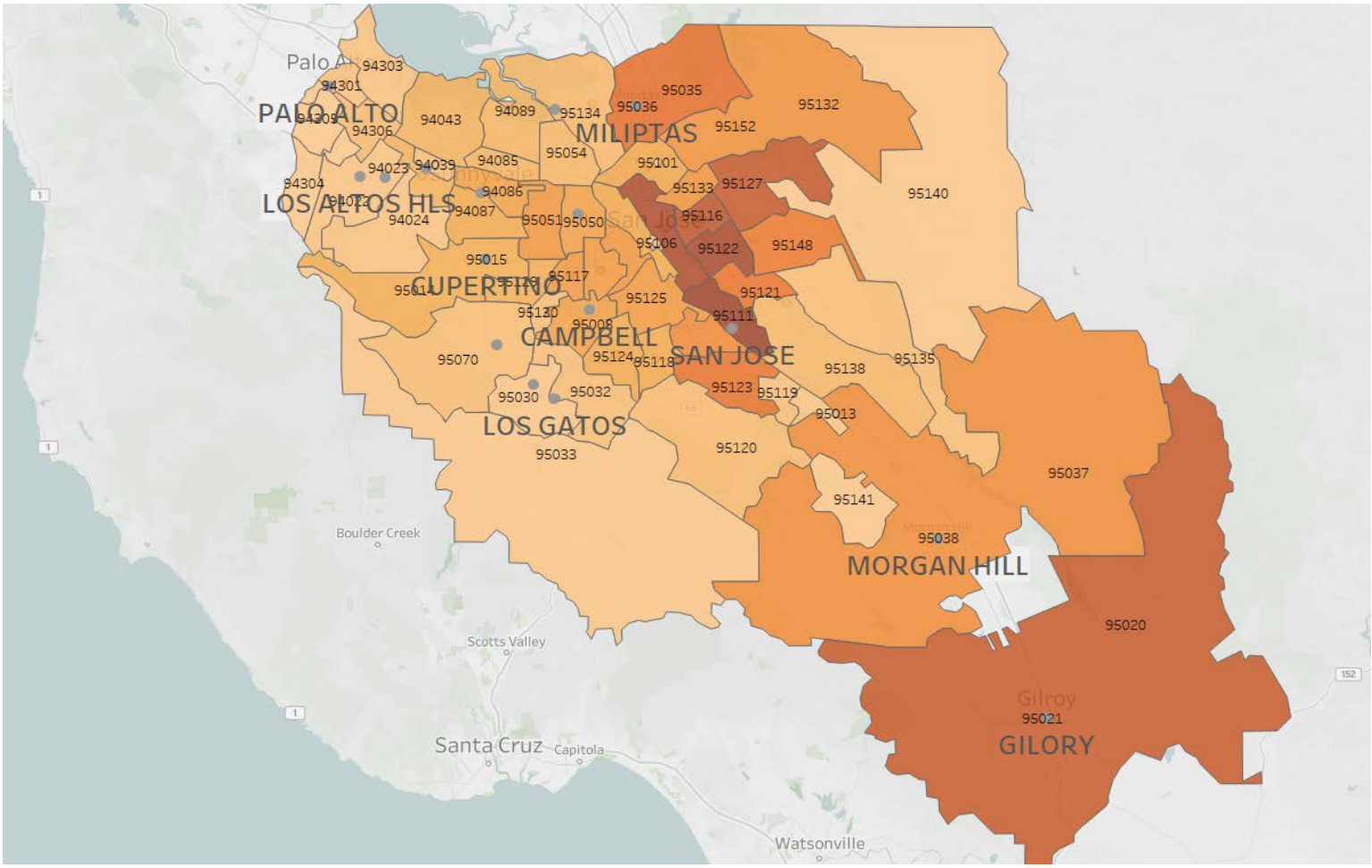


Membership by Ethnicity



Board Dashboard Annual Metrics

December 2021



Care Management Assisted Long-Term Care (LTC) Transitions

	FY20	FY21
Internal	34	24
Community Partners	26	7
Total	60	31

Audited Financial Metrics

	FY20	FY21
Premium Revenue ($1,000)	$1,147,826	$1,380,376
Interest Income ($1,000)	$6,476	$2,852
Total Revenue ($1,000)	$1,154,302	$1,383,228
Admin Expense ($1,000)	$60,812	$64,721
Admin %	5.3%	4.7%
Margin ($1,000)	$6,515	$46,210
Margin %	0.6%	3.3%

Financial Statistics

	FY21
Amount **Spent** on Medical Care per $1	92¢
Amount **Spent** on Administration per $1	4.7¢
Amount Invested in Local Economy	>$1.3B

Compliance Activity Report

December 16, 2021

- **Department of Managed Health Care (DMHC) Enforcement Matter**
  In October, DMHC assessed SCFHP an administrative penalty in the amount of $10,000 for two deficiencies in our 2017 Timely Access and Network Adequacy Compliance Report. Specifically, the Report we submitted omitted a data file for non-physician mental health providers and an enrollee satisfaction survey comparison of prior year results and discussion of relative changes. SCFHP accepted the penalty and submitted a corrective action plan that included steps already taken to successfully include both documents in the three subsequent (2018-2020) submissions.

- **Compliance Program Effectiveness (CPE) Audit**
  CMS requires Medicare plans to have an independent review of the effectiveness of its compliance program each year. In collaboration with Health Plan Alliance, SCFHP has partnered with Piedmont Community Health Plan (Piedmont) to conduct peer-review audits of our respective compliance programs to meet CMS's CPE requirement for CY 2021. The audit process is based on recently approved Medicare Part C and D Program Audit Protocols which CMS will begin using for 2022 program audits. SCFHP and Piedmont began the audits in early November and expect to conclude them in January.

- **CMS Disclosure**
  The Compliance Department previously disclosed to CMS an issue the Plan discovered that was preventing providers from receiving information about transitions of care, interdisciplinary care team (ICT) meetings, and individual care plans (ICP). This resulted from a 2018 bug fix deployed by our case management software that inadvertently disabled our fax capability through that system, resulting in 33,450 provider faxes, relating to 13,150 members, not being transmitted. Fax capability has since been restored and new processes were introduced to ensure notification of failed faxes. After discussing with SCFHP and with internal staff, CMS recently notified SCFHP that they would not be taking any compliance action.

- **Department of Health Care Services (DHCS) Annual Audit**
  The Plan recently received notice for the annual 2022 DHCS audit, which will take place between March 7 and March 18, covering a review period of March 2021 through February 2022. Compliance has begun gathering information requested by DHCS from internal operations and delegates. Unlike previous DHCS audits, which covered only the Medi-Cal line of business, this audit will cover both Medi-Cal and Cal MediConnect.

- **Performance Measure Validation**
  The Plan was selected by CMS's external quality review organization to participate in the 2021 performance measure validation audit. The audit focused on 2020 reporting of data sets used to demonstrate compliance with two Cal MediConnect requirements: members with an initial health risk assessment and members with an initial care plan completed within 90 days of enrollment. A review session took place on August 19 and the Plan recently received a draft report indicating that both data sets were deemed "reportable," meaning the data were valid compliant with CMS specifications.

Santa Clara Family Health Plan™

Unaudited Financial Statements

For Four Months Ended October 31, 2021

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$113 M		$453 M	
Medical Expense (MLR)	$106 M	93.8%	$409 M	90.4%
Administrative Expense (% Rev)	$6.5 M	5.8%	$24.4 M	5.4%
Other Income/(Expense)	$118K		$557K	
Net Surplus (Net Loss)	**$543K**		**$19.9 M**	
Cash and Investments			$420 M	
Receivables			$543 M	
Total Current Assets			$973 M	
Current Liabilities			$731 M	
Current Ratio			1.33	
Tangible Net Equity			$275 M	
% of DMHC Requirement			**781.1%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $543K is $842K or 60.8% unfavorable to budget of $1.4M surplus. YTD: Surplus of $19.9M is $14.4M or 261.2% favorable to budget of $5.5M surplus.
Enrollment	Month: Membership was 287,498 (3,485 or 1.2% lower than budget of 290,983). YTD: Member Months YTD was 1,143,700 (8,114 or 0.7% lower than budget of 1,151,814).
Revenue	Month: $112.9M ($870K or 0.8% unfavorable to budget of $113.8M). YTD: $452.7M ($2.1M or 0.5% favorable to budget of $450.6M).
Medical Expenses	Month: $106.0M ($294K or 0.3% favorable to budget of $106.3M). YTD: $409.0M ($11.5M or 2.7% favorable to budget of $420.6M).
Administrative Expenses	Month: $6.5M ($3K or 0.0% favorable to budget of $6.5M). YTD: $24.4M ($1.7M or 6.5% favorable to budget of $26.0M).
Tangible Net Equity	TNE was $274.7M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $857K vs. $3.3M annual budget, primarily software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 287,498 members is 3,485 or 1.2% lower than budget. Since the beginning of the fiscal year, total enrollment has increased by 4,828 members or 1.7%.
- Medi-Cal enrollment has been increasing since January 2020, largely due to COVID (beginning in March 2020 annual eligibility redeterminations were suspended and enrollment continues to increase as a result).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 1.6%, Medi-Cal Dual enrollment has increased 2.0%, and CMC enrollment has grown 2.9%.

	For the Month October 2021				For Four Months Ending October 31, 2021					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY22 vs. FY21
Medi-Cal	277,130	280,548	(3,418)	(1.2%)	1,102,614	1,110,674	(8,060)	(0.7%)	1,008,753	9.3%
Cal Medi-Connect	10,368	10,435	(67)	(0.6%)	41,086	41,140	(54)	(0.1%)	37,293	10.2%
Total	**287,498**	**290,983**	**(3,485)**	**(1.2%)**	**1,143,700**	**1,151,814**	**(8,114)**	**(0.7%)**	**1,046,046**	**9.3%**

Santa Clara Family Health Plan Enrollment By Network
October 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	36,062	13%	10,368	100%	46,430	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	138,096	50%	-	0%	138,096	48%
North East Medical Services	3,440	1%	-	0%	3,440	1%
Palo Alto Medical Foundation	7,346	3%	-	0%	7,346	3%
Physicians Medical Group	42,906	15%	-	0%	42,906	15%
Premier Care	15,879	6%	-	0%	15,879	6%
Kaiser	33,401	12%	-	0%	33,401	12%
Total	**277,130**	**100%**	**10,368**	**100%**	**287,498**	**100%**
Enrollment at June 30, 2021	272,590		10,080		282,670	
Net Δ from Beginning of FY22	1.7%		2.9%		1.7%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

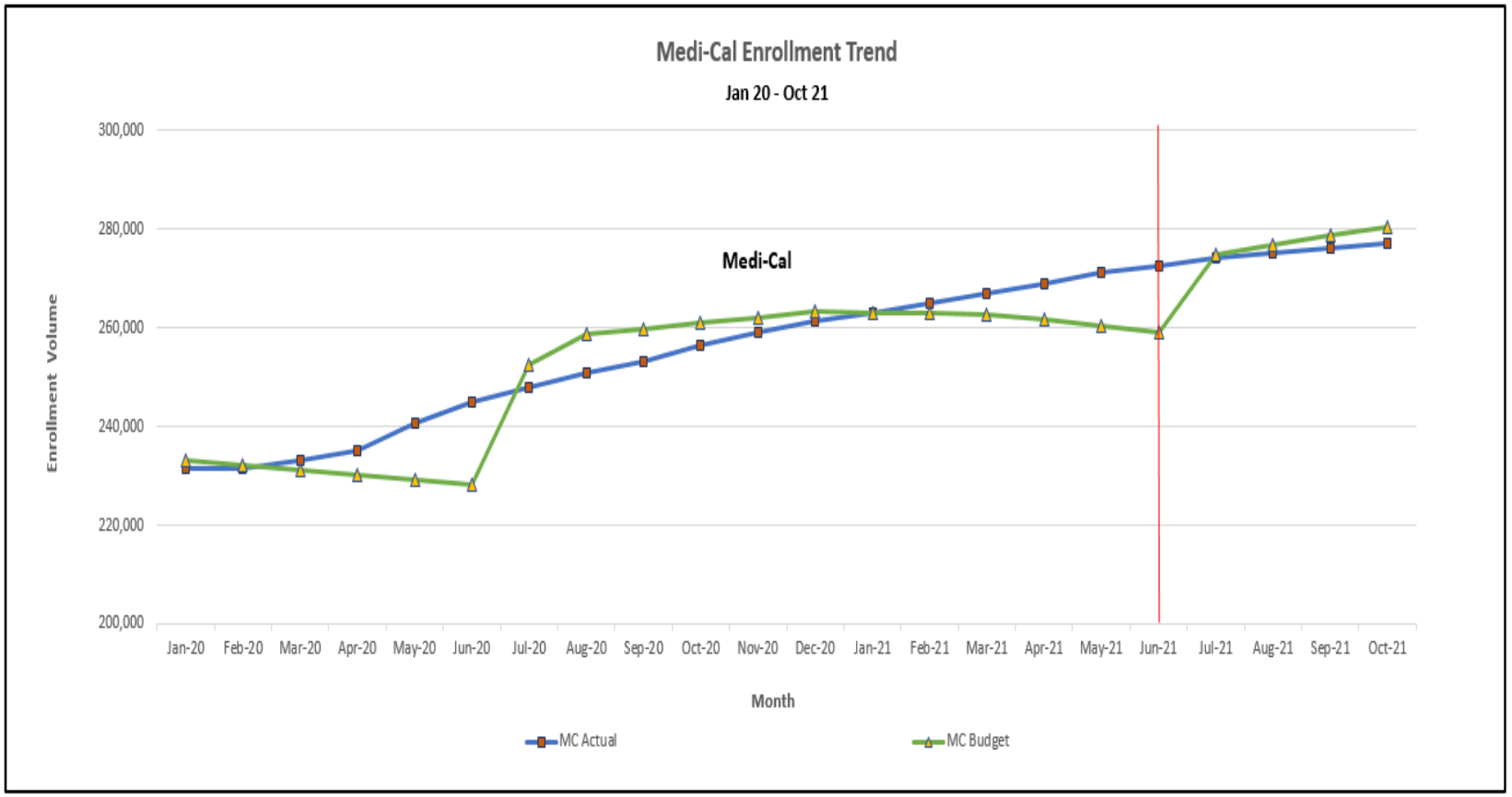
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD OCTOBER - 2021

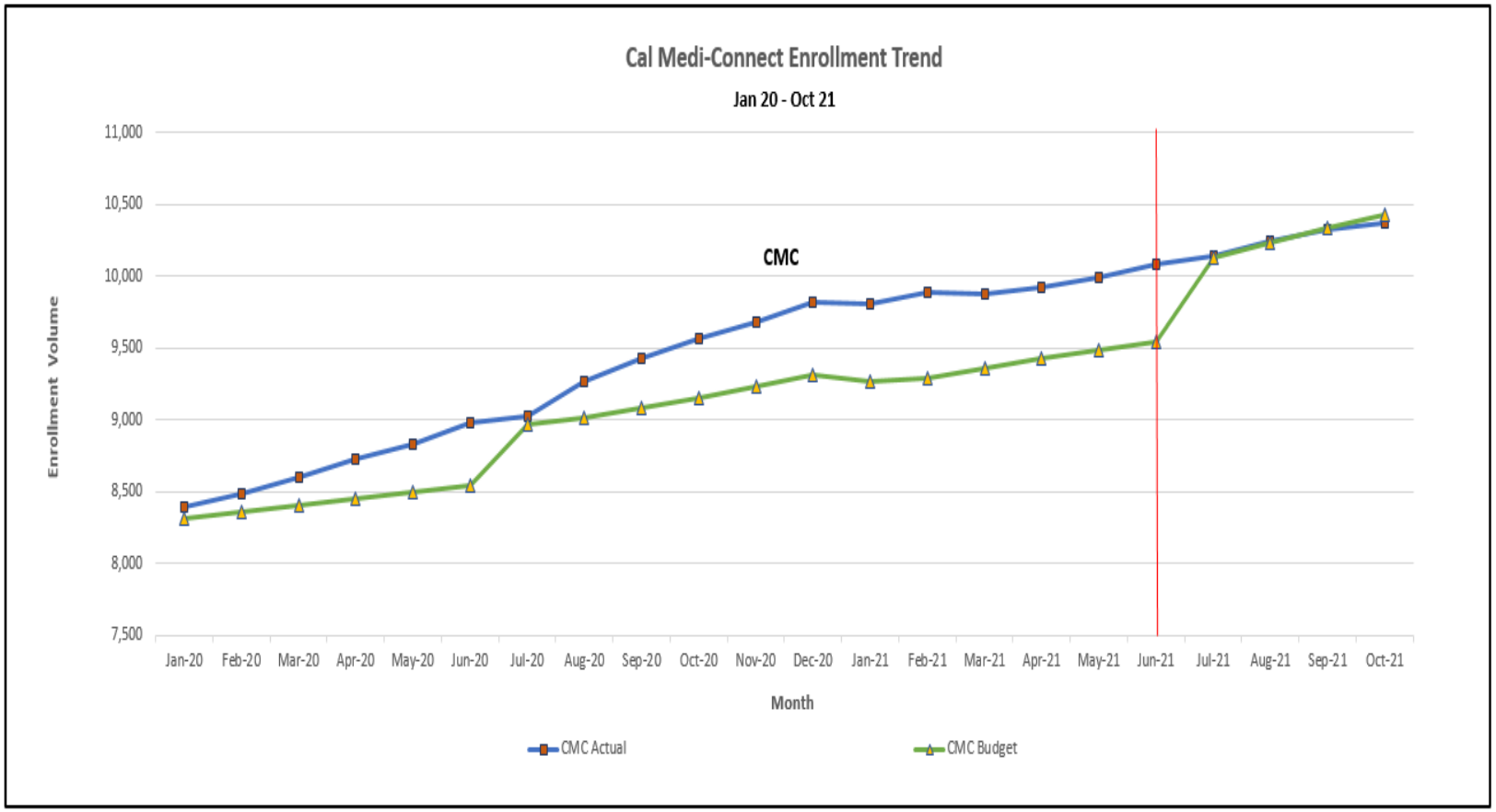
		2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	FYTD var	%
NON DUAL	Adult (over 19)	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	33,546	33,809	812	2.5%
	Child (under 19)	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	101,093	101,125	648	0.6%
	SPD	22,149	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	22,331	22,381	80	0.4%
	Adult Expansion	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	91,960	92,393	2,436	2.7%
	Long Term Care	409	389	393	388	380	373	375	367	365	414	408	401	391	26	7.1%
	Total Non-Duals	**230,802**	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**4,002**	**1.6%**
DUAL	Adult (over 21)	354	353	353	352	355	361	357	365	366	367	376	375	396	30	8.2%
	SPD	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	24,206	24,244	129	0.5%
	Long Term Care	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	1,092	1,083	23	2.2%
	SPD OE	410	498	537	590	662	742	802	863	952	1,063	1,135	1,223	1,308	356	37.4%
	Total Duals	**25,688**	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**538**	**2.0%**
	Total Medi-Cal	**256,490**	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**4,540**	**1.7%**
CMC	CMC Non-Long Term Care	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	10,122	10,160	265	2.7%
	CMC - Long Term Care	210	209	207	193	187	184	179	180	185	209	208	203	208	23	12.4%
	Total CMC	**9,570**	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**288**	**2.9%**
	Total Enrollment	**266,060**	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**4,828**	**1.7%**

Medi-Cal Enrollment Trend



- Actual enrollment, represented by the blue line, showed steeper COVID enrollment growth in FY21 followed by a general flattening in FY22.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to the extended public health emergency.

Cal Medi-Connect Enrollment Trend

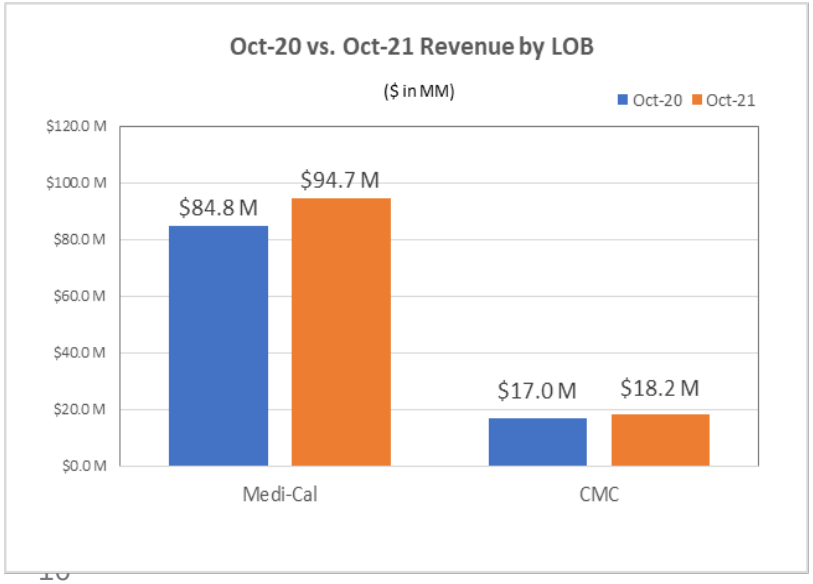


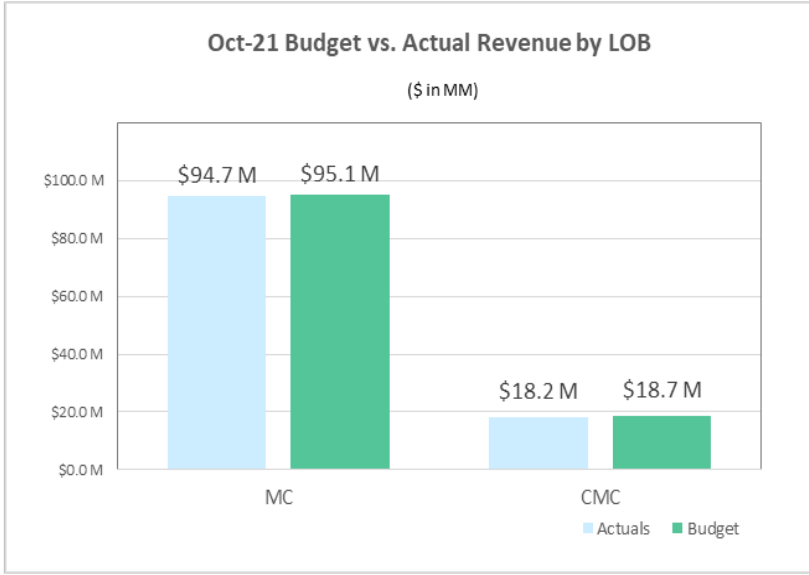
- Actual enrollment, represented by the blue line, showed steeper COVID enrollment growth in FY21 followed by a general flattening in FY22.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to the extended public health emergency.

Current Month Revenue

Current month revenue of $112.9M was $870K or 0.8% unfavorable to budget of $113.8M. The current month variance was primarily due to the following:

- Medi-Cal revenue was $574K unfavorable to budget due to lower enrollment than budget (including a one-time true-up associated with last month's estimated revenue due to DHCS' delay in sending data), offset with higher CY21 CCI and Non Dual LTC and SPD rates.
- CMC revenue was $517K unfavorable to budget due to lower Medicare Part C rate, offset with higher CY21 CCI rate.
- Supplemental kick revenue was $424K favorable to budget due to increased Behavioral Health Therapy and Health Home utilization, including higher maternity deliveries.
- MCAL Prop-56 revenue was $203K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).

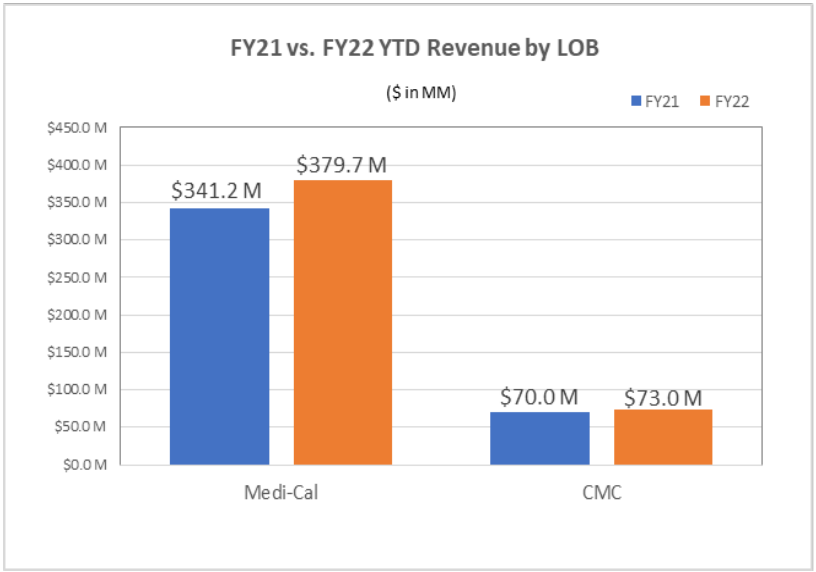


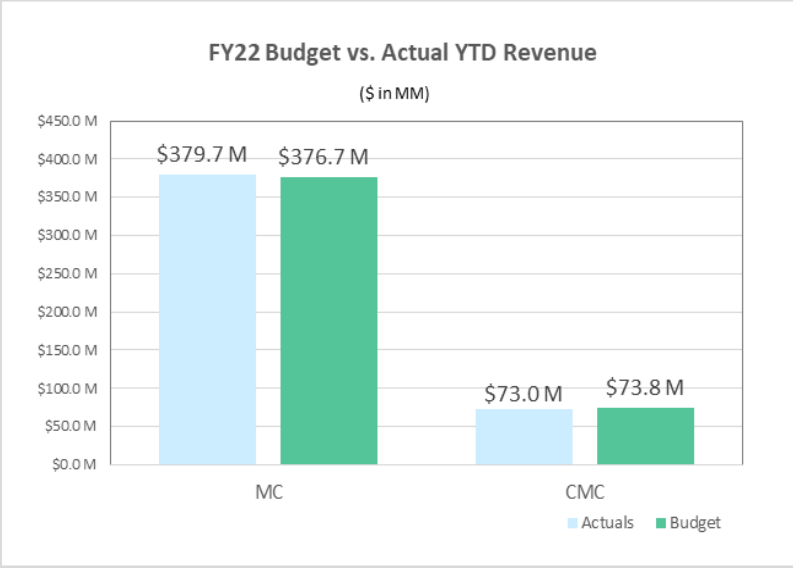


YTD Revenue

YTD revenue of $452.7M was $2.1M or 0.5% favorable to budget of $450.5M. The YTD variance was primarily due to the following:

- Supplemental kick revenue was $3.4M favorable to budget due to increased utilization in BHT, Health Homes, Hep-C and higher maternity deliveries.
- CMC revenue was $818K net unfavorable to budget due to lower than anticipated Medicare Part C rate, offset by higher CY21 CCI rate.
- MCAL Prop-56 revenue is $753K unfavorable to budget due to lower enrollment than estimated budget (offset with favorable Prop-56 expense).
- Medi-Cal revenue is $305K favorable to budget due to higher CY21 CCI, Non Dual LTC and SPD rates, offset by lower enrollment than budget.

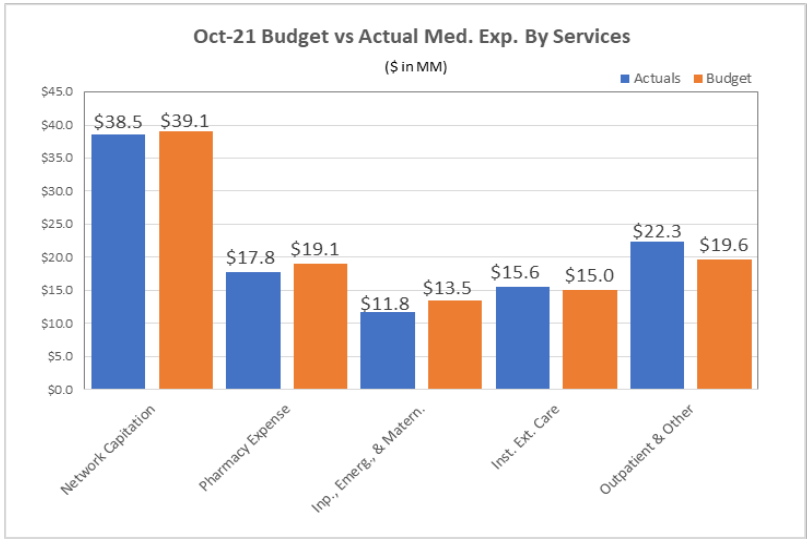


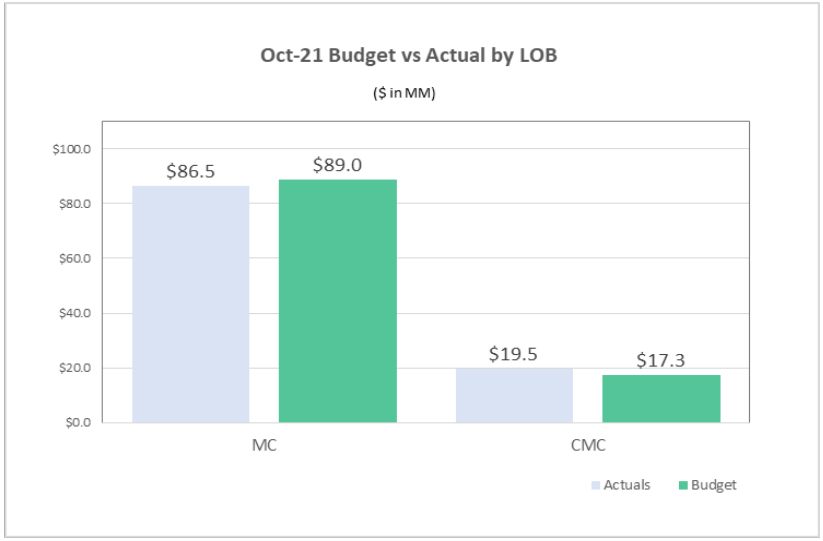


Current Month Medical Expense

Current month medical expense of $106.0M was $294K or 0.3% favorable to budget of $106.3M. The current month variance was due largely to:

- Fee-For-Service expenses reflected a $1.7M or 3.9% unfavorable variance due to increase in unit cost and utilization in Outpatient, ER, PCP, Specialty, Other MLTSS, and Transportation services.
- Pharmacy expenses were $1.3M or 6.6% favorable to budget due to lower enrollment, thus lower overall pharmacy costs compared with budget. Our budget was based on historical mix of drugs and diabetic drugs made up 24.4% of the pharmacy budget. The actual costs of diabetic drugs were lower due to the decreased enrollment.
- Capitation expense was $554K or 1.4% favorable to budget due to lower capitated enrollment.
- Vision, Reinsurance and Other expenses were $185K or 4.9% favorable to budget due to a favorable Third Party Liability claim recovery and lower VSP enrollment.

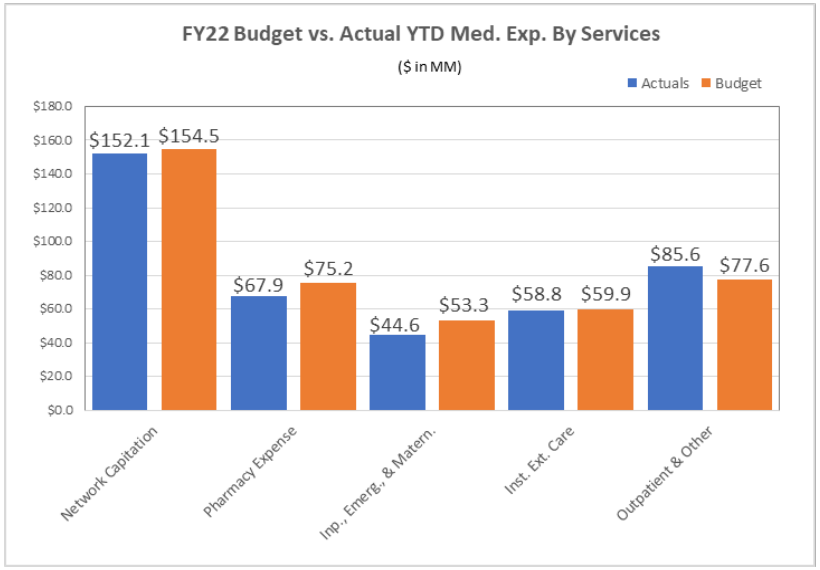


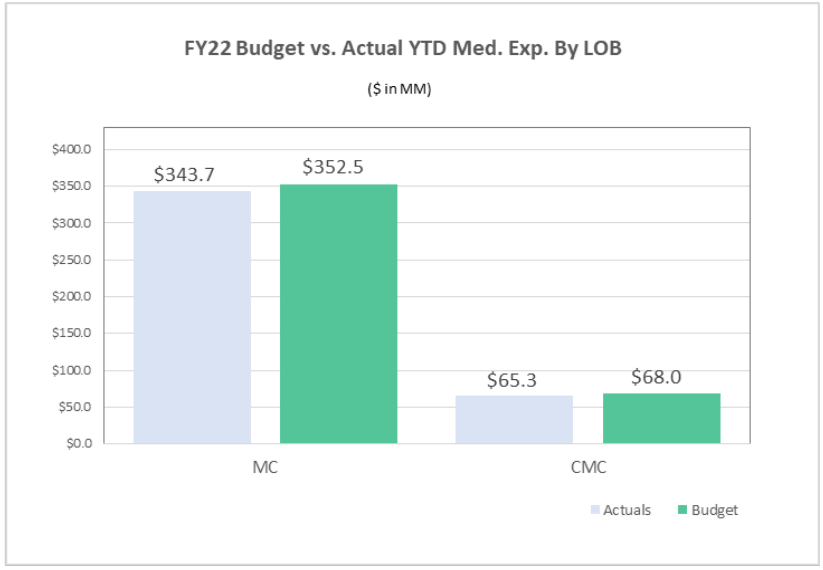


YTD Medical Expense

YTD medical expense of $409.0M was $11.5M or 2.7% favorable to budget of $420.6M.
The YTD variance was due largely to:

- Pharmacy expenses were $7.4M or 9.8% favorable to budget, due to lower enrollment, thus lower overall pharmacy costs. Actual costs of diabetic drugs were also affected by lower enrollment.
- Fee-For-Service expenses reflected a net $751K or 0.4% favorable variance due to lower Inpatient and LTC utilization, offset with increased supplemental services such as Behavioral Health Therapy, Health Home and high maternity deliveries (offset with favorable revenue variance).
- Capitation expense was $2.3M or 1.5% favorable to budget due to lower capitated MC enrollment.
- Vision, Reinsurance and Other expenses were $1.1M or 7.2% favorable to budget due to timing of spending on Board Designated expenses and lower VSP enrollment.

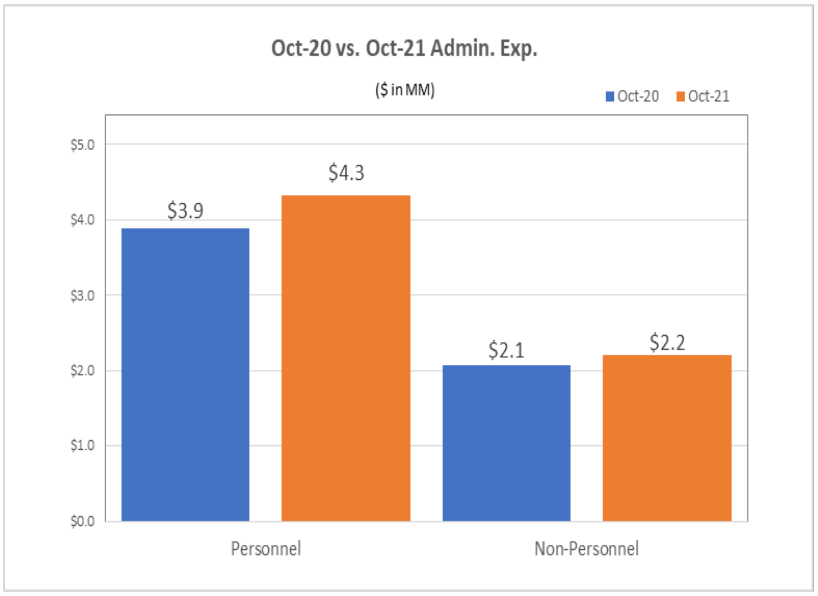


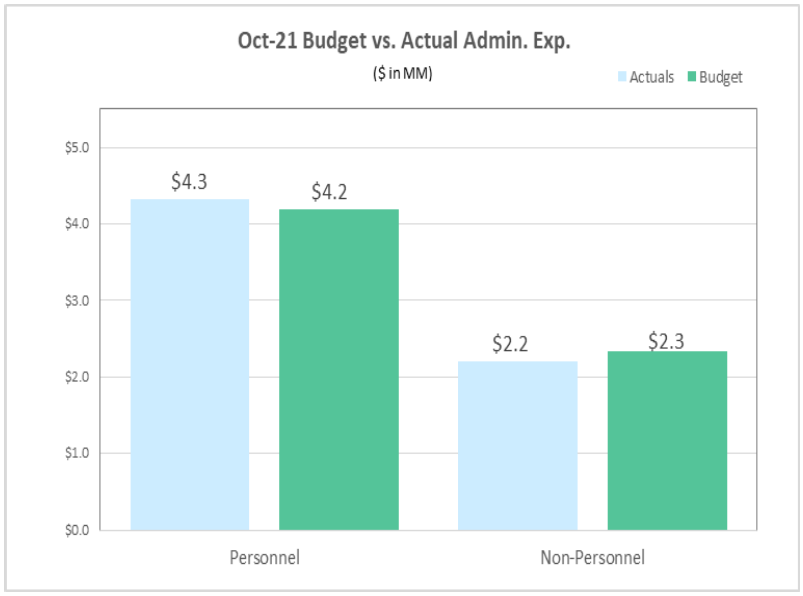


Current Month Administrative Expense

Current month expense of $6.5M was $2.7K or 0.0% favorable to budget of $6.5M. The current month variances were primarily due to the following:

- Personnel expenses were $136K or 3.2% unfavorable to budget due to GASB OPEB true-up and retro annual merit increase, offset by lower headcount than budget including payroll tax and benefit savings.
- Non-Personnel expenses were $138K or 5.9% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees) which are expected to be incurred later in the fiscal year.

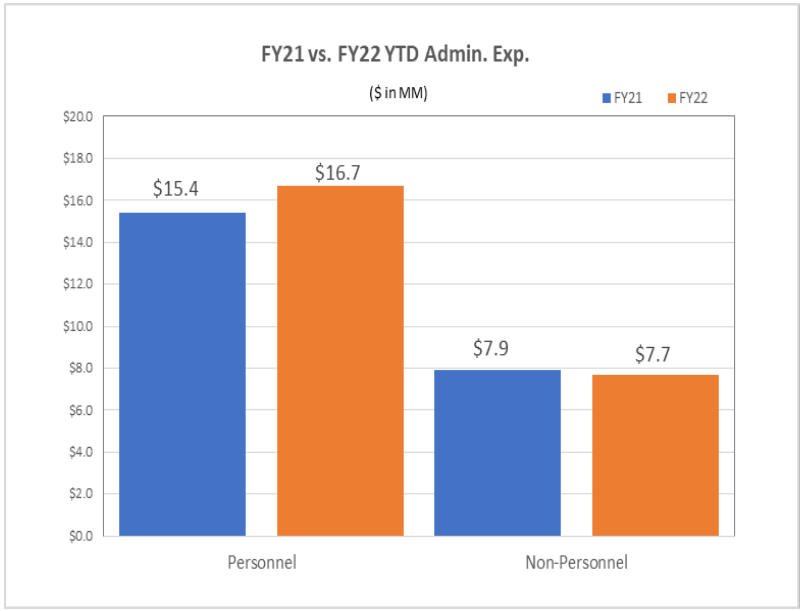


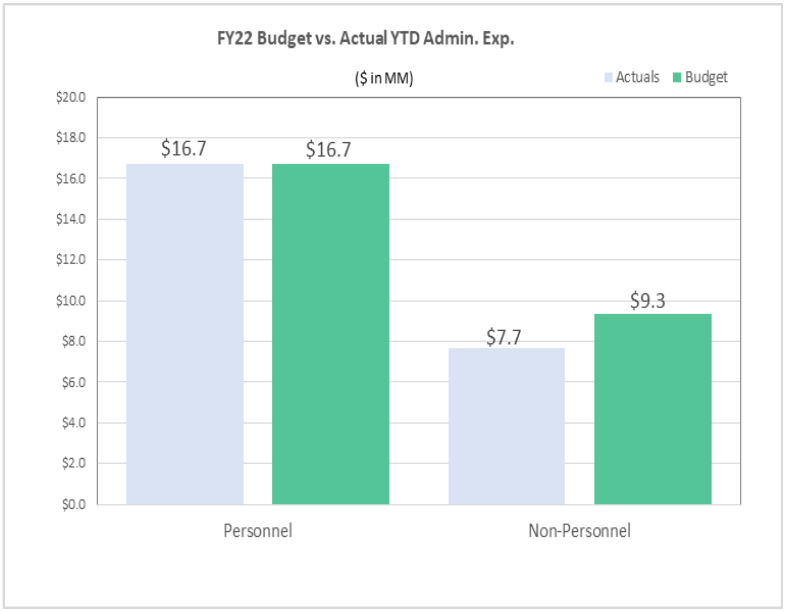


YTD Administrative Expense

YTD administrative expense of $24.3M was $1.7M or 6.5% favorable to budget of $26.0M. The YTD variance was primarily due to the following:

- Personnel expenses were $33K or 0.2% favorable to budget due to lower headcount than budget including lower payroll tax and benefits, offset with unfavorable GASB OPEB true-up.
- Non-Personnel expenses were $1.7M or 17.7% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising and other fees) which are expected to be incurred later in the fiscal year.





Balance Sheet

- Current assets totaled $973.0M compared to current liabilities of $730.7M, yielding a current ratio (Current Assets/Current Liabilities) of 1.33:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by $11.5M compared to the cash balance as of year-end June 30, 2021 due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$182,649,335	0.75%	$100,000	$390,096
Wells Fargo Investments	$167,070,265	0.11%	($14,363)	$36,960
	$349,719,600		$85,637	$427,056
Cash & Equivalents				
Bank of the West Money Market	$133,647	0.10%	$318	$1,938
City National Bank Accounts	$40,000,011	0.00%	$11	$11
Checking Accounts	$29,394,177	0.01%	$375	$1,424
	$69,527,835		$703	$3,373
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.18%	$0	$0
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$419,572,935**		**$86,341**	**$430,429**

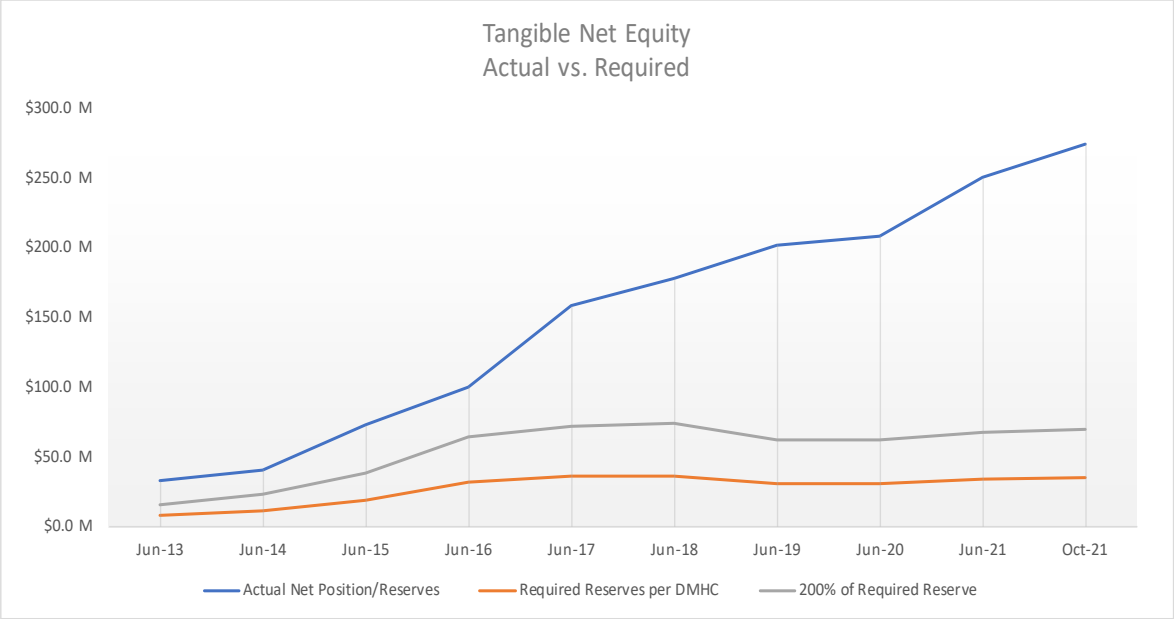
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- Overall cash and investment yield is lower than budget (0.37% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $274.7M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of October 31, 2021

	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	Oct-21
Actual Net Position/Reserves	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$274.7 M
Required Reserves per DMHC	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$35.2 M
200% of Required Reserve	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$70.3 M
Actual as % Required	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	781.1%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS OCTOBER 2021

Financial Reserve Target #1: Tangible Net Equity

	Board Funds Committed	Approved Projects	Funds Expended	Balance
Unrestricted Net Assets				**$231,095,619** *
Board Designated Funds (Note 1):				
Special Project Funding for CBOs	$4,000,000	$1,081,743	$662,727	$3,337,274
Innovation & COVID-19 Fund	$16,000,000	$5,685,155	$2,567,996	$13,432,004
Subtotal	$20,000,000	$6,766,898	$3,230,723	$16,769,277
Net Book Value of Fixed Assets				$26,536,065
Restricted Under Knox-Keene Agreement				$325,000
Total Tangible Net Equity (TNE)				$274,725,961
Current Required TNE				$35,172,940
TNE %				781.1%
SCFHP Target TNE Range:				
350% of Required TNE (Low)				$123,105,290
500% of Required TNE (High)				$175,864,700
Total TNE Above/(Below) SCFHP Low Target				**$151,620,671**
Total TNE Above/(Below) High Target				**$98,861,261**

Financial Reserve Target #2: Liquidity

Cash & Investments	$419,572,935
Less Pass-Through Liabilities:	
Hospital Directed Payments	(578,027)
MCO Tax Payable to State of CA	(14,763,539)
Whole Person Care / Prop 56	(51,365,781)
Other Pass-Through Liabilities (Note 2)	(87,564,996)
Total Pass-Through Liabilities	**(154,272,342)**
Net Cash Available to SCFHP	265,300,593
SCFHP Target Liquidity (Note 3)	
45 Days of Total Operating Expense	(169,208,420)
60 Days of Total Operating Expense	(225,611,227)
Liquidity Above/(Below) SCFHP Low Target	**96,092,173**
Liquidity Above/(Below) High Target	**$39,689,366**

- **Unrestricted Net Assets represents approximately two months of total expenses.**

Note 1: In December 2018, the Governing Board established a Board Discretionary Fund for Special Projects of $2.2M. In December 2019, the Governing Board also approved additional $1.8M for Special Project fund ($4M total) and $16M for Innovation & COVID-19 Fund.

Note 2: Other Pass-Through Liabilities include HQAF, Rate Range IGT, and DHCS overpayments.

Note 3: SCFHP Target Liquidity is based on total monthly budgeted expenses.

Capital Expenditures

- YTD Capital investments of $857K, largely due to software acquisition, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$60,124	$55,800
Hardware	$199,696	$1,060,000
Software	$493,973	$1,896,874
Building Improvements	$102,794	$62,000
Furniture & Equipment	$0	$179,101
TOTAL	**$856,587**	**$3,253,775**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Four Months Ending October 31, 2021

	Oct-2021 Actuals	% of Rev	Oct-2021 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Oct-2021 Actuals	% of Rev	YTD Oct-2021 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 94,729,253	83.9%	$ 95,082,294	83.5%	$ (353,041)	-0.4%	$ 379,703,122	83.9%	$ 376,748,856	83.6%	$ 2,954,266	0.8%
CMC MEDI-CAL	3,875,009	3.4%	3,792,052	3.3%	82,957	2.2%	15,817,858	3.5%	14,950,098	3.3%	867,760	5.8%
CMC MEDICARE	14,329,944	12.7%	14,930,085	13.1%	(600,141)	-4.0%	57,176,313	12.6%	58,861,878	13.1%	(1,685,565)	-2.9%
TOTAL CMC	18,204,953	16.1%	18,722,137	16.5%	(517,185)	-2.8%	72,994,171	16.1%	73,811,976	16.4%	(817,805)	-1.1%
TOTAL REVENUE	**$ 112,934,206**	**100.0%**	**$ 113,804,431**	**100.0%**	**$ (870,226)**	**-0.8%**	**$ 452,697,293**	**100.0%**	**$ 450,560,832**	**100.0%**	**$ 2,136,461**	**0.5%**
MEDICAL EXPENSES												
MEDI-CAL	$ 86,496,962	76.6%	$ 88,998,029	78.2%	$ 2,501,068	2.8%	$ 343,683,755	75.9%	$ 352,519,794	78.2%	$ 8,836,039	2.5%
CMC MEDI-CAL	3,641,722	3.2%	3,029,217	2.7%	(612,504)	-20.2%	12,920,807	2.9%	11,931,564	2.6%	(989,243)	-8.3%
CMC MEDICARE	15,840,116	14.0%	14,245,175	12.5%	(1,594,941)	-11.2%	52,418,147	11.6%	56,109,544	12.5%	3,691,397	6.6%
TOTAL CMC	19,481,838	17.3%	17,274,393	15.2%	(2,207,445)	-12.8%	65,338,954	14.4%	68,041,107	15.1%	2,702,153	4.0%
TOTAL MEDICAL EXPENSES	**$ 105,978,799**	**93.8%**	**$ 106,272,422**	**93.4%**	**$ 293,623**	**0.3%**	**$ 409,022,709**	**90.4%**	**$ 420,560,901**	**93.3%**	**$ 11,538,193**	**2.7%**
GROSS MARGIN	**$ 6,955,406**	**6.2%**	**$ 7,532,009**	**6.6%**	**$ (576,603)**	**-7.7%**	**$ 43,674,584**	**9.6%**	**$ 29,999,931**	**6.7%**	**$ 13,674,654**	**45.6%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 4,328,479	3.8%	$ 4,192,842	3.7%	$ (135,637)	-3.2%	$ 16,682,433	3.7%	$ 16,715,173	3.7%	$ 32,740	0.2%
RENTS AND UTILITIES	38,280	0.0%	42,067	0.0%	3,787	9.0%	146,149	0.0%	168,267	0.0%	22,118	13.1%
PRINTING AND ADVERTISING	13,353	0.0%	107,542	0.1%	94,189	87.6%	225,240	0.0%	432,167	0.1%	206,927	47.9%
INFORMATION SYSTEMS	307,453	0.3%	376,194	0.3%	68,742	18.3%	1,183,876	0.3%	1,504,777	0.3%	320,900	21.3%
PROF FEES/CONSULTING/TEMP STAFFING	1,198,148	1.1%	1,092,547	1.0%	(105,600)	-9.7%	3,517,168	0.8%	4,386,440	1.0%	869,272	19.8%
DEPRECIATION/INSURANCE/EQUIPMENT	395,541	0.4%	410,817	0.4%	15,277	3.7%	1,577,155	0.3%	1,647,455	0.4%	70,300	4.3%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	58,095	0.1%	62,842	0.1%	4,748	7.6%	217,290	0.0%	249,569	0.1%	32,279	12.9%
MEETINGS/TRAVEL/DUES	105,513	0.1%	145,533	0.1%	40,020	27.5%	415,371	0.1%	534,534	0.1%	119,163	22.3%
OTHER	85,649	0.1%	102,807	0.1%	17,158	16.7%	391,672	0.1%	402,577	0.1%	10,904	2.7%
TOTAL ADMINISTRATIVE EXPENSES	**$ 6,530,508**	**5.8%**	**$ 6,533,191**	**5.7%**	**$ 2,683**	**0.0%**	**$ 24,356,354**	**5.4%**	**$ 26,040,958**	**5.8%**	**$ 1,684,604**	**6.5%**
OPERATING SURPLUS/(LOSS)	**$ 424,898**	**0.4%**	**$ 998,818**	**0.9%**	**$ (573,920)**	**-57.5%**	**$ 19,318,230**	**4.3%**	**$ 3,958,973**	**0.9%**	**$ 15,359,257**	**388.0%**
INTEREST & INVESTMENT INCOME	$ 86,341	0.1%	$ 350,000	0.3%	$ (263,659)	-75.3%	$ 430,429	0.1%	$ 1,400,000	0.3%	$ (969,571)	-69.3%
OTHER INCOME	31,732	0.0%	35,986	0.0%	(4,253)	-11.8%	126,701	0.0%	143,943	0.0%	(17,242)	-12.0%
NON-OPERATING INCOME	**$ 118,073**	**0.1%**	**$ 385,986**	**0.3%**	**$ (267,913)**	**-69.4%**	**$ 557,130**	**0.1%**	**$ 1,543,943**	**0.3%**	**$ (986,813)**	**-63.9%**
NET SURPLUS (LOSS)	**$ 542,971**	**0.5%**	**$ 1,384,804**	**1.2%**	**$ (841,833)**	**-60.8%**	**$ 19,875,360**	**4.4%**	**$ 5,502,916**	**1.2%**	**$ 14,372,444**	**261.2%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of October 31, 2021

	Oct-2021	Sep-2021	Aug-2021	Oct-2020
Assets				
Current Assets				
Cash and Investments	$ 419,572,935	$ 449,737,033	$ 410,684,675	$ 352,583,853
Receivables	543,449,653	523,104,967	544,807,886	523,710,482
Prepaid Expenses and Other Current Assets	9,965,990	11,700,387	9,900,313	9,350,628
Total Current Assets	**$ 972,988,578**	**$ 984,542,387**	**$ 965,392,874**	**$ 885,644,963**
Long Term Assets				
Property and Equipment	$ 52,379,458	$ 52,197,243	$ 52,015,817	$ 50,220,519
Accumulated Depreciation	(25,843,393)	(25,504,456)	(25,157,882)	(21,806,251)
Total Long Term Assets	26,536,065	26,692,788	26,857,935	28,414,268
Total Assets	**$ 999,524,643**	**$ 1,011,235,174**	**$ 992,250,809**	**$ 914,059,230**
Deferred Outflow of Resources	**$ 6,939,744**	**$ 7,162,621**	**$ 7,413,357**	**$ 8,402,260**
Total Assets & Deferred Outflows	**$ 1,006,464,387**	**$ 1,018,397,795**	**$ 999,664,166**	**$ 922,461,490**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 6,148,888	$ 7,115,339	$ 5,588,358	$ 7,120,503
Deferred Rent	47,138	47,437	47,735	47,900
Employee Benefits	3,624,197	3,245,599	3,210,465	2,585,153
Retirement Obligation per GASB 75	2,058,287	1,978,037	1,897,787	2,450,166
Deferred Revenue - Medicare	0	0	0	20,476,272
Whole Person Care / Prop 56	51,365,781	48,292,369	50,100,271	42,736,765
Payable to Hospitals	103,313	103,357	103,357	531,963
Payable to Hospitals	474,714	23,516,453	23,516,453	206,574
Pass-Throughs Payable	22,600,898	182	182	26,787
Due to Santa Clara County Valley Health Plan and Kaiser	29,394,756	24,985,401	20,402,761	18,589,122
MCO Tax Payable - State Board of Equalization	14,763,539	35,014,087	24,885,874	36,461,565
Due to DHCS	64,964,098	67,081,490	60,193,218	47,266,463
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,268,582
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	106,913,541	103,669,528	115,818,873	99,575,513
Total Current Liabilities	**$ 730,744,108**	**$ 743,334,237**	**$ 734,050,292**	**$ 705,637,355**
Non-Current Liabilities				
Net Pension Liability GASB 68	455,000	341,250	(10,335)	1,136,608
Total Non-Current Liabilities	**$ 455,000**	**$ 341,250**	**$ (10,335)**	**$ 1,136,608**
Total Liabilities	**$ 731,199,108**	**$ 743,675,487**	**$ 734,039,957**	**$ 706,773,962**
Deferred Inflow of Resources	**$ 539,318**	**$ 539,318**	**$ 539,318**	**$ 1,661,827**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,337,274	$ 3,337,274	$ 3,337,274	$ 3,439,274
Board Designated Fund: Innovation & COVID-19 Fund	13,432,004	13,682,004	13,682,004	13,830,001
Invested in Capital Assets (NBV)	26,536,065	26,692,788	26,857,935	28,414,268
Restricted under Knox-Keene agreement	325,000	325,000	325,000	305,350
Unrestricted Net Equity	211,220,259	210,813,536	210,648,389	162,651,895
Current YTD Income (Loss)	19,875,360	19,332,389	10,234,291	5,384,914
Total Net Assets / Reserves	**$ 274,725,961**	**$ 274,182,990**	**$ 265,084,892**	**$ 214,025,701**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,006,464,387**	**$ 1,018,397,795**	**$ 999,664,166**	**$ 922,461,490**

Cash Flow Statement

Santa Clara Family Health Plan

	Oct-2021	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$ 70,221,579	$ 410,709,532
Medical Expenses Paid	(98,325,431)	(404,087,414)
Adminstrative Expenses Paid	(1,996,103)	5,178,209
Net Cash from Operating Activities	**$ (30,099,956)**	**$ 11,800,327**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	$ (182,215)	$ (856,587)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	118,073	557,130
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ (30,164,097)**	**$ 11,500,870**
Cash & Investments (Beginning)	449,737,033	408,072,066
Cash & Investments (Ending)	**$ 419,572,935**	**$ 419,572,935**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Surplus/(Loss)	$ 424,898	$ 19,318,230
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	338,937	1,377,186
Changes in Operating Assets/Liabilities		
Premiums Receivable	(20,344,686)	(31,230,128)
Prepaids & Other Assets	1,734,397	(1,249,486)
Accounts Payable & Accrued Liabilities	2,124,444	28,478,250
State Payable	(22,367,941)	(10,757,633)
IGT, HQAF & Other Provider Payables	4,409,355	5,609,077
Net Pension Liability	113,750	455,000
Medical Cost Reserves & PDR	3,244,013	(673,783)
IHSS Payable	0	0
Total Adjustments	**$ (30,524,854)**	**$ (7,517,903)**
Net Cash from Operating Activities	**$ (30,099,956)**	**$ 11,800,327**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Four Months Ending October 31, 2021

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$379,703,122	$15,817,858	$57,176,313	$72,994,171	**$452,697,293**
MEDICAL EXPENSE	$343,683,755	$12,920,807	$52,418,147	$65,338,954	**$409,022,709**
(MLR)	90.5%	81.7%	91.7%	89.5%	90.4%
GROSS MARGIN	$36,019,368	$2,897,051	$4,758,166	$7,655,217	**$43,674,584**
ADMINISTRATIVE EXPENSE	$20,429,068	$851,044	$3,076,242	$3,927,286	**$24,356,354**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$15,590,300	$2,046,007	$1,681,924	$3,727,930	**$19,318,230**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$467,297	$19,467	$70,366	$89,833	**$557,130**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$16,057,596	$2,065,473	$1,752,290	$3,817,764	**$19,875,360**
PMPM (ALLOCATED BASIS)					
REVENUE	$344.37	$384.99	$1,391.63	$1,776.62	**$395.82**
MEDICAL EXPENSES	$311.70	$314.48	$1,275.82	$1,590.30	**$357.63**
GROSS MARGIN	$32.67	$70.51	$115.81	$186.32	**$38.19**
ADMINISTRATIVE EXPENSES	$18.53	$20.71	$74.87	$95.59	**$21.30**
OPERATING INCOME/(LOSS)	$14.14	$49.80	$40.94	$90.73	**$16.89**
OTHER INCOME/(EXPENSE)	$0.42	$0.47	$1.71	$2.19	**$0.49**
NET INCOME/(LOSS)	$14.56	$50.27	$42.65	$92.92	**$17.38**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	1,102,614	41,086	41,086	41,086	1,143,700
REVENUE BY LOB	83.9%	3.5%	12.6%	16.1%	100.0%

Santa Clara Family Health Plan™

Appendices

Statement of Operations by Line of Business – Current Month

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For the Month October 2021

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$94,729,253	$3,875,009	$14,329,944	$18,204,953	**$112,934,206**
MEDICAL EXPENSE	$86,496,962	$3,641,722	$15,840,116	$19,481,838	**$105,978,799**
(MLR)	91.3%	94.0%	110.5%	107.0%	93.8%
GROSS MARGIN	$8,232,291	$233,287	($1,510,173)	($1,276,885)	**$6,955,406**
ADMINISTRATIVE EXPENSE	$5,477,793	$224,075	$828,640	$1,052,716	**$6,530,508**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$2,754,499	$9,212	($2,338,813)	($2,329,601)	**$424,898**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$99,040	$4,051	$14,982	$19,033	**$118,073**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$2,853,538	$13,263	($2,323,831)	($2,310,567)	**$542,971**
PMPM (ALLOCATED BASIS)					
REVENUE	$341.82	$373.75	$1,382.13	$1,755.88	**$392.82**
MEDICAL EXPENSES	$312.12	$351.25	$1,527.79	$1,879.04	**$368.62**
GROSS MARGIN	$29.71	$22.50	($145.66)	($123.16)	**$24.19**
ADMINISTRATIVE EXPENSES	$19.77	$21.61	$79.92	$101.54	**$22.71**
OPERATING INCOME/(LOSS)	$9.94	$0.89	($225.58)	($224.69)	**$1.48**
OTHER INCOME/(EXPENSE)	$0.36	$0.39	$1.45	$1.84	**$0.41**
NET INCOME/(LOSS)	$10.30	$1.28	($224.13)	($222.86)	**$1.89**
ALLOCATION BASIS:					
MEMBER MONTHS	277,130	10,368	10,368	10,368	287,498
REVENUE BY LOB	83.9%	3.4%	12.7%	16.1%	100.0%

Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD NOVEMBER - 2021

		2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	FYTD var	%
NON DUAL	Adult (over 19)	29,835	30,327	30,750	31,307	31,711	32,106	32,577	32,997	32,995	33,281	33,546	33,809	34,245	1,248	3.8%
	Child (under 19)	98,930	99,012	99,172	99,377	99,557	99,872	100,245	100,477	101,010	101,085	101,093	101,125	101,411	934	0.9%
	SPD	22,169	22,245	22,350	22,308	22,281	22,290	22,291	22,301	22,363	22,276	22,331	22,381	22,463	162	0.7%
	Adult Expansion	82,060	83,250	84,477	85,477	86,677	88,035	89,361	89,957	90,711	91,392	91,960	92,393	93,186	3,229	3.6%
	Long Term Care	389	393	388	380	373	375	367	365	414	408	401	391	385	20	5.5%
	Total Non-Duals	**233,383**	**235,227**	**237,137**	**238,849**	**240,599**	**242,678**	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**5,593**	**2.3%**
DUAL	Adult (over 21)	353	353	352	355	361	357	365	366	367	376	375	396	398	32	8.7%
	SPD	23,760	23,988	23,899	24,155	24,206	24,168	24,146	24,115	23,980	24,159	24,206	24,244	24,307	192	0.8%
	Long Term Care	1,208	1,182	1,115	1,074	1,054	1,038	1,031	1,060	1,127	1,115	1,092	1,083	1,106	46	4.3%
	SPD OE	498	537	590	662	742	802	863	952	1,063	1,135	1,223	1,308	1,372	420	44.1%
	Total Duals	**25,819**	**26,060**	**25,956**	**26,246**	**26,363**	**26,365**	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**690**	**2.6%**
	Total Medi-Cal	**259,202**	**261,287**	**263,093**	**265,095**	**266,962**	**269,043**	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**6,283**	**2.3%**
CMC	CMC Non-Long Term Care	9,470	9,613	9,614	9,706	9,696	9,745	9,809	9,895	9,939	10,037	10,122	10,160	10,211	316	3.2%
	CMC - Long Term Care	209	207	193	187	184	179	180	185	209	208	203	208	204	19	10.3%
	Total CMC	**9,679**	**9,820**	**9,807**	**9,893**	**9,880**	**9,924**	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**335**	**3.3%**
	Total Enrollment	**268,881**	**271,107**	**272,900**	**274,988**	**276,842**	**278,967**	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**6,618**	**2.3%**

Santa Clara Family Health Plan™

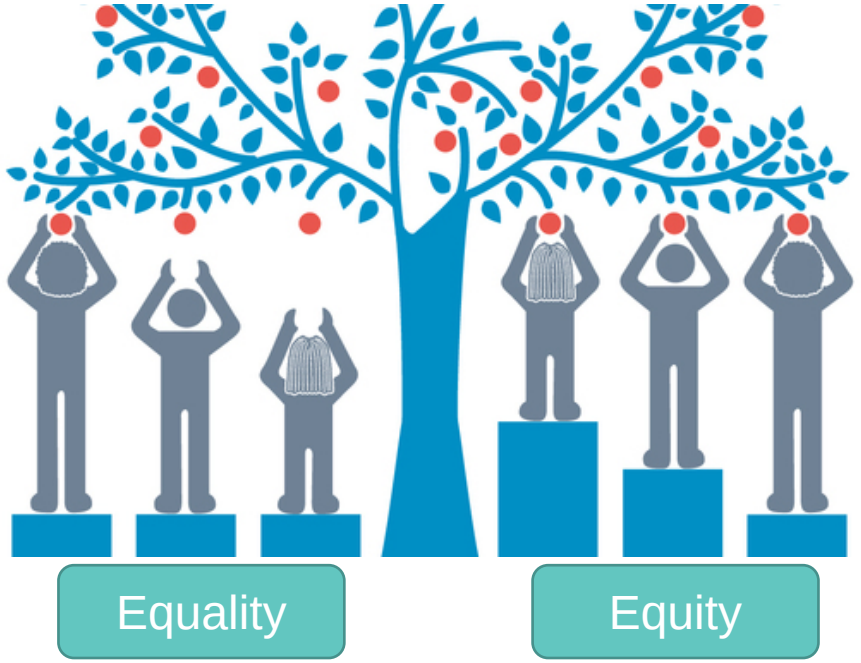
SCFHP Equity Steering Committee

December 16, 2021

Vision

Health for all – a fair and just community where everyone has access to opportunities to be healthy.

Health Equity!



Common Terminology

- **Health equity:** everyone has a fair and just opportunity to be as healthy as possible.
- **Health disparity:** a health difference and pattern among specific patient populations with outcomes being more or less for a specific group
  - *Examples: difference in health, burden of illness, injury, disability or mortality*
- **Social Determinants of Health (SDOH):** economic and social conditions where people are born, live, learn, work, play and age that affect their health, functioning and quality of life
  - *Examples: safe housing, local food markets, access to education and jobs, social support*
- **Social needs:** immediate necessities based on the individual's preferences and priorities
  - *Examples: lack of adequate housing, not able to pay for utilities, not able to modify diet to combat diabetes*

Understanding the Relationship

Santa Clara Family Health Plan

Health Equity

Social Determinants of Health (SDOH)

Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Build Environment	Social and Community Context
• Employment • Income • Expenses • Debt • Medical Bills • Support	• Literacy • Language • Vocational training • Higher Education	• Health Coverage • Provider Linguistic and Cultural Competency • Quality of Care	• Housing • Transportation • Safety • Food Insecurity • Walkability • Zip Code	• Social Integration • Support Systems • Community Engagement • Discrimination

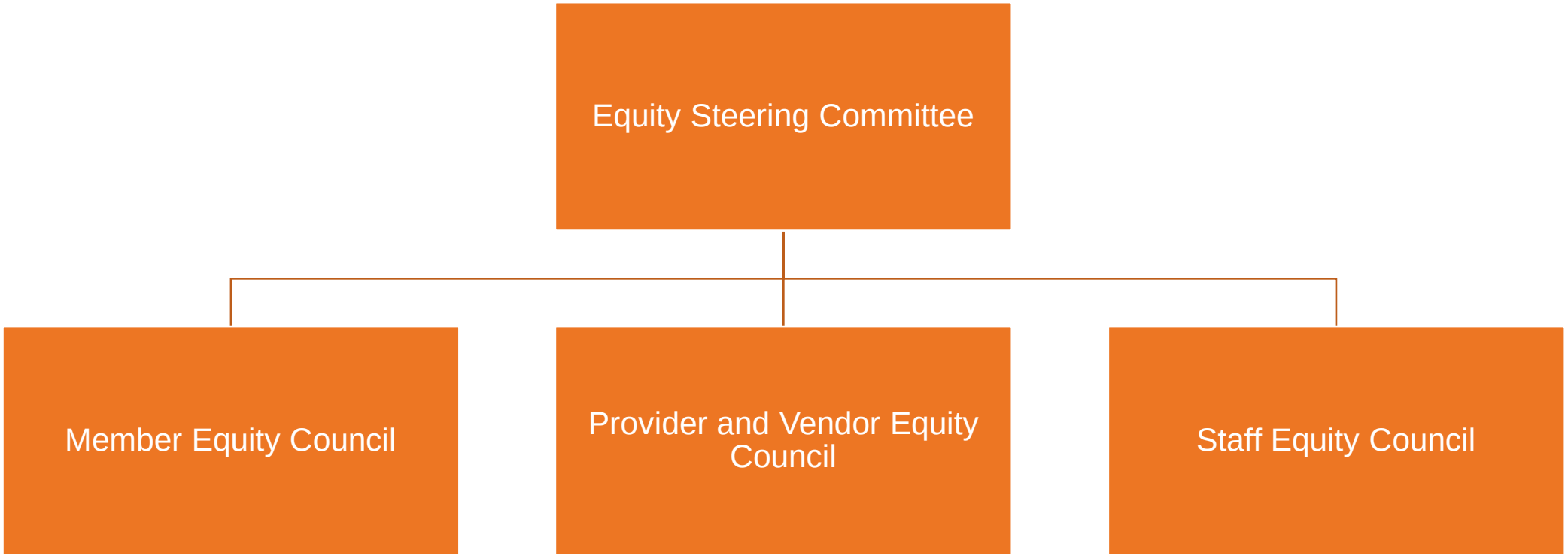
Health Disparities

Equity Steering Committee

Purpose

- To align, develop, coordinate, strengthen, and/or expand organization-wide efforts
  - to raise health equity for our members and
  - to create an equitable and inclusive workplace
- To serve as an advisory body to the executive team in support of the Strategic Plan and Plan Objectives

Equity Steering Committee



Membership: Executive Sponsor, Council Chairs, Project Manager, Staff Members (2)

Three Councils

Focus is to develop, strengthen, and/or expand activities that…

- **Member Equity Council**: promote health equity and reduce health disparities among members
  - Department Representatives: QI (Chair), Community Engagement, Customer Service, Grievance & Appeals, Case Management, LTSS
  - Work closely with Consumer Advisory Committee (Medi-Cal), Consumer Advisory Board (CMC), and the Blanca Alvarado Community Resource Center Resident Advisory Group
- **Provider and Vendor Equity Council**: promote culturally and linguistically appropriate standards of care for our members, and promote diversity of and opportunity for vendors
  - Department Representatives: PNO (Chair), Operations, Medical Director, IT, Compliance
  - Work closely with the Provider Advisory Council
- **Staff Equity Council**: promote a culture of inclusion and belonging at SCFHP, making it an employer of choice
  - Folds current Diversity Committee into organization-wide focus on equity
  - Membership: HR, Strategies and Analytics, 10-15 Staff members with Chair elected by Council

Santa Clara Family Health Plan™

Dental Coverage for Medi-Cal Members

December 16, 2021

Medi-Cal Medical and Dental Delivery Systems in Santa Clara County

- Medical Care: The majority of enrollees receive medical care through two managed care plans— SCFHP and Anthem. A small percentage receives care through Medi-Cal Fee-For-Service (FFS).
- Dental Care: All enrollees receive dental care through a separate FFS delivery system, the Medi-Cal Dental Program, formerly called Denti-Cal.
- Medical and Dental Integration Pilot: SB 849 established the dental integration demonstration pilot under which Health Plan of San Mateo will "test the impact to oral care access, quality and utilization as well as medical cost impacts by the delivery of covered dental care services as a managed care benefit under the operation of the MCP. The program will integrate dental services into medical services."
  - The pilot is authorized up to six years.
  - The pilot is in San Mateo County only.
  - No further expansion of this approach is anticipated until the state has outcome data from the San Mateo County pilot.

SB 849 Performance Measures for San Mateo County Pilot

Children and Adults
Annual Dental Visits
Use of Preventive Services
Use of Diagnostic Services
Treatment/Prevention of Caries
Exams/Oral Health Evaluations
Use of Dental Treatment Services
Preventive Services to Fillings Ratio
Overall Utilization of Dental Visits- 1 year
Overall Utilization of Dental Visits- 2 years
Overall Utilization of Dental Visits- 3 years
Continuity of Care
Usual Source of Care

Children Only
Use of Sealants
Count of Sealants
Count of Fluoride Varnishes

SCFHP's Role in Dental Health

- Promote utilization of SCFHP-covered services related to dental health – Dental Varnish
  - Bright Futures recommends fluoride varnish to be performed between 6 months and 5 years old, and periodic fluoride supplementation if water source is deficient in fluoride
  - Inform providers about American Academy of Pediatrics office fluoride varnishing training and certification
  - Educate providers on accurate coding of fluoride varnish for reimbursement (FFS rate + $25 Prop 56 supplemental)
- Remind providers of the child dental assessment components of the Staying Healthy Assessment (SHA) and follow up activities based on the assessment
  - SHA is performed for new members and annually

SCFHP's Role in Dental Health

- Educate members about Medi-Cal Dental Program benefits and the importance of dental care
    - Member Handbooks, Provider Directories, member ID cards
    - Member newsletter (covered every year), Member orientation, SCFHP website, and social media
- Educate PCPs about members' dental benefit and referral process
    - Provider Manual, Provider Orientation, Provider Authorization
- Opportunities
    - Add dental care education to Baby Shower for pregnant members starting in December 2021
    - Query PCPs on any barriers that members are experiencing with dental care access
    - Request that DHCS provide our members' data for SB 849 performance measures

Santa Clara Family Health Plan™

Government Relations Update

December 16, 2021

Federal Issues

Congress

- Infrastructure reconciliation bill
- Medicare sequestration

Administration

- Employer vaccination mandate

State Issues

2022 Initiatives Updates

- Enhanced Care Management and Community Supports
- Medi-Cal Rx
- Commercial Plan Reprocurement

Legislation & Budget

- Risk adjustment in Medi-Cal managed care rate-setting
- Projected State budget surplus

Local Issues

Health and Hospital Committee

- 12/15 discussion of CalAIM transition from Whole Person Care to Enhanced Care Management and Community Supports

Children, Seniors, and Families Committee

- 12/16 discussion of behavioral health services for children and youth