Regular Meeting of the

Santa Clara County Health Authority
Governing Board

Thursday, December 13, 2018, 2:30 PM - 5:00 PM
Santa Clara Family Health Plan, Board Room
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
Residence
2060 Bryant Street
Palo Alto, CA 94301

Via Teleconference
Business
2500 Grant Road
Mountain View, CA 94040

Via Teleconference
Business
4000 Moorpark Avenue
San Jose, CA 95117

AGENDA

1.	**Roll Call** Welcome new Board Member, Susan Murphy.	Mr. Darrow	2:30	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Board reserves the right to limit the duration of public comment period to 30 minutes.	Mr. Darrow	2:35	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. Darrow	2:40	5 min

a. Approve minutes of the September 27, 2018 **Regular Board** Meeting

b. Accept minutes of the October 25, 2018 **Executive/Finance Committee** Meeting
- Ratify approval of the FY 2017-18 External Independent Auditor's Report
- Ratify approval of the August 2018 Financial Statements
- Ratify approval to pay anniversary bonuses for the latest milestone achieved by current staff prior to July 2018

c. Accept minutes of the November 15, 2018 **Executive/Finance Committee** Meeting
- Ratify approval of the September 2018 Financial Statements

d. Accept minutes of the November 15, 2018 **Compliance Committee** Meeting
- Ratify acceptance of the Compliance Activity Report
- Ratify acceptance of the Compliance Monitoring Report
- Ratify acceptance of the Fraud, Waste, and Abuse Report

e. Accept minutes of the October 10, 2018 **Quality Improvement Committee** Meeting
- Ratify approval of the Email Response Evaluation
- Ratify approval of the Accessibility of Services Analysis
- Ratify approval of the Continuity and Coordination between Medical and Behavioral Healthcare
- Ratify approval of the Annual Assessment of Experience with UM Process
- Ratify approval of the Assessment of Physician Directory Adequacy
- Ratify approval of the Member Understanding of Marketing Information Analysis
- Ratify acceptance of Committee Reports
  - Credentialing Committee – August 15, 2018
  - Pharmacy & Therapeutics Committee - June 21, 2018
  - Utilization Management Committee – July 18, 2018

f. Accept minutes of the December 5, 2018 **Quality Improvement Committee** Meeting
- Ratify approval of MedImpact Audit CAP
- Ratify approval of Quality and Accuracy Assessment of Pharmacy Benefit Information on the Member Portal
- Ratify approval of Quality and Accuracy Assessment of Pharmacy Benefit and Personalized Information
- Ratify approval of Performance Evaluation of Clinical Practice Guidelines
- Ratify approval of Member Experience Analysis
- Ratify approval of Member Satisfaction with Complex Case Management Analysis
- Ratify approval of Continuity and Coordination of Medical Care Analysis
- Ratify approval of Policy QI.28 Health Homes Program
- Ratify approval of Network Adequacy Assessment
- Ratify acceptance of Committee Reports
  - Credentialing Committee – October 3, 2018
  - Pharmacy and Therapeutics Committee – September 20, 2018
  - Utilization Management Committee – October 17, 2018

g. Accept minutes of the November 14, 2018 **Provider Advisory Council** Meeting

h. Accept minutes of the December 11, 2018 **Consumer Advisory Committee** Meeting

4. CEO Update Ms. Tomcala 2:45 5 min

Discuss status of current topics and initiatives.

Possible Action: Accept CEO Update

5.	**Annual Report to the County Board of Supervisors** Review draft report regarding the activities of the Santa Clara County Health Authority. **Possible Action:** Approve the Annual Report to be submitted to the County Board of Supervisors	Ms. Tomcala	2:50	5 min
6.	**Compliance Report** Review and discuss quarterly compliance activities. **Possible Action:** Accept Compliance Report	Ms. Larmer	2:55	15 min
7.	**Conflict of Interest** Consider revisions to the Conflict of Interest Code. **Possible Action:** Adopt resolution approving the revised Conflict of Interest Code	Ms. Larmer	3:10	5 min
8.	**October 2018 Financial Statements** Review recent organizational financial performance. **Possible Action:** Approve October 208 Financial Statements	Mr. Cameron	3:15	15 min
9.	**Fund Retiree Healthcare Liability** Review CalPERS 6/30/2018 retiree health care liability. **Possible Action:** Approve resolution to fund outstanding retiree health care liability over three years	Mr. Cameron	3:30	5 min
10.	**Board Discretionary Fund** Discuss potential funding of the Board Discretionary Fund for strategic investments. **Possible Action:** Approve annual determination of funding for the Special Project Board Discretionary Fund (Policy GO.02)	Mr. Cameron Ms. Tomcala	3:35	10 min
11.	**Board Discretionary Fund Expenditures** Consider potential special project investments. **Possible Action:** Approve select special project investments	Ms. Tomcala	3:45	10 min
12.	**Signature Authority Policy** Discuss signature authority for CEO and management staff. **Possible Action:** Approve Signature Authority Policy	Mr. Cameron	3:55	5 min
13.	**Network Detection and Prevention Report** Review report on firewall intrusion, detection, and prevention efforts.	Mr. Tamayo	4:00	5 min
14.	**Publicly Available Salary Schedule Ranges** Consider changes to the Publicly Available Salary Schedule. **Possible Action:** Approve Publicly Available Salary Schedule	Ms. Valdez	4:05	5 min

Announcement Prior to Recessing to Closed Session
Announcement that the Governing Board will recess into closed session to discuss Items 14(a), (b), & (c) below.

15.	**Adjourn to Closed Session**		4:10	

a. **Contract Rates** (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.

b. **Contract Rates** (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.

c. **Publicly Employee Performance Evaluation** (Government Code Section: 54957(b)):
It is the intention of the Governing Board to meet in Closed Session to consider the performance evaluation of the Chief Executive Officer.

16.	**Report from Closed Session**	Mr. Darrow	4:50	5 min
17.	**Annual CEO Evaluation Process** Consider potential annual salary adjustment and incentive bonus for the Chief Executive Officer. **Possible Action:** Approve an annual salary increase and incentive bonus for the CEO	Mr. Darrow	4:55	5 min
18.	**Adjournment**		5:00	

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 Governing Board 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

September 27, 2018, 2:30 pm – 5:00 pm
Santa Clara Family Health Plan, Board Room
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Members Present
Bob Brownstein, Chair
Darrell Evora
Kathleen King
Liz Kniss
Paul Murphy
Ria Paul, M.D.
Evangeline Sangalang
Brenda Taussig
Linda Williams *(via telephone)*

Members Absent
Dolores Alvarado
Brian Darrow
Chris Dawes
Jolene Smith

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Chris Turner, Chief Operating Officer
Jeff Robertson, Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Sharon Valdez, VP of Human Resources
Neal Jarecki, Controller
Beth Paige, Director of Compliance
Jordan Yamashita, Compliance Manager
Rita Zambrano, Executive Assistant

Others Present
Julie Mason, Medicare Compliance Solutions
Cassidee Brusa, Aerotek
Kylie Moon, Aerotek
Tiffany Washington, Anthem

1. **Roll Call**

   Bob Brownstein, Chair, called the meeting to order at 2:35 pm. Roll call was taken and a quorum was established. Mr. Brownstein welcomed Evangeline Sangalang as a new member of the Santa Clara County Health Authority Governing Board.

2. **Public Comment**

   There were no public comments.

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 28, 2018 **Regular Board** Meeting

b. Accept minutes of the July 26, 2018 **Executive/Finance Committee** Meeting and:
- Ratify approval of the Tentative Agreement with SEIU
- Ratify approval of the May 2018 Financial Statements
- Ratify the appoint of the Matrix Trust Company to provide retirement plan trustee services
- Ratify appointment of the HR VP, CFO, and CEO as representatives for the retirement plans
- Ratify designation of office furniture as surplus

c. Accept minutes of the August 23, 2018 **Executive/Finance Committee** Meeting and:
- Ratify approval of the Interim June 2018 Financial Statements
- Ratify acceptance of the Network Detection and Prevention Report

d. Accept minutes of the June 28, 2018 **Compliance Committee** Meeting and:
- Ratify acceptance of the Compliance Activity Report
- Ratify acceptance of the Compliance Monitoring Report
- Ratify acceptance of the Fraud, Waste, and Abuse Report

e. Accept minutes of the August 23, 2018 **Compliance Committee** Meeting and:
- Ratify acceptance of the Compliance Activity Report
- Ratify acceptance of the Compliance Monitoring Report

f. Accept minutes of the August 8, 2018 **Quality Improvement Committee** Meeting and
- Ratify approval of the Cultural Needs and Preferences Assessment Evaluation
- Ratify approval of the Availability of Practitioners Evaluation
- Ratify approval of the Member Services Telephone Access Evaluation
- Ratify approval of the Cultural and Linguistics Program Work plan
- Ratify acceptance of Committee Reports
    - o Credentialing Committee – August 1, 2018
    - o Pharmacy & Therapeutics Committee – Sept 2, 2018
    - o Utilization Management Committee –July 18, 2018

g. Accept minutes of the August 8, 2018 **Provider Advisory Committee** Meeting

h. Accept minutes of the September 11, 2018 **Consumer Advisory Committee** Meeting

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

Liz Kniss joined the meeting at 2:47 pm.

4. CMS Program Audit Presentation

Robin Larmer, Chief Compliance & Regulatory Affairs Officer, introduced Julie Mason, Medicare Compliance Solutions. Ms. Mason provided an overview of the CMS Program Audit process, the preliminary SCFHP audit results, possible outcomes, and next steps.

Ms. Mason noted that SCFHP was the last California Medicare-Medicaid Plan to undergo a comprehensive Program Audit of its Cal MediConnect Plan. The scope of the audit included a review of SCFHP's Compliance Program Effectiveness (CPE), Part D Formulary Administration (FA), Part D Coverage Determinations, Appeals and Grievances (CDAG), Medicare Medicaid Plan Service

Authorization Requests, Appeals and Grievances (SARAG), and Medicare Medicaid Plan Care Coordination Quality Improvement Program Effectiveness (CCQIPE).

The audit began with CMS validation of the data universes for each of the five subject areas, and moved into a five-day substantive review (all but CPE conducted via webinar), for each of the areas.

SCFHP anticipates that CMS will identify deficiencies in several areas. Although a great deal of progress has been made to address known opportunities for improvement, not all work was completed before the audit notice was received. Corrective Action Plans (CAPs) will be required, and Civil Monetary Penalties will be imposed.

Ms. Larmer advised that she would meet with any interested Board member one-on-one if they had questions about the audit.

Mr. Brownstein suggested that staff and the Executive/Finance Committee develop a timely method of communication to keep the Board apprised of significant compliance problems and audit follow-up actions.

5. Compliance Report

Ms. Larmer presented the Operational Compliance Report, noting the primary focus is on better integrating compliance with operations. Extensive collaborative work has gone into the process of preparing the Corrective Action Plans (CAPs) in anticipation of the CMS audit findings.

Ms. Larmer noted the Plan received a potential Fraud, Waste, and Abuse complaint and has launched an investigation of the provider.

Ms. Larmer reported that DHCS and DMHC audits are scheduled to take place in March 2019. In addition, the Plan has completed the onsite portion of an audit being conducted by the California State Auditor's Office. This audit is focused on DHCS oversight of the health plans.

It was moved, seconded, and the Compliance Report was **unanimously approved.**

6. 2018 Compliance Program

Ms. Larmer presented the 2018 Compliance Program, developed to provide guidance to ensure that the Medi-Cal and Cal MediConnect Plans are operated in an ethical and legal manner. The Program outlines the seven elements of an effective Compliance Program as defined by CMS.

It was moved, seconded, and the 2018 Compliance Program was **unanimously approved.**

7. Standards of Conduct

Ms. Larmer presented SCFHP's revised Standards of Conduct, noting the revisions add specificity around the ethical and business performance of staff, Governing Board members, and the organization. The document outlines SCFHP's Code of Ethics, which addresses, among other things, personal and professional integrity, confidentiality and security, avoiding conflicts of interest, proper use of health care resources, and obeying the law.

It was moved, seconded, and the Standards of Conduct were **unanimously approved** with direction to the staff to consider Mr. Murphy's suggestion of augmenting language related to whistle blower protection.

8. Brown Act Training

The Brown Act Training was deferred and the Board discussed completing the training electronically.

9. Resolution for CalPERS Post-Retirement Service

Ms. Larmer requested the Board's consideration of a resolution authorizing the CalPERS Post-Retirement Service of the Director of Compliance to ensure adequate coverage during a Compliance team member's parental leave.

> **It was moved, seconded, and** the Resolution authorizing Post-Retirement Service of the Director of Compliance and Waiver of the 180-Day Wait Period was **unanimously approved.**

10. CEO Update

Christine Tomcala, Chief Executive Officer, welcomed the Board to the new building, noting that the front lobby and amenity area are expected to be completed soon.

Ms. Tomcala noted she would be conducting a New Board Member Orientation and invited any other Board members interested in attending.

Ms. Tomcala reported that Chris Dawes submitted his resignation, and discussion ensued regarding the significant contribution Mr. Dawes made to SCFHP during his years of service on the Board.

Ms. Tomcala reminded the committee that Dr. Jeff Robertson will be stepping back from the CMO role and will shift to a part-time Medical Director position. A new CMO has been hired and is expected to start on October 31.

Ms. Tomcala noted that Verity Health System filed for bankruptcy protection and there are several parties interested in acquiring the local hospitals, including the county.

There was a discussion regarding the draft Public Charge Rulemaking penalizing immigrants who use various benefits, and the potential impact it will have on health plans.

Ms. Tomcala reminded the Board that the Plan sponsored an outdoor classroom space for Veggielution in honor of the Plan's 20th Anniversary and noted they have been actively finishing the shade structure.

Ms. Tomcala also shared that the Plan recently participated in the San Jose PRIDE event.

> **It was moved, seconded, and unanimously approved to** accept the CEO Update.

11. July 2018 Financial Statements

Dave Cameron, Chief Financial Officer, presented the July 2018 financial statements, which reflected a current month net surplus of $497 thousand ($334 thousand favorable to budget).

Enrollment declined to 258,556 members. Medi-Cal enrollment has continued to decline since October 2016. CMC membership has grown modestly over the past few months due to continued outreach efforts.

Revenue reflected a favorable current month variance of $799 thousand (1.0%) largely due to retroactive revenue received. Medical expenses reflected an unfavorable current month variance of $1.1 million

(1.5%) largely due to increased Inpatient, Outpatient and Long Term Care expenses. Administrative expenses reflected a favorable current month variance of $501 thousand (10.5%) largely due to delayed hiring and printing costs. The Plan is actively seeking to recruit additional permanent staff.

The balance sheet reflected a current ratio of 1.31 versus the minimum required by DMHC of 1.00 Tangible Net Equity (TNE) was $194.1 million, or 542.7% of the minimum required by DMHC of $35.8 million.

> **It was moved, seconded, and** the July 2018 Financial Statements were **unanimously approved.**

12. Satellite Office

Ms. Tomcala discussed development of a Community Resource Center to provide services closer to the neighborhoods where the majority of members live. Planning is underway; key requirements have been identified, geographic areas have been identified and visited, and a real estate broker has been engaged. The Plan has is seeking to collaborate with other safety net organizations with whom SCFHP currently partners. Interested parties may include Valley Health Plan, The Health Trust, and Community Health Partnership.

> **It was moved, seconded and unanimously approved** to delegate to the Executive/Finance Committee the authority to approve a budget and contracts for establishment of a Community Resource Center within 5-10 miles of the Story and King intersection.

13. Provider Advisory Council Charter

Ms. Tomcala presented a revised charter for the Provider Advisory Council Charter. At the last Provider Advisory Council, two changes were recommended:

1) Add a reference to seek an *effective* system of care.
2) Allow the CEO to appoint physicians enrolled in an accredited Residency program as non-voting members.

> **It was moved, seconded, and** the Provider Advisory Council Charter was **unanimously approved.**

14. Publicly Available Salary Schedule Ranges

Sharon Valdez, VP of Human Resources, provided an update to the Publicly Available Salary Schedule, noting the positions that were added or removed since the last meeting.

> **It was moved, seconded, and** the Publicly Available Salary Schedule was **unanimously approved.**

15. 2019 Board Meeting Calendar

The proposed 2019 SCCHA Governing Board and Executive/Finance Committee meeting calendar and was presented for consideration.

> **It was moved, seconded, and** the 2019 SCCHA Governing Board and Executive/Finance

16. Adjournment

The meeting was adjourned at 4:53 pm.

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Bob Brownstein
Chair

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, October 25, 2018, 11:30 AM - 1:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Approved

Members Present
Brian Darrow, Chair
Bob Brownstein
Dolores Alvarado
Linda Williams

Members Absent
Liz Kniss

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

Others Present
Chris Pritchard, Moss Adams
Rianne Suicco, Moss Adams

1. **Roll Call**

   Brian Darrow, Chair, called the meeting to order at 11:35 am. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The minutes of the August 23, 2018 Executive/Finance Committee were reviewed.

   It was moved, seconded, and the August 23, 2018 Executive/Finance Committee Minutes were **approved.** Bob Brownstein abstained.

3. **Public Comment**

   There were no public comments.

4. Fiscal Year 2017-18 External Independent Auditor's Report

Dave Cameron, Chief Financial Officer, introduced Chris Pritchard, Partner, and Rianne Suicco, Senior Manager, 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, 2018. He indicated the financial statements once again received an unmodified opinion and reflected a fiscal year net surplus of $19.6 million. Ms. Suicco reviewed a summary of the Plan's financial statements and advised that: (1) management's accounting estimates were reasonable, (2) no audit adjustments to the financial statements were necessary, and (3) there were no disagreements with management.

It was moved, seconded, and the FY2017-18 External Independent Auditor's Report was **unanimously approved**.

5. August 2018 Financial Statements

Mr. Cameron presented the August 2018 financial statements, which reflected a current month net loss of $800 thousand ($456 thousand unfavorable to budget) and a year-to-date net loss of $303 thousand ($122 thousand unfavorable to budget). Enrollment declined 1,875 from the prior month to 256,681 members. Medi-Cal enrollment has continued to decline since October 2016, largely in the Medicaid Expansion (MCE), Adult, and Child categories of aid. CMC membership has grown modestly over the past few months due to continued outreach efforts. Revenue reflected a favorable current month variance of $3.0 million (3.6%) largely due to retroactive revenue received. Medical expenses reflected an unfavorable current month variance of $3.7 million (4.8%) largely due to increased medical expense estimates. Administrative expenses reflected a favorable current month variance of $0.1 million (2.0%) largely due to delayed printing costs. The balance sheet reflected a current ratio of 1.25:1, versus the minimum required by DMHC of 1.0:1.

It was moved, seconded, and the August 2018 Financial Statements were **unanimously approved**.

6. Signature Authority Policy

Mr. Cameron discussed the Signature Authority Level previously approved by the Governing Board, as documented in minutes. The Finance Department is drafting the policy for the signatory limit and will bring it to the next Executive/Finance Committee meeting for approval.

7. Anniversary Bonuses

Ms. Tomcala noted longevity bonuses were negotiated in the recent agreement with SEIU, and it is organizational practice to offer recognition programs to all employees, both represented and non-represented. In implementing this service award program effective last July, a question arose regarding staff who achieved an anniversary milestone shortly prior to July. Discussion ensued regarding recognition of all staff (except the Executive Team) with greater than five years of seniority.

It was moved, seconded and unanimously approved to pay anniversaries bonuses for the latest anniversary milestone achieved by current staff prior to July 2018.

8. Compliance Update

Robin Larmer, Chief Compliance & Regulatory Affairs Officer, discussed the CMS Program Audit noting the Plan has yet to receive the draft final report with the total number of conditions. We expect the final draft report on or around November 6, 2018.

To date, seven Immediate Corrective Action Required (ICAR) conditions have been identified, three for Grievance & Appeals (G&A), two for Utilization Management (UM), one for G&A and UM combined, and one for Pharmacy. The Plan submitted Corrective Action Plans (CAPs) for the seven ICARs. The CAPs encompass a total of 46 individual actions, 27 of which (58.7%) have been completed. SCFHP anticipates that CMS' draft final report will identify Corrective Action Required (CAR) conditions in several areas, and that additional CAPs will be required. We also anticipate that CMS will assess Civil Monetary Penalties.

Ms. Larmer will provide an update to the Committee in November.

Ms. Larmer further noted the Plan received a potential Fraud, Waste, and Abuse (FWA) complaint. The Plan notified the State, and referred the matter to its FWA vendor for investigation. Ms. Larmer will keep this Committee apprised of the progress and outcome of the investigation.

It was moved, seconded and the Compliance Update was **unanimously approved.**

9. CEO Update

Ms. Tomcala noted that the search for a Satellite Office location is underway, and that discussions are ongoing with potential co-location partners.

Ms. Tomcala updated the Committee on the status of pending appointments to the Board by the SCC Board of Supervisors.

It was moved, seconded, and unanimously approved to accept the CEO update.

10. Adjourn to Closed Session

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

11. Report from Closed Session

Mr. Darrow reported the Committee met in Closed Session to discuss plan partner rates.

12. Adjournment

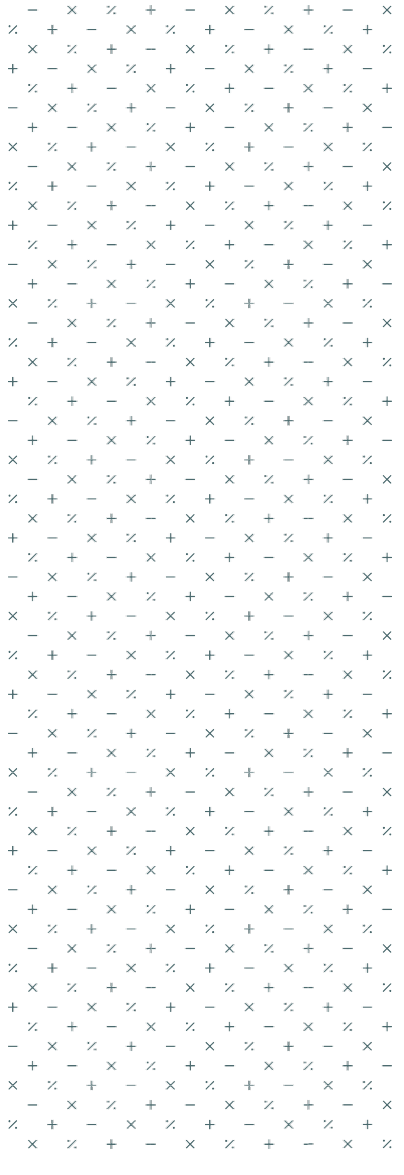
The meeting was adjourned at 1:20 PM.

_____
Brain Darrow, Chair

MOSSADAMS

2018 Audit Results:

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



Report of Independent Auditors

Unmodified Opinion

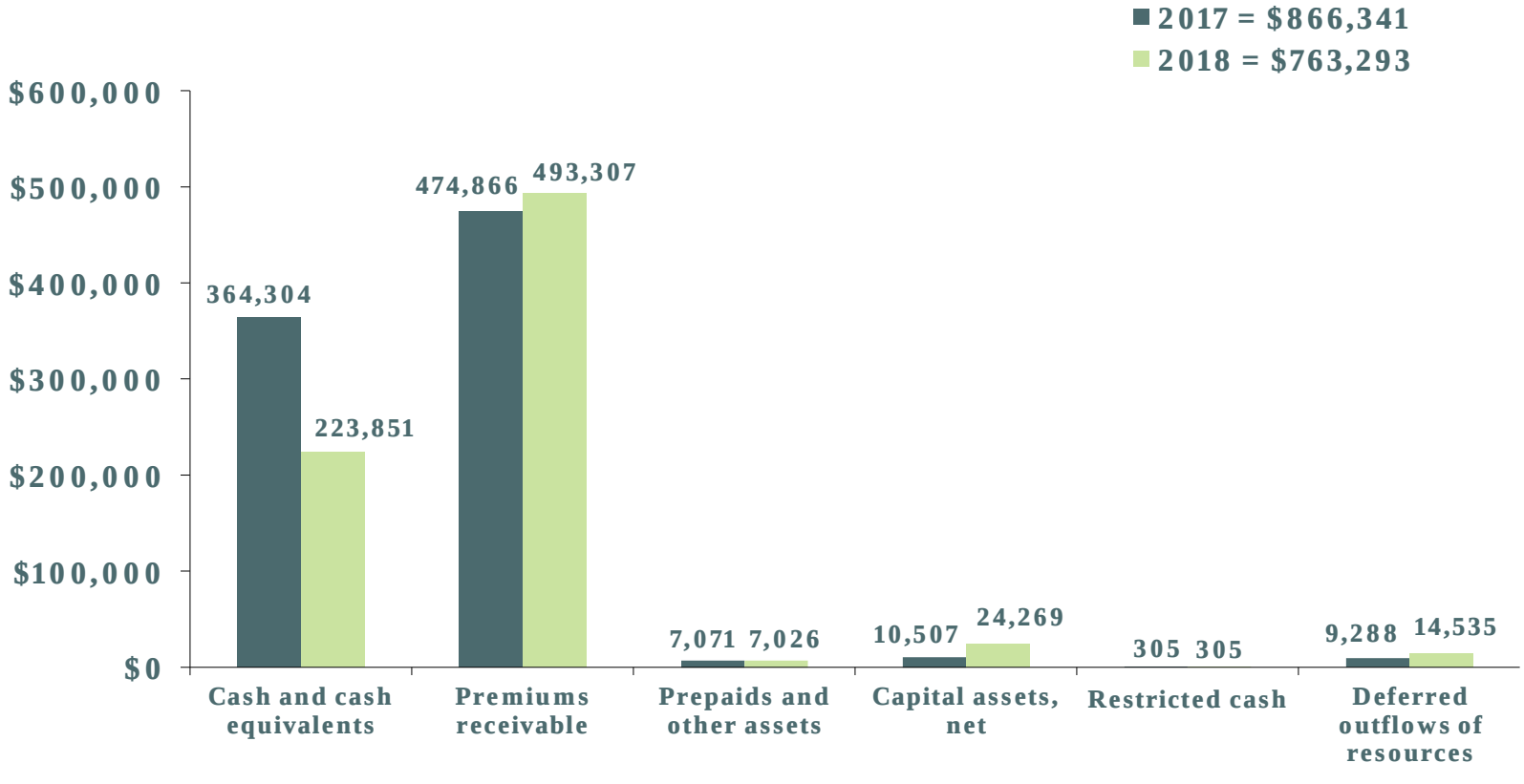
Combined financial statements are fairly presented in accordance with generally accepted accounting principles.

MOSSADAMS

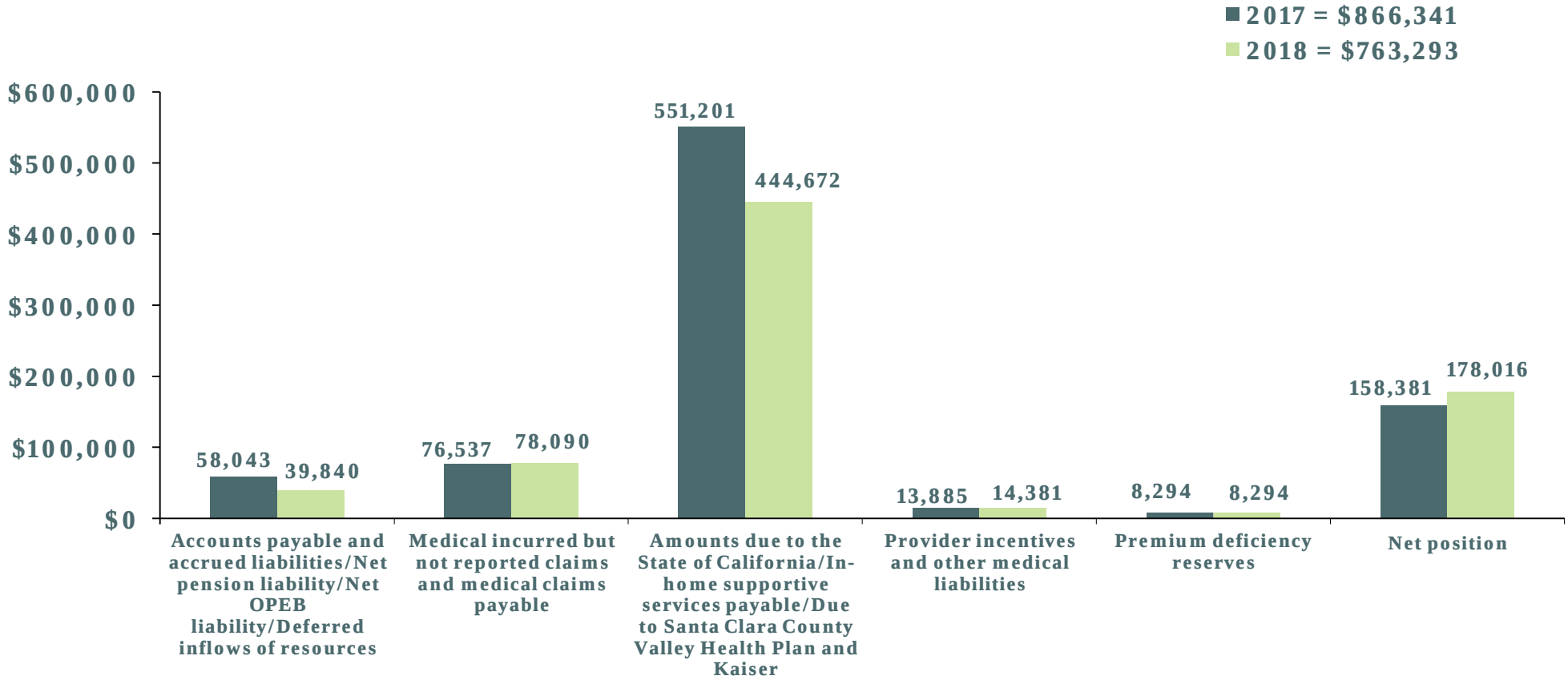
Combined Statements of Net Position

Better Together: Moss Adams & Santa Clara Family Health Plan

Asset Composition (in Thousands)



Liabilities and Net Position Balance (in Thousands)



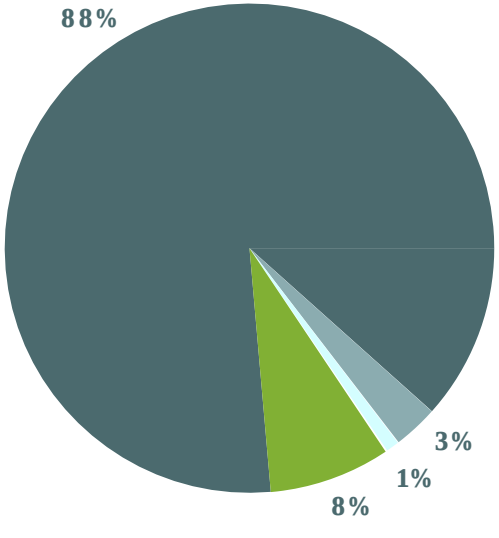
MOSSADAMS

Operations

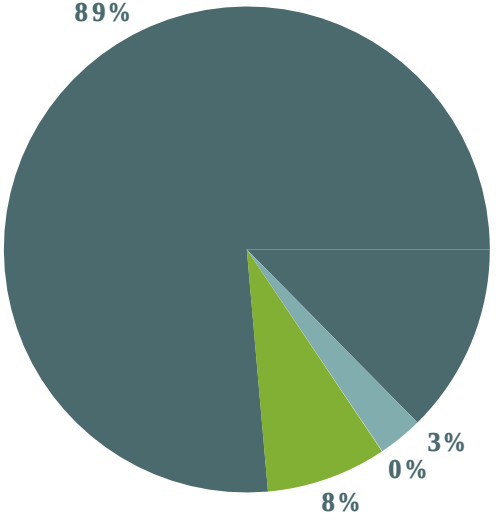
Better Together: Moss Adams & Santa Clara Family Health Plan

Operating Expenses (in Thousands)

June 30, 2018
$1,313,245

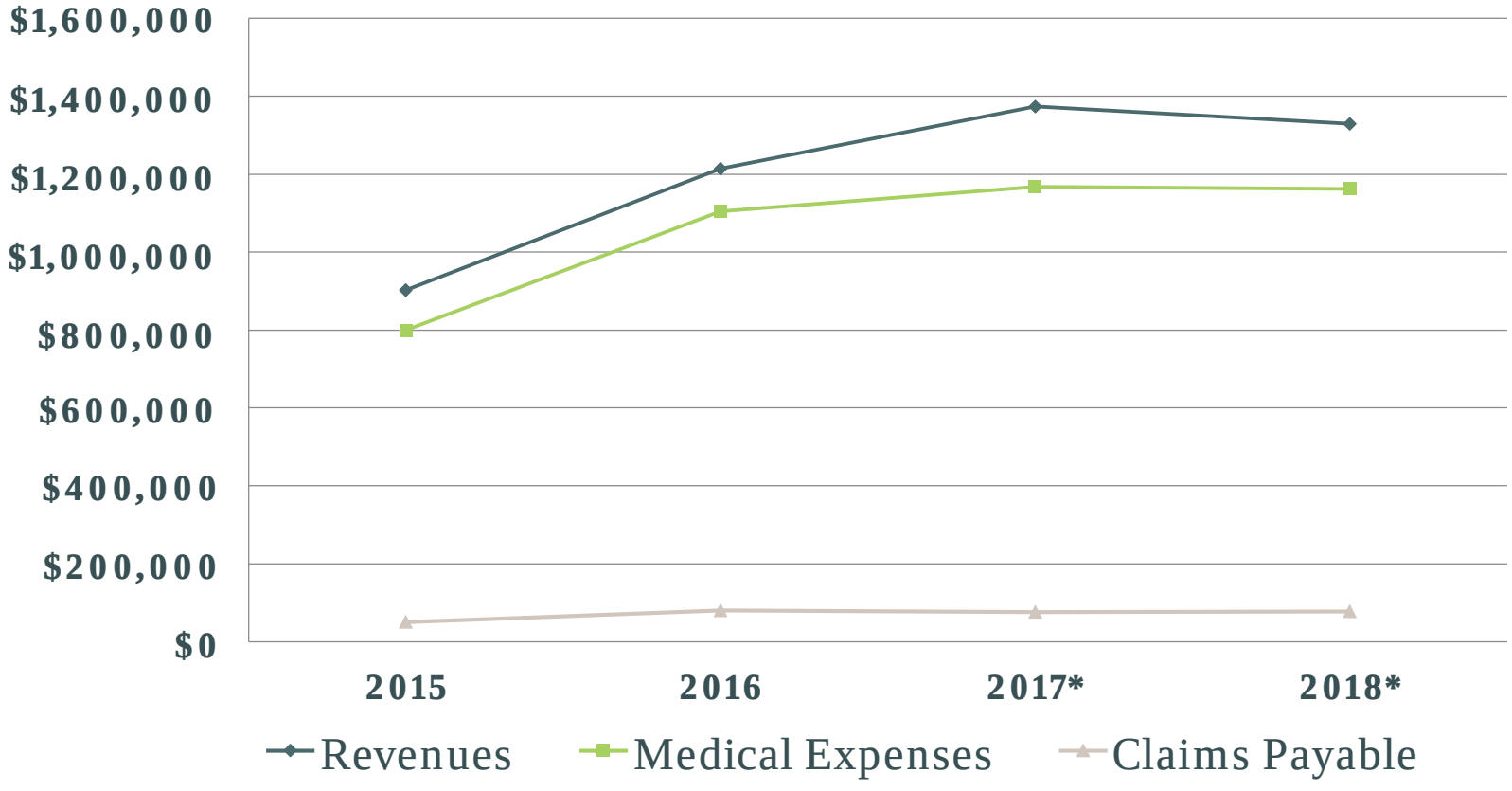


June 30, 2017
$1,316,670



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

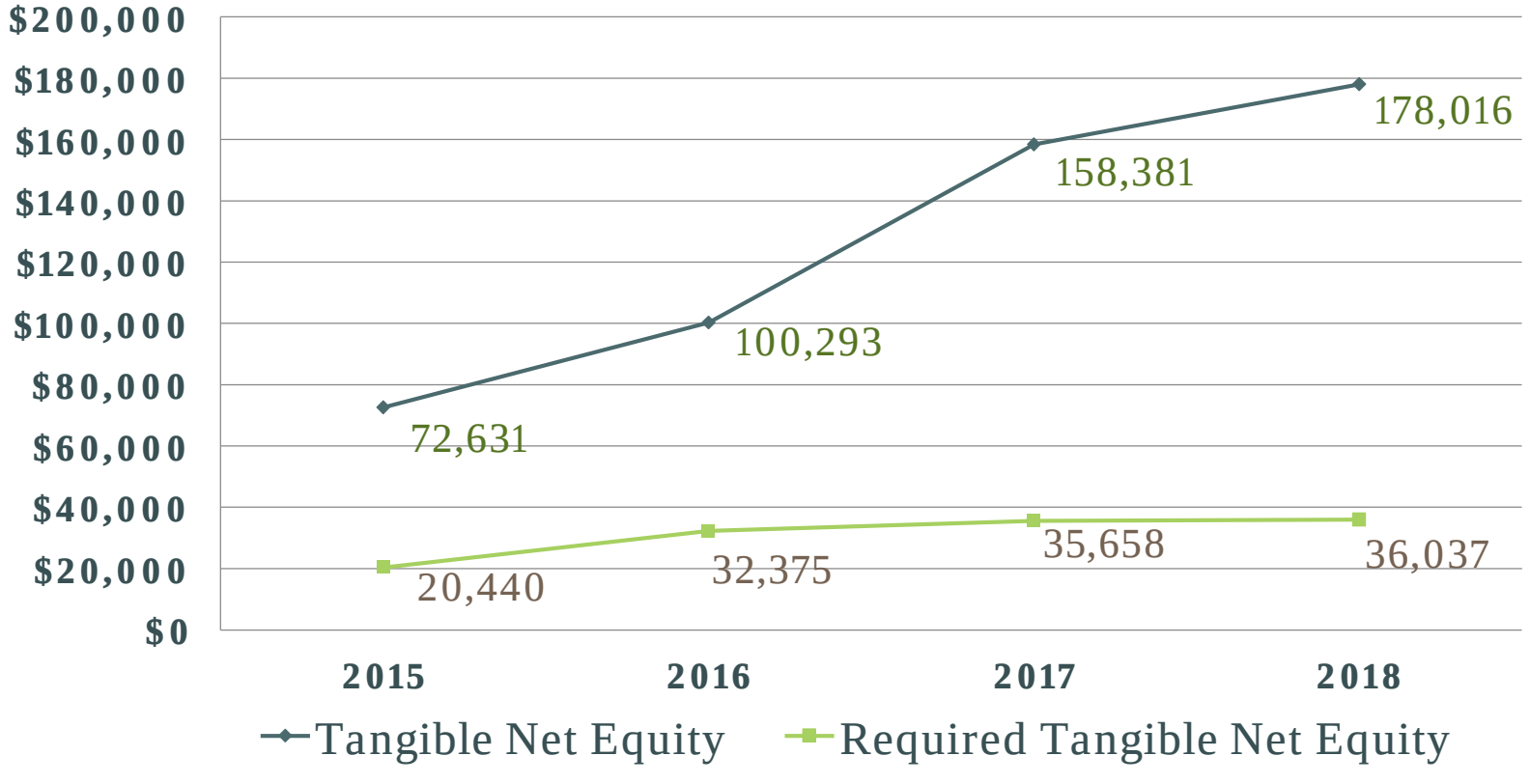
Revenues, Medical Expenses, and Claims Payable (in Thousands)



*2017 and 2018 data not available in the Annual Department of Managed Health Care Filing. Amounts are from the Health Authority's internal reports.

Source: Annual Department of Managed Health Care Filing

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*
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management

Questions?

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Two Months Ended August 31, 2018

Agenda

Santa Clara Family Health Plan

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Financial Highlights

	MTD		YTD	
Revenue	$84 M		$166 M	
Medical Expense (MLR)	$80 M	94.8%	$157 M	94.6%
Administrative Expense (% Rev)	$5.2 M	6.2%	$9.5 M	5.7%
Other Income/Expense	$70,604		$154,206	
Net Surplus (Loss)	**($800,117)**		**($303,188)**	
Cash on Hand			$235 M	
Net Cash Available to SCFHP			$229 M	
Receivables			$498 M	
Total Current Assets			$741 M	
Current Liabilities			$593 M	
Current Ratio			1.25	
Tangible Net Equity			$178 M	
% of DMHC Requirements			**491.6%**	

Financial Highlights

Net Surplus (Loss)	▶ Loss of $800K for the month ($456K unfavorable to budget of -$344K) ▶ YTD: Loss of $303K ($122K unfavorable to budget of -$181K)
Enrollment	▶ MTD Membership was 256,681 (566 less than budget of 257,247) ▶ YTD Member months were 515,237 (396 less than budget of 515,633)
Revenue	▶ Total revenue for the month is at $84.1M ($3M or 3.6% favorable to budget of $81.1M) ▶ YTD: $166.2M ($3.8M or 2.3% favorable to budget of $162.5M)
Medical Expenses	▶ Month: $79.7M ($3.7M or 4.8% unfavorable to budget of $76.1M) ▶ YTD: $157.2M ($4.8M or 3.2% unfavorable to budget of $152.4M)
Administrative Expenses	▶ Month: $5.2M ($0.1M or 2.0% favorable to budget of $5.3M) ▶ YTD: $9.5M ($0.6M or 6.0% favorable to budget of $10.1M)
Tangible Net Equity	▶ TNE was $177.7M (491.6% of minimum DMHC requirements of $36.2M)
Capital Expenditures	▶ YTD Capital Investment of $3.7M was primarily due to building renovation work
Ratios	▶ MTD MLR at 94.8% compared to budget of 93.7% ▶ MTD ALR at 6.2% compared to budget of 6.6%

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- As detailed on page 14, much of the Medi-Cal Non-Dual enrollment decline has been in the Medicaid Expansion (MCE), Adult, Child, and SPD categories of aid. Medi-Cal Dual enrollment has stabilized.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the end of FY18 by 1.1%.
  - Healthy Kids membership decreased since the end of FY18 by 0.3%.
  - CMC membership increased since the end of FY18 by 0.5%.

	For the Month of August 2018			For Two Months Ending August 31 2018				
	Actual	Budget	Variance	Actual	Budget	Variance	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	245,954	246,818	-(0.4%)	493,709	494,805	-(0.2%)	524,262	-(5.8%)
Healthy Kids	3,187	2,914	9.4%	6,465	5,838	10.7%	5,251	23.1%
Medicare	7,540	7,515	0.3%	15,063	14,990	0.5%	14,930	0.9%
Total	**256,681**	**257,247**	**-(0.2%)**	**515,237**	**515,633**	**-(0.1%)**	**544,443**	**-(5.4%)**

#VALUE!

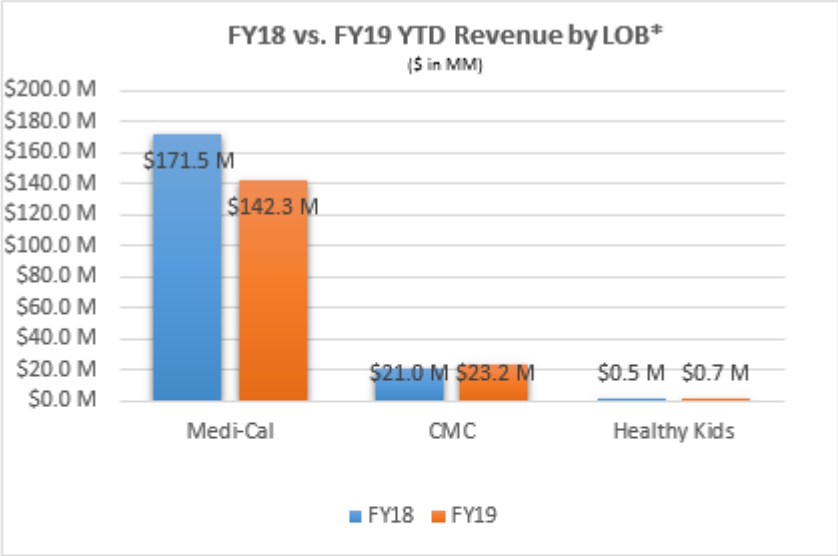
Santa Clara Family Health Plan Enrollment By Network
August 2018

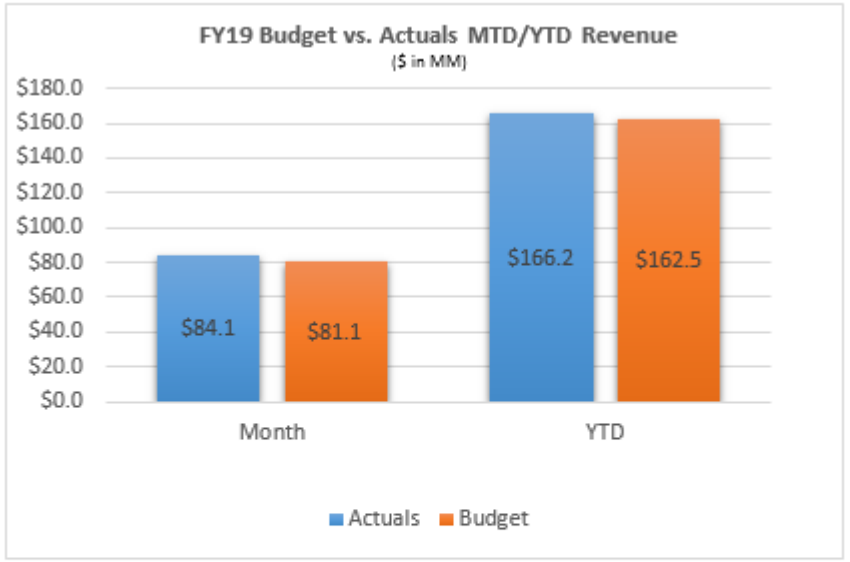
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	29,985	12%	368	12%	7,540	100%	37,893	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	122,410	50%	1,386	43%	-	0%	123,796	48%
Palo Alto Medical Foundation	7,241	3%	92	3%	-	0%	7,333	3%
Physicians Medical Group	44,905	18%	1,111	35%	-	0%	46,016	18%
Premier Care	15,487	6%	230	7%	-	0%	15,717	6%
Kaiser	25,926	11%	-	0%	-	0%	25,926	10%
Total	**245,954**	**100%**	**3,187**	**100%**	**7,540**	**100%**	**256,681**	**100%**
Enrollment at June 30, 2018	248,776		3,196		7,503		259,475	
Net Δ from June 30, 2018	-1.1%		-0.3%		0.5%		-1.1%	

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

Revenue

- Current month revenue of $84.1M is $3.0M or 3.6% favorable to budget of $81.1M. YTD revenue of $166.2M is $3.8M or 2.3% favorable to budget of $162.5M. The current month variances were due to a variety of factors, including:
  - Current month revenue includes unbudgeted prior year Medi-Cal retroactive revenue of $2.8M.
  - Medicare revenue for the month came in $656K above budget due to YTD rate adjustments.
  - Current month revenue variances also result from the mix of members between programs and within Medi-Cal categories of aid.





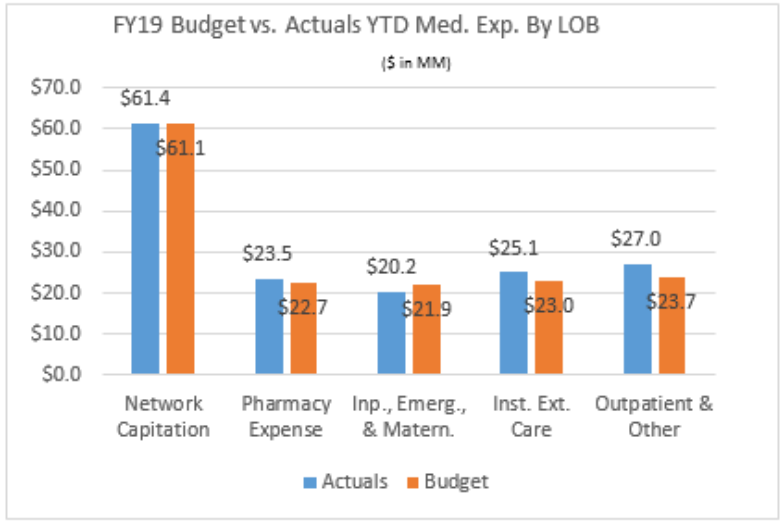
	FY18 vs. FY19 YTD Revenue by LOB*			
	FY18	FY19	Variance	
Medi-Cal	$171.5 M	$142.3 M	($29.2 M)	-17.0%
CMC	$21.0 M	$23.2 M	$2.2 M	10.6%
Healthy Kids	$0.5 M	$0.7 M	$0.2 M	30.4%
Total Revenue	**$193.0 M**	**$166.2 M**	**($26.8 M)**	**-13.9%**

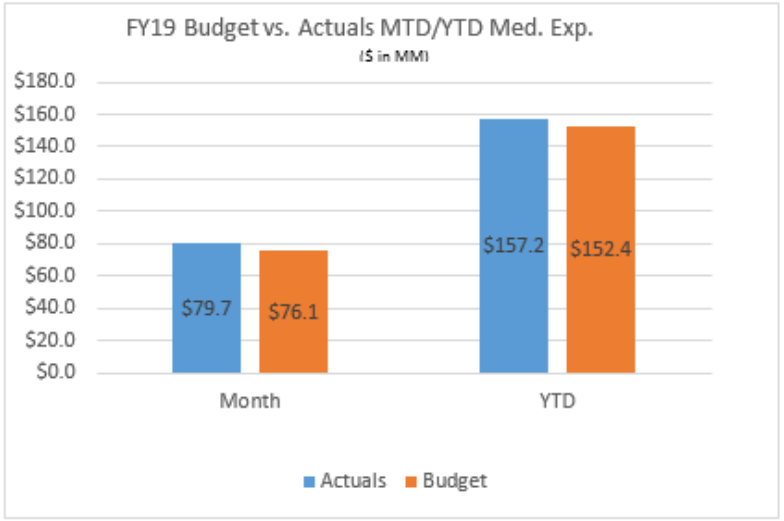
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$84.1	$81.1	$3.0	3.6%
YTD	$166.2	$162.5	$3.8	2.3%

**IHSS was included in FY18 revenue through 12/31/17*

Medical Expense

- Current month medical expense of $79.7M is $3.7M or 4.8% unfavorable to budget of $76.1M. YTD medical expense of $157.2M is $4.8M or 3.2% unfavorable to budget of $152.4M. The current month variances were due to a variety of factors, including:
  - Increased Pharmacy, Specialist Services, Outpatient Services, and LTC expenses contributed to the unfavorable variance.
  - Pharmacy costs reflect a change in methodology in calculating the costs, an increase in scripts/1,000, and a decrease in generics use.
  - Increased estimates for prior period medical expenses.





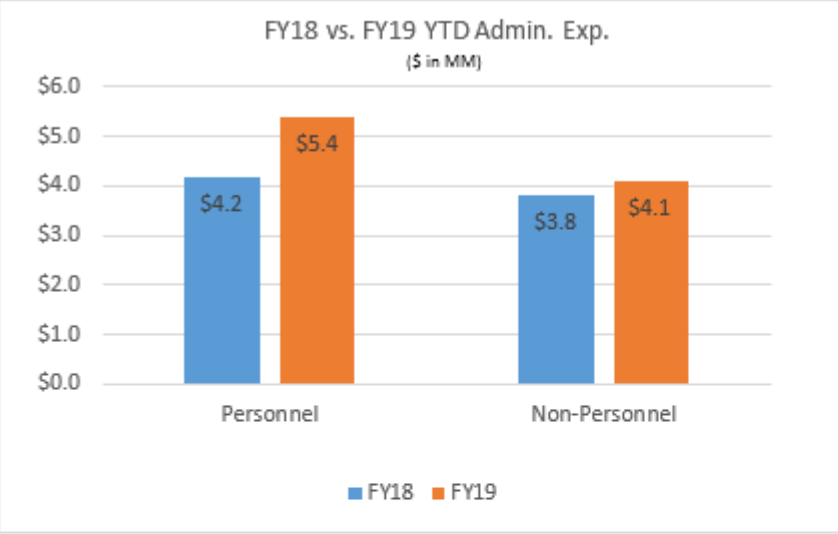
	FY19 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$61.4	$61.1	-$0.3	-0.5%
Pharmacy Expense	$23.5	$22.7	-$0.7	-3.3%
Inp., Emerg., & Matern.	$20.2	$21.9	$1.7	7.6%
Inst. Ext. Care	$25.1	$23.0	-$2.1	-9.4%
Outpatient & Other	$27.0	$23.7	-$3.3	-13.9%
Total Medical Expense	**$157.2**	**$152.4**	**-$4.8**	**-3.2%**

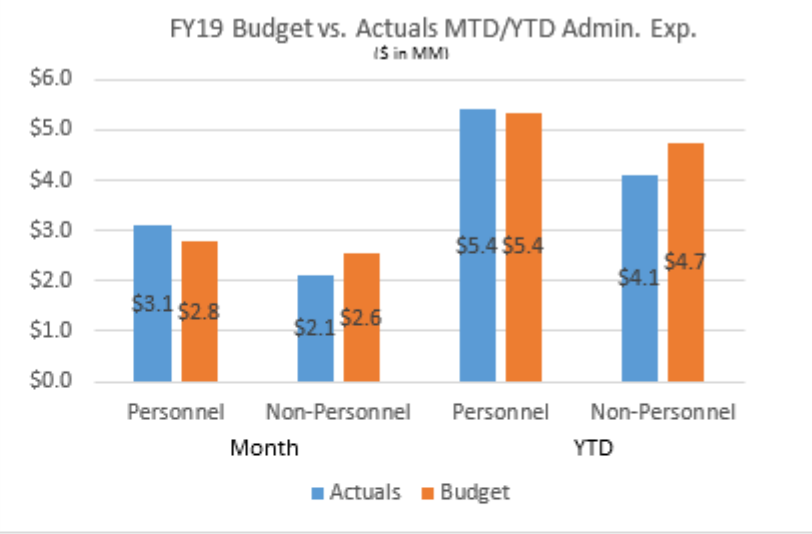
	FY19 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$79.7	$76.1	-$3.7	-4.8%
YTD	$157.2	$152.4	-$4.8	-3.2%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $5.2M is $0.1M or 2.0% favorable to budget of $5.3M. YTD admin expense of $9.5M is $0.6M or 6.0% favorable to budget of $10.1M.
  - Personnel Expenses are 12% above budget due to additional accrual for prior month expenses and lower vacancies than budgeted.
  - Printing and postage are favorable to the YTD budget due to timing of expenses.
  - Consulting and temp staff expenses have seen an increase due to CMC program and data validation audits.





	FY18 vs. FY19 YTD Admin. Exp.			
	FY18	FY19	Variance	
Personnel	$4.2	$5.4	$1.2	29.9%
Non-Personnel	$3.8	$4.1	$0.3	6.9%
Total Administrative Expense	$8.0	$9.5	$1.5	18.9%

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$3.1	$2.8	-$0.3	-12.0%
	Non-Personnel	$2.1	$2.6	$0.4	17.3%
	MTD Total	$5.2	$5.3	$0.1	2.0%
YTD	Personnel	$5.4	$5.4	$0.0	-0.8%
	Non-Personnel	$4.1	$4.7	$0.7	13.8%
	YTD Total	$9.5	$10.1	$0.6	6.0%

Balance Sheet

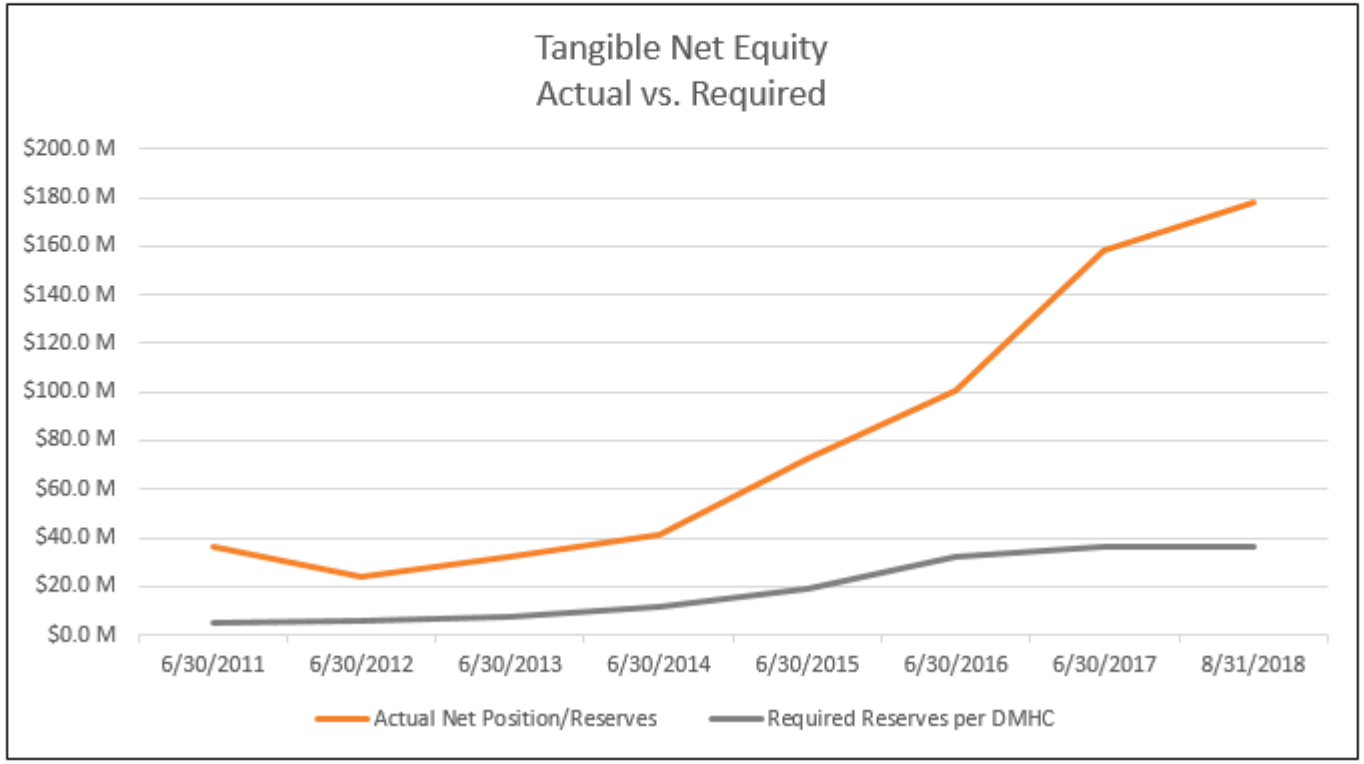
- Current assets totaled $741M compared to current liabilities of $593M, yielding a current ratio (Current Assets/Current Liabilities) of 1.25:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash as of August 31, 2018 increased by $11.3M compared to the cash balance as of year-end June 30, 2018. The overall cash position increased largely due to timing of receipt of revenues, largely paid in arrears.
- Current Cash & Equivalents components and yields were as follows:

Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$77,255,846	1.29%	$100,000	$200,000
Cash & Equivalents				
Bank of the West Money Market	$294,023	0.90%	$18,398	$18,836
Wells Fargo Bank Accounts	$157,633,120	1.76%	$192,371	$285,044
	$157,927,143		$210,769	$303,880
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.08%	$13	$25
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$235,488,840**		**$310,782**	**$503,905**

Tangible Net Equity

- TNE was $177.7M or 491.6% of the most recent quarterly DMHC minimum requirement of $36.2M. TNE trends for SCFHP are shown below.

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	8/31/2018
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$177.7 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.2 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$72.3 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	491.6%



Reserves Analysis

SCFHP RESERVES ANALYSIS August 2018	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$177,712,675
Current Required TNE	$36,150,664
Excess TNE	**$141,562,011**
Actual as % Required	491.6%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	$126,527,325
500% of Required TNE (High)	$180,753,321
TNE Above/(Below) SCFHP Low Target	**$51,185,350**
TNE Above/(Below) High Target	**($3,040,646)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$235,488,840
Less Pass-Through Liabilities	
Net Payable to State of CA [1]	-
Other Pass-Through Liabilities	($6,746,392)
Total Pass-Through Liabilities	**($6,746,392)**
Net Cash Available to SCFHP	$228,742,448
SCFHP Target Liability	
45 Days of Total Operating Expense	($120,210,934)
60 Days of Total Operating Expense	($160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$108,531,514**
Liquidity Above/(Below) High Target	**$68,461,203**
[1] Pass-Through from State of CA (excludes IHSS)	
Receivables Due to SCFHP	$124,682,883
Payable Due From SCFHP	($18,113,329)
Net Receivables/(Payables)	**$106,569,554**

Capital Expenditures

- Capital investments of $3.7M were made in the two months ending August 2018, largely due to the renovation of the new building (in order to lower the long term occupancy costs).
- YTD capital expenditure includes the following:

Expenditure	YTD Actual	Annual Budget	
New Building	$3,581,258	$ 7,874,631	Note 1
Systems	80,000	1,125,000	
Hardware	53,672	1,550,000	
Software	12,000	702,000	
Furniture and Fixtures	0	0	
Automobile	0	0	
Leasehold Improvements	0	0	
TOTAL	**$3,726,930**	**$11,251,631**	

Note 1: Includes FY18 budget rollover of $6,628,131

Santa Clara Family Health Plan™

Financial Statements

Enrollment By Aid Category

Santa Clara Family Health Plan

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,184	27,000	26,651
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,201	99,296	98,245
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,979	10,916	10,834
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,765	10,748	10,697
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	390	442	419
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385
	Aged (21 Over)															
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,941	23,024	23,066
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,165	1,211	1,185
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**

Income Statement

Santa Clara Family Health Plan

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 71,610,496	85.1%	$ 69,143,332	85.2%	$ 2,467,164	3.6%	$ 142,305,969	85.6%	$ 138,500,737	85.3%	$ 3,805,232	2.7%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,248,570	2.7%	2,477,641	3.1%	(229,072)	-9.2%	4,451,492	2.7%	4,942,095	3.0%	(490,603)	-9.9%
CMC MEDICARE	9,880,625	11.7%	9,224,921	11.4%	655,703	7.1%	18,740,067	11.3%	18,400,741	11.3%	339,326	1.8%
TOTAL CMC	12,129,194	14.4%	11,702,562	14.4%	426,632	3.6%	23,191,559	14.0%	23,342,836	14.4%	(151,277)	-0.6%
HEALTHY KIDS	361,742	0.4%	302,765	0.4%	58,978	19.5%	704,566	0.4%	606,568	0.4%	97,998	16.2%
TOTAL REVENUE	**$ 84,101,433**	**100.0%**	**$ 81,148,659**	**100.0%**	**$ 2,952,774**	**3.6%**	**$ 166,202,094**	**100.0%**	**$ 162,450,141**	**100.0%**	**$ 3,751,953**	**2.3%**
MEDICAL EXPENSE												
MEDI-CAL	$ 66,923,649	79.6%	$ 64,747,368	79.8%	$ (2,176,281)	-3.4%	$ 132,014,835	79.4%	$ 129,763,211	79.9%	$ (2,251,624)	-1.7%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,742,786	3.3%	2,173,057	2.7%	(569,730)	-26.2%	4,967,040	3.0%	4,334,547	2.7%	(632,493)	-14.6%
CMC MEDICARE	9,810,763	11.7%	8,879,052	10.9%	(931,711)	-10.5%	19,671,443	11.8%	17,709,957	10.9%	(1,961,485)	-11.1%
TOTAL CMC	12,553,550	14.9%	11,052,109	13.6%	(1,501,441)	-13.6%	24,638,482	14.8%	22,044,504	13.6%	(2,593,978)	-11.8%
HEALTHY KIDS	270,592	0.3%	272,690	0.3%	2,098	0.8%	513,303	0.3%	546,316	0.3%	33,012	6.0%
TOTAL MEDICAL EXPENSES	**$ 79,747,790**	**94.8%**	**$ 76,072,167**	**93.7%**	**$ (3,675,623)**	**-4.8%**	**$ 157,166,621**	**94.6%**	**$ 152,354,031**	**93.8%**	**$ (4,812,590)**	**-3.2%**
MEDICAL OPERATING MARGIN	**$ 4,353,643**	**5.2%**	**$ 5,076,492**	**6.3%**	**$ (722,849)**	**-24.5%**	**$ 9,035,473**	**5.4%**	**$ 10,096,111**	**6.2%**	**$ (1,060,637)**	**-28.3%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 3,107,387	3.7%	$ 2,774,397	3.4%	$ (332,990)	-12.0%	$ 5,399,972	3.2%	$ 5,354,488	3.3%	$ (45,484)	-0.8%
RENTS AND UTILITIES	94,864	0.1%	127,791	0.2%	32,927	25.8%	212,046	0.1%	270,782	0.2%	58,736	21.7%
PRINTING AND ADVERTISING	74,246	0.1%	159,150	0.2%	84,904	53.3%	228,671	0.1%	218,300	0.1%	(10,371)	-4.8%
INFORMATION SYSTEMS	256,725	0.3%	226,473	0.3%	(30,252)	-13.4%	476,645	0.3%	452,946	0.3%	(23,699)	-5.2%
PROF FEES/CONSULTING/TEMP STAFFING	1,176,581	1.4%	985,418	1.2%	(191,163)	-19.4%	2,115,931	1.3%	1,985,591	1.2%	(130,340)	-6.6%
DEPRECIATION/INSURANCE/EQUIPMENT	341,508	0.4%	457,566	0.6%	116,058	25.4%	683,783	0.4%	931,633	0.6%	247,850	26.6%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	73,825	0.1%	474,930	0.6%	401,105	84.5%	183,565	0.1%	574,066	0.4%	390,501	68.0%
MEETINGS/TRAVEL/DUES	77,734	0.1%	109,539	0.1%	31,805	29.0%	155,333	0.1%	209,909	0.1%	54,576	26.0%
OTHER	21,494	0.0%	17,804	0.0%	(3,690)	-20.7%	36,922	0.0%	105,191	0.1%	68,269	64.9%
TOTAL ADMINISTRATIVE EXPENSES	**$ 5,224,364**	**6.2%**	**$ 5,333,069**	**6.6%**	**$ 108,705**	**2.0%**	**$ 9,492,868**	**5.7%**	**$ 10,102,906**	**6.2%**	**$ 610,038**	**6.0%**
OPERATING SURPLUS (LOSS)	$ (870,721)	-1.0%	$ (256,576)	-0.3%	$ (614,145)	239.4%	$ (457,394)	-0.3%	$ (6,795)	0.0%	$ (450,599)	6631.4%
OTHER INCOME/EXPENSE												
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(119,559)	-0.1%	(119,560)	-0.1%	1	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(150,000)	-0.1%	(150,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	205,384	0.2%	47,605	0.1%	157,779	331.4%	423,766	0.3%	95,210	0.1%	328,556	345.1%
OTHER INCOME/EXPENSE	**70,604**	**0.1%**	**(87,175)**	**-0.1%**	**157,779**	**-181.0%**	**154,206**	**0.1%**	**(174,350)**	**-0.1%**	**328,556**	**-188.4%**
NET SURPLUS (LOSS)	**$ (800,117)**	**-1.0%**	**$ (343,751)**	**-0.4%**	**$ (456,365)**	**132.8%**	**$ (303,188)**	**-0.2%**	**$ (181,145)**	**-0.1%**	**$ (122,043)**	**67.4%**

Balance Sheet

	August 2018	July 2018	June 2018	May 2018
Assets				
Current Assets				
Cash and Marketable Securities	$235,488,840	$138,960,658	$224,156,209	$256,044,077
Receivables	497,747,680	576,211,580	493,307,425	480,311,521
Prepaid Expenses and Other Current Assets	7,792,800	7,913,589	7,024,982	7,654,827
Total Current Assets	**741,029,320**	**723,085,826**	**724,488,615**	**744,010,425**
Long Term Assets				
Property and Equipment	42,306,060	39,686,231	38,579,130	34,170,890
Accumulated Depreciation	(14,888,918)	(14,609,331)	(14,309,761)	(14,013,419)
Total Long Term Assets	27,417,142	25,076,900	24,269,369	20,157,471
Total Assets	**768,446,462**	**748,162,727**	**748,757,984**	**764,167,896**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,405,010**
Total Deferred Outflows and Assets	**782,981,702**	**762,697,967**	**763,293,224**	**778,572,906**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	5,065,866	4,472,838	8,351,090	5,046,194
Deferred Rent	(0)	8,506	17,011	23,310
Employee Benefits	1,527,690	1,583,454	1,473,524	1,538,777
Retirement Obligation per GASB 45	5,002,354	4,942,575	4,882,795	5,475,935
Advance Premium - Healthy Kids	80,809	61,095	66,195	66,668
Deferred Revenue - Medicare	8,858,943	-	9,928,268	-
Whole Person Care/Prop 56	6,746,392	6,140,476	9,263,004	8,678,072
Payable to Hospitals	0	0	0	13,264,966
Due to Santa Clara County Valley Health Plan and Kaiser	12,243,869	8,871,601	6,691,979	4,630,360
MCO Tax Payable - State Board of Equalization	18,113,329	9,038,963	(0)	14,483,915
Due to DHCS	28,918,776	26,453,103	24,429,978	48,612,592
Liability for In Home Support Services (IHSS)	413,549,551	413,549,551	413,549,551	390,509,778
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	90,857,988	94,834,552	92,470,504	93,643,327
Total Current Liabilities	**593,340,092**	**572,331,239**	**573,498,425**	**588,348,418**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	1,974,796	1,899,796	1,824,796	7,682,370
Total Non-Current Liabilities	**7,894,296**	**7,819,296**	**7,744,296**	**13,601,870**
Total Liabilities	**601,234,388**	**580,150,535**	**581,242,721**	**601,950,288**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**485,329**
Net Assets / Reserves				
Invested in Capital Assets	17,633,610	17,903,481	18,067,094	18,276,241
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	160,076,903	159,807,032	140,008,115	139,798,969
Current YTD Income (Loss)	(303,188)	496,929	19,635,303	17,756,729
Total Net Assets / Reserves	177,712,675	178,512,791	178,015,863	176,137,289
Total Liabilities, Deferred Inflows, and Net Assets	**782,981,702**	**762,697,967**	**763,293,224**	**778,572,906**

Cash Flow

Cash Flows from Operating Activities	
Premiums Received	184,363,966
Medical Expenses Paid	(153,227,248)
Adminstrative Expenses Paid	(16,500,923)
Net Cash from Operating Activities	**$14,635,795**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(3,726,930)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	423,766
Net Increase/(Decrease) in Cash & Cash Equivalents	11,332,631
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Aug 18)	235,488,840
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**(303,188)**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	579,157
Changes in Operating Assets/Liabilities	
Premiums Receivable	(4,440,255)
Other Receivable	(423,766)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(767,819)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(6,699,834)
State Payable	22,602,127
Santa Clara Valley Health Plan & Kaiser Payable	5,551,889
Net Pension Liability	150,000
Medical Cost Reserves & PDR	(1,612,516)
Deferred Inflow of Resources	-
Total Adjustments	**$14,359,826**
Net Cash from Operating Activities	**$14,635,795**

Statement of Operations - YTD

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Two Months Ending August 31 2018

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 142,305,969	$ 4,451,492	$ 18,740,067	$ 23,191,559	$ 704,566	**$ 166,202,094**
MEDICAL EXPENSE	$ 132,014,835	$ 4,967,040	$ 19,671,443	$ 24,638,482	$ 513,303	**$ 157,166,621**
(MLR)	92.8%	111.6%	105.0%	106.2%	72.9%	**94.6%**
GROSS MARGIN	$ 10,291,134	$ (515,548)	$ (931,376)	$ (1,446,924)	$ 191,263	**$ 9,035,473**
ADMINISTRATIVE EXPENSE	$ 8,128,007	$ 254,253	$ 1,070,365	$ 1,324,619	$ 40,242	**$ 9,492,868**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 2,163,128	$ (769,801)	$ (2,001,741)	$ (2,771,542)	$ 151,021	**$ (457,394)**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 132,035	$ 4,130	$ 17,387	$ 21,518	$ 654	**$ 154,206**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 2,295,163	$ (765,671)	$ (1,984,354)	$ (2,750,025)	$ 151,674	**$ (303,188)**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 288.24	$ 295.52	$ 1,244.11	$ 1,539.64	$ 108.98	**$ 322.57**
MEDICAL EXPENSES	$ 267.39	$ 329.75	$ 1,305.94	$ 1,635.70	$ 79.40	**$ 305.04**
GROSS MARGIN	$ 20.84	$ (34.23)	$ (61.83)	$ (96.06)	$ 29.58	**$ 17.54**
ADMINISTRATIVE EXPENSES	$ 16.46	$ 16.88	$ 71.06	$ 87.94	$ 6.22	**$ 18.42**
OPERATING INCOME/(LOSS)	$ 4.38	$ (51.11)	$ (132.89)	$ (184.00)	$ 23.36	**$ (0.89)**
OTHER INCOME/(EXPENSE)	$ 0.27	$ 0.27	$ 1.15	$ 1.43	$ 0.10	**$ 0.30**
NET INCOME/(LOSS)	$ 4.65	$ (50.83)	$ (131.74)	$ (182.57)	$ 23.46	**$ (0.59)**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	493,709	15,063	15,063	15,063	6,465	515,237
REVENUE BY LOB	85.6%	2.7%	11.3%	14.0%	0.4%	100.0%

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, November 15, 2018, 11:30 AM - 1:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Members Present
Brian Darrow, Chair
Bob Brownstein
Dolores Alvarado *(via telephone)*
Linda Williams
Liz Kniss *(via telephone)*

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

1. **Roll Call**

   Brian Darrow, Chair, called the meeting to order at 11:35 am. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The minutes of the October 25, 2018 Executive/Finance Committee were reviewed.

   It was moved, seconded and the October 25, 2028 Executive/Finance Committee Minutes were **unanimously approved.**

3. **Public Comment**

   There were no public comments.

4. **Adjourn to Closed Session**

   Contract Rates (Welfare and Institutions Code Section 14087.35(n)):
   The Executive/Finance Committee met in Closed Session to discuss plan partner rates.

Linda Williams arrived at 11:43

5. Report from Closed Session

Mr. Darrow reported the Committee met in Closed Session to discuss plan partner rates.

6. September 2018 Financial Statements

Dave Cameron, Chief Financial Officer, presented the September 2018 financial statements, which reflected a current month net surplus of $301 thousand ($137 thousand unfavorable to budget) and a year-to-date net loss of $2 thousand ($258 thousand unfavorable to budget). Enrollment declined 34 from the prior month to to 256,647 members. Medi-Cal enrollment has declined since October 2016, largely in the Medicaid Expansion (MCE), Adult, and Child categories of aid. CMC membership has grown modestly over the past few months due to continued outreach efforts. Revenue reflected a favorable current month variance of $2.1 million (2.6%) largely due to retroactive revenue received and additional projected Medicare risk score revenue. Medical expenses reflected an unfavorable current month variance of $2.7 million (3.6%) largely due to a one-time retroactive capitation adjustment of $2.2 million and increased medical expense estimates. Administrative expenses reflected a favorable current month variance of $200 thousand (3.6%). Personnel expenses were at budget while non-personnel expenses reflected additional contracted services partially offset by the deferred timing of certain costs. The balance sheet reflected a current ratio of 1.25:1, versus the minimum required by DMHC of 1.0:1.

> **It was moved, seconded, and** the September 2018 Financial Statements were **unanimously approved.**

7. Signature Authority Policy

Mr. Cameron discussed the Signature Authority level previously approved by the Governing Board, as documented in minutes. The Finance Department is drafting a Signature Authority policy and will bring it to the next Governing Board meeting for approval.

8. Medicare Risk Adjustment Overview

The Medicare Risk Adjustment Overview was deferred.

9. Compliance Update

Robin Larmer, Chief Compliance & Regulatory Affairs Officer, discussed the CMS Program Audit, noting the Plan has yet to receive the Draft Final Report indicating the total number of Conditions resulting from the Audit.

Ms. Larmer presented the Committee with the Plan's 2018 CMS Audit Actions Tracker, reflecting the Corrective Action Plans (CAPs) implemented in response to the Immediate Corrective Action Conditions (ICARs) identified by CMS subsequent its to issuance of the Preliminary Draft Report.

Seven ICARs have been identified, three for Grievance & Appeals (G&A), two for Utilization Management (UM), one for G&A and UM combined, and one for Pharmacy. The Plan submitted CAPs encompassing a total of 46 individual actions, 27 of which (58.7%) have been completed. SCFHP anticipates that the DraftFinal Report will identify Corrective Action Required (CAR) conditions in several areas, and that additional CAPs will be required. We also anticipate that CMS will assess Civil Monetary Penalties.

Ms. Larmer will provide an update at the next Governing Board meeting on December 13, 2018.

It was moved, seconded, and the Compliance Update was **unanimously approved.**

10. CEO Update

Christine Tomcala, Chief Executive Officer, shared that the construction of the outdoor classroom space for Veggielution in honor of the Plan's 20th Anniversary is now complete.

Ms. Tomcala updated the Committee on the Patient-Centered Medical Home (PCMH) support payments discussed at last May's Executive/Finance meeting. The Committee approved payments of up to $10,000 per entity for PCMH certification survey fees and practive transformation. Ms. Tomcala noted the Plan would move forward with payments to seven clinics that are pursuing this designation: Asian Americans for Community Involvement, Gardner Downtown Health Center, Indian Health Center Meridian, North East Medical Services Lundy Clinic, Planned Parenthood Mar Monte Blossom Hill, Planned Parenthood Mar Monte Mountain View, and Ravenswood Family Health Center.

Ms. Tomcala noted that the Plan was advised that its auto-assignment rate for the 2019 calendar year is 67%.

Ms. Tomcala reported the Plan is actively working with a broker to identify a location for a satellite office and indicated it has been difficult finding a suitable location. Discussions are ongoing with potential co-location partners. The Plan recently learned that Alum Rock Counseling Center may be looking for space on the east side, presenting a possible co-location opportunity.

Discussions on the extension of the Cal MediConnect program are ongoing. CMS declined DHCS' request for a one-year extension, but indicated it would consider a three-year extension .

Ms. Tomcala noted that the California State Auditor recently released a report indicating there may have been $4 billion in overpayments due to Medi-Cal eligibility errors from 2014 through 2017. The report identified questionable payments in all 58 counties and across both managed care and fee for service. Questionable managed care premiums identified in Santa Clara County totaled $33 million.

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It was moved, seconded and unanimously approved to accept the CEO update.

11. Adjournment

The meeting was adjourned at 1:08 PM.

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Brian Darrow, Chairman

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Three Months Ended September 30, 2018

Agenda

Santa Clara Family Health Plan

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Financial Highlights

	MTD		YTD	
Revenue	$83 M		$249 M	
Medical Expense (MLR)	$79 M	94.6%	$236 M	94.6%
Administrative Expense (% Rev)	$4.4 M	5.3%	$13.9 M	5.6%
Other Income/(Expense)	$232,001		$386,208	
Net Surplus (Loss)	**$300,834**		**($2,354)**	
Cash on Hand			$233 M	
Net Cash Available to SCFHP			$226 M	
Receivables			$502 M	
Total Current Assets			$742 M	
Current Liabilities			$594 M	
Current Ratio			1.25	
Tangible Net Equity			$178 M	
% of DMHC Requirements			**527.1%**	

Financial Highlights

Net Surplus (Loss)	▶ Month: Surplus of $301K is $137K or 31.3% unfavorable to budget of $438K. ▶ YTD: Loss of $2K is $258K or 100.9% unfavorable to budget of $256K.
Enrollment	▶ Month: Membership was 256,647 (531 favorable to budget of 256,116). ▶ YTD: Member months were 771,884 (135 favorable to budget of 771,749).
Revenue	▶ Month: $83.1M ($2.1M or 2.6% favorable to budget of $81.0M). ▶ YTD: $249.3M ($5.8M or 2.4% favorable to budget of $243.4M).
Medical Expenses	▶ Month: $78.6M ($2.7M or 3.6% unfavorable to budget of $75.9M). ▶ YTD: $235.7M ($7.5M or 3.3% unfavorable to budget of $228.2M).
Administrative Expenses	▶ Month: $4.4M ($0.2M or 3.6% favorable to budget of $4.6M). ▶ YTD: $13.9M ($0.8M or 5.3% favorable to budget of $14.7M).
Tangible Net Equity	▶ TNE was $178.0M (527.1% of minimum DMHC requirements of $33.8M)
Capital Expenditures	▶ YTD Capital Investment of $3.8M was primarily due to building renovation work.
Ratios	▶ MTD MLR at 94.6% compared to budget of 93.7%. ▶ MTD ALR at 5.3% compared to budget of 5.7%.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- As detailed on page 14, much of the Medi-Cal Non-Dual enrollment decline has been in the Medicaid Expansion (MCE), Adult and Child categories of aid. Medi-Cal Dual enrollment has stabilized while CMC enrollment has grown due to outreach efforts. Since March 2018, non-dual LTC enrollment has increased by 19.8% to 423 members.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the end of FY18 by 1.2%.
  - Healthy Kids membership has decreased since the end of FY18 by 1.0%.
  - CMC membership has increased since the end of FY18 by 1.3%.

	For the Month of September 2018			For Three Months Ending September 30 2018				
	Actual	Budget	Variance	Actual	Budget	Variance	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	245,884	245,657	0.1%	739,593	740,462	-(0.1%)	785,963	-(5.9%)
Healthy Kids	3,163	2,904	8.9%	9,628	8,742	10.1%	7,494	28.5%
Medicare	7,600	7,555	0.6%	22,663	22,545	0.5%	22,313	1.6%
Total	**256,647**	**256,116**	**0.2%**	**771,884**	**771,749**	**0.0%**	**815,770**	**-(5.4%)**

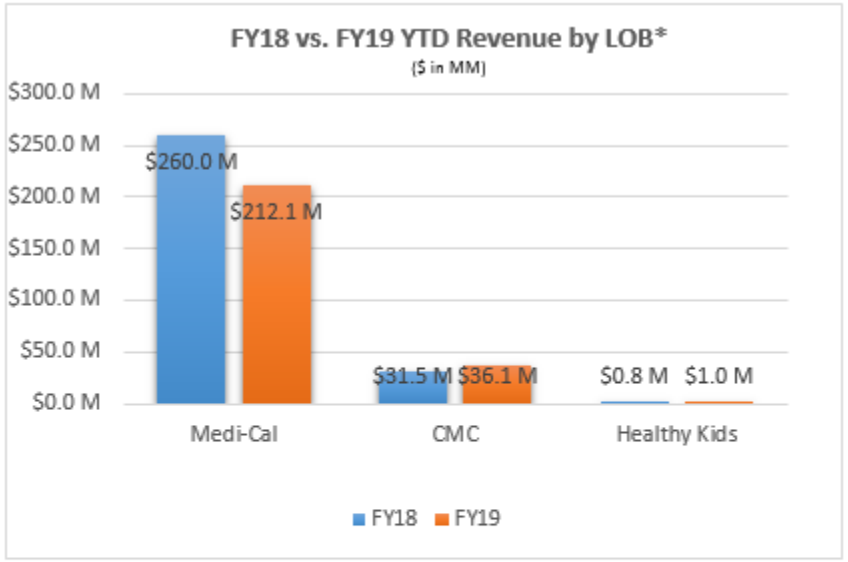
Santa Clara Family Health Plan Enrollment By Network
September 2018

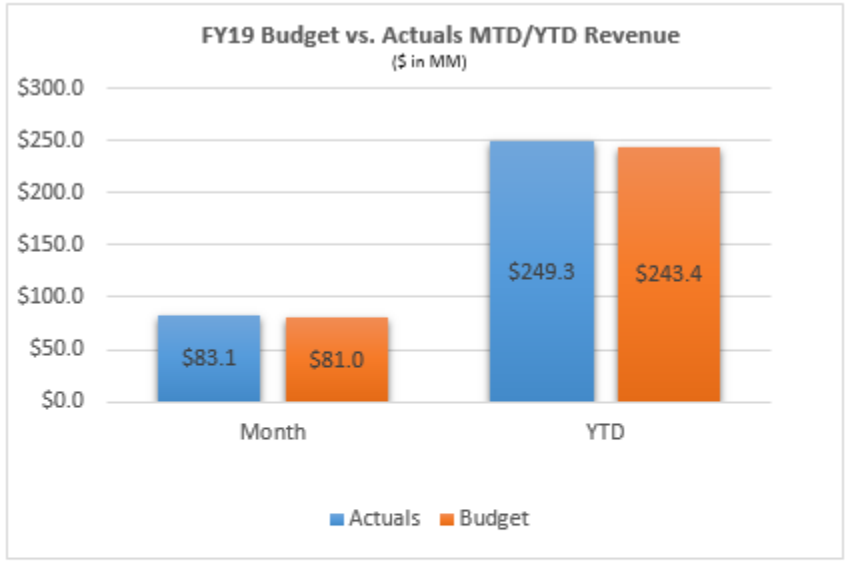
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	29,701	12%	331	10%	7,600	100%	37,632	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	122,852	50%	1,374	43%	-	0%	124,226	48%
Palo Alto Medical Foundation	7,176	3%	99	3%	-	0%	7,275	3%
Physicians Medical Group	44,979	18%	1,124	36%	-	0%	46,103	18%
Premier Care	15,251	6%	235	7%	-	0%	15,486	6%
Kaiser	25,925	11%	-	0%	-	0%	25,925	10%
Total	**245,884**	**100%**	**3,163**	**100%**	**7,600**	**100%**	**256,647**	**100%**
Enrollment at June 30, 2018	248,776		3,196		7,503		259,475	
Net Δ from June 30, 2018	-1.2%		-1.0%		1.3%		-1.1%	

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

Revenue

- Current month revenue of $83.1M is $2.1M or 2.6% favorable to budget of $81.0M. YTD revenue of $249.3M is $5.8M or 2.4% favorable to budget of $243.4M. The current month variances were due to a variety of factors, including:
  - Current month revenue includes unbudgeted prior year non-dual and MLTSS retroactive revenue of $600K.
  - Additional Medicare revenue of $1.1M was due to revisions in sweep and risk score adjustment estimates.
  - Mix of members between programs and within the Medi-Cal categories of aid.





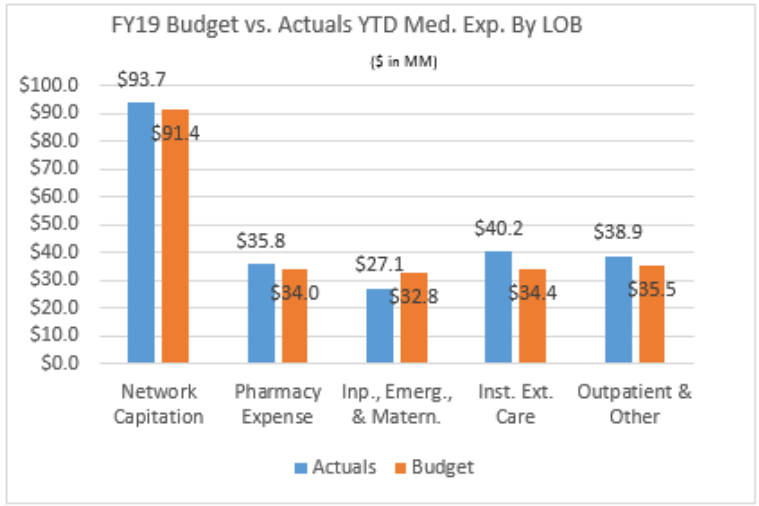
	FY18 vs. FY19 YTD Revenue by LOB*			
	FY18	FY19	Variance	
Medi-Cal	$260.0 M	$212.1 M	($47.9 M)	-18.4%
CMC	$31.5 M	$36.1 M	$4.6 M	14.7%
Healthy Kids	$0.8 M	$1.0 M	$0.3 M	35.8%
Total Revenue	**$292.3 M**	**$249.3 M**	**($43.0 M)**	**-14.7%**

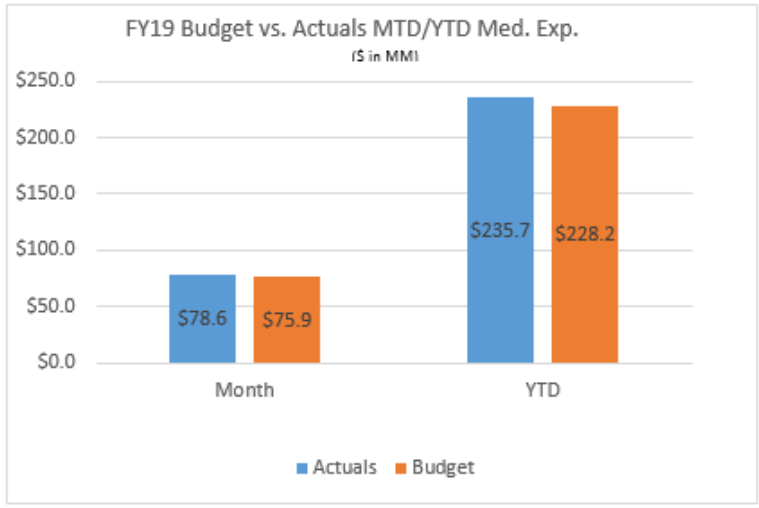
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$83.1	$81.0	$2.1	2.6%
YTD	$249.3	$243.4	$5.8	2.4%

**IHSS was included in FY18 revenue through 12/31/17*

Medical Expense

- Current month medical expense of $78.6M is $2.7M or 3.6% unfavorable to budget of $75.9M. YTD medical expense of $235.7M is $7.5M or 3.3% unfavorable to budget of $228.2M. The current month variances were due to a variety of factors, including:
  - Increased Pharmacy, Specialist Services, Outpatient Services, and LTC expenses contributed to the unfavorable variance.
  - Pharmacy costs exceed budget due to an increase in scripts/1,000, and a decrease in generics use.
  - FY18 & FY19 retroactive capitation adjustment of $2.2M
  - Increased estimates for prior period medical expenses.





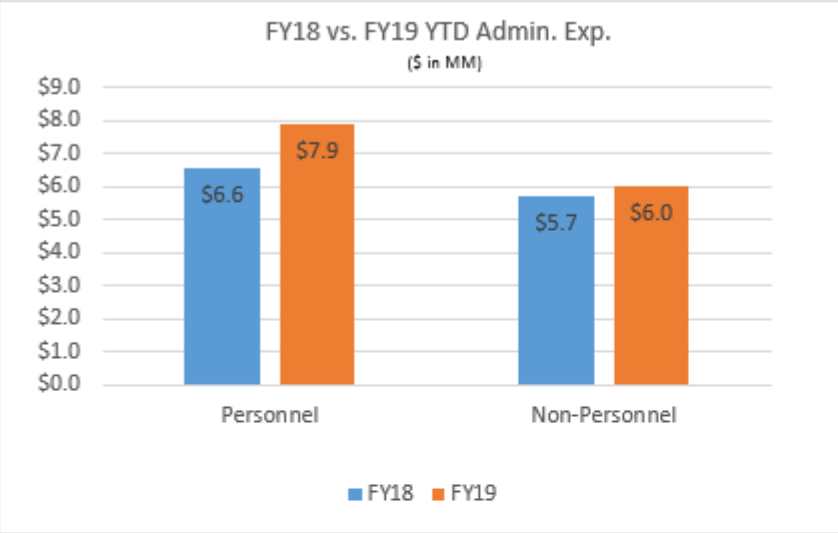
	FY19 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$93.7	$91.4	-$2.3	-2.5%
Pharmacy Expense	$35.8	$34.0	-$1.8	-5.2%
Inp., Emerg., & Matern.	$27.1	$32.8	$5.7	17.5%
Inst. Ext. Care	$40.2	$34.4	-$5.8	-17.0%
Outpatient & Other	$38.9	$35.5	-$3.4	-9.5%
Total Medical Expense	**$235.7**	**$228.2**	**-$7.5**	**-3.3%**

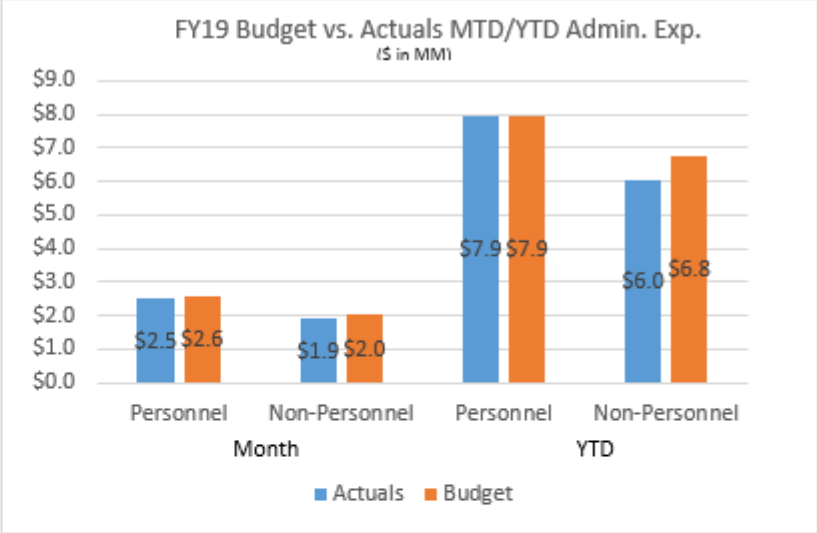
	FY19 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$78.6	$75.9	-$2.7	-3.6%
YTD	$235.7	$228.2	-$7.5	-3.3%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $4.4M is $0.2M or 3.6% favorable to budget of $4.6M. YTD admin expense of $13.9M is $0.8M or 5.3% favorable to budget of $14.7M.
  - YTD Personnel Expenses are at budget.
  - YTD Postage and training expenses are favorable due to timing of expenses, while consulting and temp staff expenses have seen an increase due to CMC program and data validation audits.





		FY18 vs. FY19 YTD Admin. Exp.			
		FY18	FY19	Variance	
Personnel		$6.6	$7.9	$1.3	20.4%
Non-Personnel		$5.7	$6.0	$0.3	5.3%
Total Administrative Expense		**$12.3**	**$13.9**	**$1.6**	**13.4%**

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.5	$2.6	$0.1	2.8%
	Non-Personnel	$1.9	$2.0	$0.1	4.6%
	MTD Total	**$4.4**	**$4.6**	**$0.2**	**3.6%**
YTD	Personnel	$7.9	$7.9	$0.0	0.4%
	Non-Personnel	$6.0	$6.8	$0.7	11.1%
	YTD Total	**$13.9**	**$14.7**	**$0.8**	**5.3%**

Balance Sheet

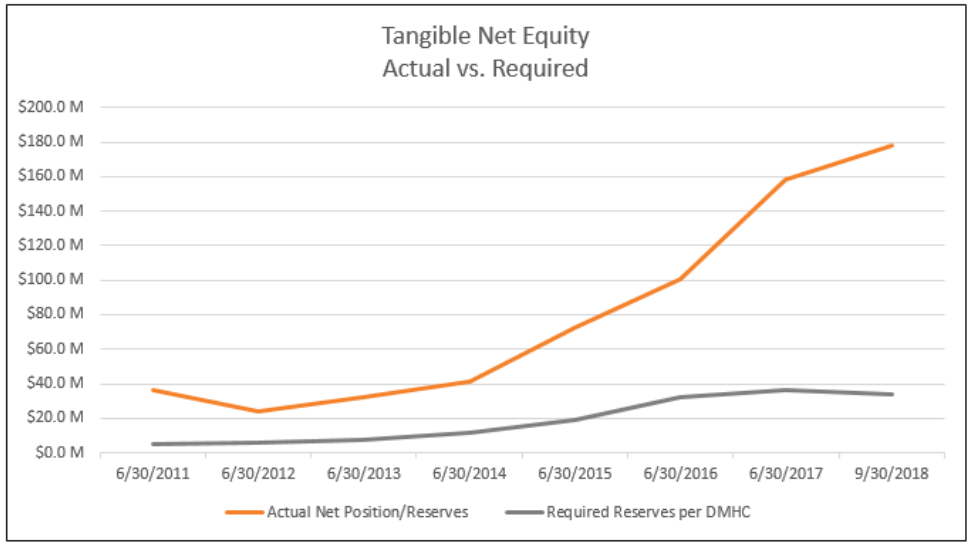
- Current assets totaled $742.4M compared to current liabilities of $594.1M, yielding a current ratio (Current Assets/Current Liabilities) of 1.25:1 vs. the DMHC minimum requirement of 1.0:1
- Cash as of September 30, 2018 increased by $9.1M compared to the cash balance as of year-end June 30, 2018. The overall cash position increased largely due to timing of receipt of revenues, largely paid in arrears.
- Current Cash & Equivalents components and yields were as follows:

Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$77,744,296	1.29%	$100,000	$300,000
Cash & Equivalents				
Bank of the West Money Market	$438,247	0.90%	$4,206	$23,041
Wells Fargo Bank Accounts	$154,791,584	1.76%	$252,246	$537,290
	$155,229,831		$256,452	$560,332
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.08%	$13	$38
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$233,279,977**		**$356,465**	**$860,370**

Tangible Net Equity

- TNE was $178.0M or 527.1% of the most recent quarterly DMHC minimum requirement of $33.8M. TNE trends for SCFHP are shown below.

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	9/30/2018
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$33.8 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$67.5 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	527.1%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS September 2018

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$178,013,509
Current Required TNE	$33,773,116
Excess TNE	**$144,240,392**
Actual as % Required	527.1%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	$118,205,907
500% of Required TNE (High)	$168,865,581
TNE Above/(Below) SCFHP Low Target	**$59,807,602**
TNE Above/(Below) High Target	**$9,147,927**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$233,279,977
Less Pass-Through Liabilities	
Net Payable to State of CA (1)	-
Other Pass-Through Liabilities	($7,324,264)
Total Pass-Through Liabilities	**($7,324,264)**
Net Cash Available to SCFHP	$225,955,713
SCFHP Target Liability	
45 Days of Total Operating Expense	($120,210,934)
60 Days of Total Operating Expense	($160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$105,744,779**
Liquidity Above/(Below) High Target	**$65,674,468**

(1) Pass-Through from State of CA	
Receivables Due to SCFHP	$501,964,866
Payable Due From SCFHP	(471,778,166)
Net Receivables/(Payables)	**$30,186,700**

Capital Expenditures

- Capital investments of $3.8M were made in the three months ending September 2018, largely due to the renovation of the new building.
- YTD capital expenditure includes the following:

Expenditure	YTD Actual	Annual Budget	
New Building	$3,626,167	$ 7,874,631	Note 1
Systems	-	1,125,000	
Hardware	59,760	1,550,000	
Software	92,000	702,000	
Furniture and Fixtures	-	-	
Automobile	-	-	
Leasehold Improvements	-	-	
TOTAL	**$3,777,927**	**$11,251,631**	

Note 1: Includes FY18 budget rollover of $6,628,131

Santa Clara Family Health Plan™

Financial Statements

Enrollment By Aid Category

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,184	27,000	26,651	26,567
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,201	99,296	98,245	98,183
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,979	10,916	10,834	10,905
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,765	10,748	10,697	10,653
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14	13
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	390	442	419	423
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385	382
	Aged (21 Over)																
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,941	23,024	23,066	23,083
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485	521
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2	2
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,165	1,211	1,185	1,193
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222	214
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**

Income Statement

Santa Clara Family Health Plan

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 69,787,783	84.0%	$ 68,930,940	85.1%	$ 856,842	1.2%	$ 212,093,752	85.1%	$ 207,431,678	85.2%	$ 4,662,074	2.2%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,278,550	2.7%	2,490,829	3.1%	(212,279)	-8.5%	6,730,042	2.7%	7,432,924	3.1%	(702,882)	-9.5%
CMC MEDICARE	10,671,348	12.8%	9,274,023	11.4%	1,397,325	15.1%	29,411,415	11.8%	27,674,763	11.4%	1,736,651	6.3%
TOTAL CMC	12,949,898	15.6%	11,764,852	14.5%	1,185,046	10.1%	36,141,456	14.5%	35,107,687	14.4%	1,033,769	2.9%
HEALTHY KIDS	342,904	0.4%	301,726	0.4%	41,178	13.6%	1,047,470	0.4%	908,294	0.4%	139,176	15.3%
TOTAL REVENUE	**$ 83,080,584**	**100.0%**	**$ 80,997,518**	**100.0%**	**$ 2,083,066**	**2.6%**	**$ 249,282,678**	**100.0%**	**$ 243,447,659**	**100.0%**	**$ 5,835,019**	**2.4%**
MEDICAL EXPENSE												
MEDI-CAL	$ 67,607,122	81.4%	$ 64,480,730	79.6%	$ (3,126,392)	-4.8%	$ 199,621,957	80.1%	$ 194,243,941	79.8%	$ (5,378,016)	-2.8%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,406,823	2.9%	2,184,623	2.7%	(222,200)	-10.2%	7,373,863	3.0%	6,519,170	2.7%	(854,693)	-13.1%
CMC MEDICARE	8,263,339	9.9%	8,927,200	11.0%	663,860	7.4%	27,934,782	11.2%	26,637,157	10.9%	(1,297,625)	-4.9%
TOTAL CMC	10,670,163	12.8%	11,111,823	13.7%	441,660	4.0%	35,308,645	14.2%	33,156,327	13.6%	(2,152,318)	-6.5%
HEALTHY KIDS	292,463	0.4%	271,754	0.3%	(20,709)	-7.6%	805,766	0.3%	818,070	0.3%	12,303	1.5%
TOTAL MEDICAL EXPENSES	**$ 78,569,748**	**94.6%**	**$ 75,864,308**	**93.7%**	**$ (2,705,440)**	**-3.6%**	**$ 235,736,369**	**94.6%**	**$ 228,218,338**	**93.7%**	**$ (7,518,030)**	**-3.3%**
MEDICAL OPERATING MARGIN	**$ 4,510,836**	**5.4%**	**$ 5,133,210**	**6.3%**	**$ (622,374)**	**-29.9%**	**$ 13,546,310**	**5.4%**	**$ 15,229,321**	**6.3%**	**$ (1,683,011)**	**-28.8%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,515,262	3.0%	$ 2,588,590	3.2%	$ 73,328	2.8%	$ 7,915,234	3.2%	$ 7,943,078	3.3%	$ 27,843	0.4%
RENTS AND UTILITIES	29,882	0.0%	17,611	0.0%	(12,271)	-69.7%	241,928	0.1%	288,393	0.1%	46,465	16.1%
PRINTING AND ADVERTISING	71,428	0.1%	61,150	0.1%	(10,278)	-16.8%	300,099	0.1%	279,450	0.1%	(20,649)	-7.4%
INFORMATION SYSTEMS	137,666	0.2%	226,473	0.3%	88,807	39.2%	614,311	0.2%	679,419	0.3%	65,108	9.6%
PROF FEES/CONSULTING/TEMP STAFFING	1,166,810	1.4%	948,052	1.2%	(218,758)	-23.1%	3,282,741	1.3%	2,933,643	1.2%	(349,098)	-11.9%
DEPRECIATION/INSURANCE/EQUIPMENT	362,165	0.4%	457,566	0.6%	95,401	20.8%	1,045,948	0.4%	1,389,199	0.6%	343,251	24.7%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	49,080	0.1%	161,005	0.2%	111,925	69.5%	232,645	0.1%	735,071	0.3%	502,426	68.4%
MEETINGS/TRAVEL/DUES	94,032	0.1%	130,176	0.2%	36,145	27.8%	249,364	0.1%	340,085	0.1%	90,721	26.7%
OTHER	15,679	0.0%	17,804	0.0%	2,125	11.9%	52,601	0.0%	122,995	0.1%	70,395	57.2%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,442,004**	**5.3%**	**$ 4,608,427**	**5.7%**	**$ 166,423**	**3.6%**	**$ 13,934,872**	**5.6%**	**$ 14,711,333**	**6.0%**	**$ 776,462**	**5.3%**
OPERATING SURPLUS (LOSS)	$ 68,832	0.1%	$ 524,783	0.6%	$ (455,950)	-86.9%	$ (388,562)	-0.2%	$ 517,988	0.2%	$ (906,549)	-175.0%
OTHER INCOME/EXPENSE												
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(179,339)	-0.1%	(179,340)	-0.1%	1	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(225,000)	-0.1%	(225,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	366,781	0.4%	47,605	0.1%	319,176	670.5%	790,547	0.3%	142,815	0.1%	647,732	453.5%
OTHER INCOME/EXPENSE	**232,001**	**0.3%**	**(87,175)**	**-0.1%**	**319,176**	**-366.1%**	**386,208**	**0.2%**	**(261,525)**	**-0.1%**	**647,733**	**-247.7%**
NET SURPLUS (LOSS)	**$ 300,834**	**0.4%**	**$ 437,608**	**0.5%**	**$ (136,774)**	**-31.3%**	**$ (2,354)**	**0.0%**	**$ 256,462**	**0.1%**	**$ (258,817)**	**-100.9%**

Balance Sheet

	September 2018	August 2018	July 2018	June 2018
Assets				
Current Assets				
Cash and Marketable Securities	$233,279,977	$235,488,840	$302,258,460	$224,156,209
Receivables	501,964,866	497,747,680	498,614,458	493,307,425
Prepaid Expenses and Other Current Assets	7,176,276	7,792,800	8,080,915	7,024,982
Total Current Assets	**742,421,119**	**741,029,320**	**808,953,833**	**724,488,615**
Long Term Assets				
Property and Equipment	42,357,057	42,306,060	31,288,225	38,579,130
Accumulated Depreciation	(15,212,360)	(14,888,918)	(10,954,498)	(14,309,761)
Total Long Term Assets	27,144,697	27,417,142	20,333,727	24,269,369
Total Assets	**769,565,816**	**768,446,462**	**829,287,560**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**9,287,513**	**14,535,240**
Total Deferred Outflows and Assets	**784,101,056**	**782,981,702**	**838,575,073**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	5,194,835	5,065,866	4,857,207	8,351,090
Deferred Rent	(0)	(0)	86,298	17,011
Employee Benefits	1,584,704	1,527,690	1,265,956	1,473,524
Retirement Obligation per GASB 45	5,062,134	5,002,354	4,878,139	4,882,795
Advance Premium - Healthy Kids	87,424	80,809	60,466	66,195
Deferred Revenue - Medicare	-	8,858,943	-	9,928,268
Whole Person Care/Prop 56	7,324,264	6,746,392	2,065,180	9,263,004
Payable to Hospitals	-	0	28,642,083	0
Due to Santa Clara County Valley Health Plan and Kaiser	11,186,460	12,243,869	4,905,409	6,691,979
MCO Tax Payable - State Board of Equalization	27,231,162	18,113,329	18,491,922	(0)
Due to DHCS	30,997,453	28,918,776	190,634,704	24,429,978
Liability for In Home Support Services (IHSS)	413,549,552	413,549,551	314,762,788	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	89,491,100	90,857,988	91,216,364	92,470,504
Total Current Liabilities	**594,083,611**	**593,340,091**	**664,241,040**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,049,796	1,974,796	6,932,370	1,824,796
Total Non-Current Liabilities	**7,969,296**	**7,894,296**	**12,851,870**	**7,744,296**
Total Liabilities	**602,052,907**	**601,234,387**	**677,092,910**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**485,329**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	17,350,172	17,633,610	20,333,727	18,067,094
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	160,360,340	160,076,903	137,741,483	140,008,115
Current YTD Income (Loss)	(2,354)	(303,188)	2,616,274	19,635,303
Total Net Assets / Reserves	178,013,509	177,712,675	160,996,834	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**784,101,056**	**782,981,702**	**838,575,073**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	$274,423,873
Medical Expenses Paid	(234,221,292)
Adminstrative Expenses Paid	(28,091,433)
Net Cash from Operating Activities	**$12,111,149**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(3,777,927)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	790,547
Net Increase/(Decrease) in Cash & Cash Equivalents - YTD	**9,123,768**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Sep 18)	**$233,279,977**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**($2,354)**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	902,599
Changes in Operating Assets/Liabilities	
Premiums Receivable	(8,657,442)
Other Receivable	(790,547)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(151,294)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(14,728,527)
State Payable	33,798,636
Santa Clara Valley Health Plan & Kaiser Payable	4,494,481
Net Pension Liability	225,000
Medical Cost Reserves & PDR	(2,979,404)
Deferred Inflow of Resources	-
Total Adjustments	**$11,210,903**
Net Cash from Operating Activities	**$12,111,148**

Statement of Operations - YTD

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Three Months Ending September 30 2018

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 212,093,752	$ 6,730,042	$ 29,411,415	$ 36,141,456	$ 1,047,470	**$ 249,282,678**
MEDICAL EXPENSE	$ 199,621,957	$ 7,373,863	$ 27,934,782	$ 35,308,645	$ 805,766	**$ 235,736,369**
(MLR)	94.1%	109.6%	95.0%	97.7%	76.9%	**94.6%**
GROSS MARGIN	$ 12,471,795	$ (643,821)	$ 1,476,633	$ 832,811	$ 241,704	**$ 13,546,310**
ADMINISTRATIVE EXPENSE	$ 11,856,015	$ 376,209	$ 1,644,095	$ 2,020,303	$ 58,553	**$ 13,934,872**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 615,780	$ (1,020,030)	$ (167,462)	$ (1,187,492)	$ 183,150	**$ (388,562)**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 328,592	$ 10,427	$ 45,566	$ 55,993	$ 1,623	**$ 386,208**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 944,371	$ (1,009,603)	$ (121,895)	$ (1,131,499)	$ 184,773	**$ (2,354)**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 286.77	$ 296.96	$ 1,297.77	$ 1,594.73	$ 108.79	**$ 322.95**
MEDICAL EXPENSES	$ 269.91	$ 325.37	$ 1,232.62	$ 1,557.99	$ 83.69	**$ 305.40**
GROSS MARGIN	$ 16.86	$ (28.41)	$ 65.16	$ 36.75	$ 25.10	**$ 17.55**
ADMINISTRATIVE EXPENSES	$ 16.03	$ 16.60	$ 72.55	$ 89.15	$ 6.08	**$ 18.05**
OPERATING INCOME/(LOSS)	$ 0.83	$ (45.01)	$ (7.39)	$ (52.40)	$ 19.02	**$ (0.50)**
OTHER INCOME/(EXPENSE)	$ 0.44	$ 0.46	$ 2.01	$ 2.47	$ 0.17	**$ 0.50**
NET INCOME/(LOSS)	$ 1.28	$ (44.55)	$ (5.38)	$ (49.93)	$ 19.19	**$ (0.00)**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	739,593	22,663	22,663	22,663	9,628	771,884
REVENUE BY LOB	85.1%	2.7%	11.8%	14.5%	0.4%	100.0%

Regular Meeting of the
Santa Clara County Health Authority
Compliance Committee

Thursday, November 15, 2018
1:00 PM – 2:30 PM
6201 San Ignacio Ave.
San Jose, CA 95119

Minutes - DRAFT

Members Present

Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Dave Cameron, Chief Financial Officer
Chris Turner, Chief Operations Officer
Jeff Robertson, MD, Chief Medical Officer

Staff Present

Beth Paige, Director, Compliance
Mai Phuong Nguyen, Compliance Oversight Mgr
Ron Smothers, Medicare Compliance Program Manager
Regina Wong-Valle, Compliance Audit Manager

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:15 pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the August 23, 2018 Regular Compliance Committee Meeting**

   Minutes of the August 23, 2018 regular Compliance Committee meeting were approved as presented.

4. **CMS Program Audit Corrective Actions**

   Ms. Larmer explained that SCFHP had received its notice of ICARs from CMS. There were seven. Corrective Action Plans for all of the ICARs have been submitted and accepted by CMS. One

area that will be re-evaluated is the G&A staffing given the sudden loss of a key staff member. Christine has attested to the completion of the corrective actions in response to the ICARs.

While waiting for the draft final report, which will identify the additional conditions cited by CMS (Corrective Action Required Conditions, or CARs), Compliance has requested that the business units begin to develop CAPs for the conditions anticipated based on the preliminary report.

5. Compliance Activity and Audit Report

a) Ms. Larmer and Ms. Paige presented the status of State Regulatory Audits.

- As of today, SCFHP has not received the preliminary report from DMHC regarding its March 2018 Audit. DMHC has notified the plan that it will conduct a routine survey of the Plan starting on March 18, 2019. The agency has requested a large volume of doucments to cover the audit period of November 1, 2016 through October 31, 2018. Compliance is working with Business Units to collect the information.
- DHSC issued the final report from its April 2018 audit. SCFHP had 7 findings requiring corrective action. CAPs were submitted in October and DHCS is asking for some additional information. DHCS has confirmed that rather than conducting its annual audit in April 2019, it will conduct a joint audit with DMHC beginning March 18, 2019.

b) Delegate and Internal Corrective Action Plans Requested following audit:
Ms. Larmer noted the written November Compliance Report identifies the delegate and internal audit corrective actions that have been issued. The reasons and due dates for the CAPs were reviewed.

Ms. Larmer highlighted the Claims Department CAP for untimely processing of provider disputes. The issue, occurring between April 12 and July 9 and discovered on July 9, was related to faxes being blocked and directed into a user's junk email folder. 589 PDRs were received during the timeframe; 266 were non-compliant. The fax line was unblocked, staff educated, and backlog PDRs completed by August 14, 2018. The Compliance Department recommends acceptance of the CAP.

c) Ms. Larmer explained that going forward, the results of NCQA pre-delegation and annual delegate audits would be brought to the Compliance Committee. She noted that in Q3 2018, the Plan's Health Services team audited delegates Golden Castle and New Directions, both of which provide case management and/or care coordination services to Plan members. The audits demonstrated that both were compliant with the applicable NCQA requirements.

A **motion** was made to accept the Compliance Activity and Audit Report as well as the Claims CAP specifically; the motion was **seconded and unanimously approved.**

6. Review CMC and Medi-Cal Compliance Dashboard and Work Plans

Ms. Nguyen presented the Compliance Dashboard for Q3 2018. She highlighted the following:

- Enrollment: although they missed the goal in July and August, the Enrollment team is back to 100% in September and October for mailing of new member packets and ID cards.
- Customer Service: although CS rates continue to be below goal, there are positive trends toward goal for speed of answer and abandonment rate. Service level has fallen below goal in the last 4 months for CMC.
- Case Mangement shows positive trends for HRA and ICP for CMC. Note that data for the SPD HRA is missing.
- Claims has returned to 100% timeliness for processing clean claims and contracted provider disputes.
- Grievance and Appeals' performance for all dashboard measures (CMC and Medi-Cal) has fluctuated significantly.
- Company-wide Compliance for new employee training and key personnel filings did not meet goal in Q3. New employee training did not meet it because general compliance training was not offered during the timeframe. This was corrected on 8/1/18. The Key Personnel filing was a Board member filing.

Compliance will request that Departments that have not shown improvements update their work/corrective action plans.

A **motion** was made to approve the Compliance Dashboard; the motion was **seconded and unanimously approved.**

7. Training

Ms. Paige gave an update on the required Compliance Training.

a) Governing Board Training
The Governing Board will be sent copies of the HIPAA, FWA and General Compliance training and asked to sign and return an attestation that they have received and reviewed the training.

b) Status of Staff HIPAA, FWA and Compliance Training

Training for HIPAA, FWA and Compliance was assigned to Staff. Three staff members had not completed their HIPAA training by the deadline and their QNXT access was revoked until they completed training, which they quickly did. Six consultants have not completed

training, primarily the CMS Compliance Training. Compliance is working with the Department Directors to have them work with their consultants to complete this.

The next training that will be implemented is the distribution of the Standards of Conduct and Compliance Program. Staff will be required to attest that they have received and will abide by the Standards. Both documents have been posted to SharePoint for staff access. HR will disseminate the documents to new hires and temps.

A **motion** was made to accept the Training report; the motion was **seconded and unanimously approved.**

8. Fraud, Waste and Abuse Report

a) Discuss any credible FWA cases and recovery efforts

Ms. Larmer presented the FWA report. She highlighted the activity conducted by the FWA vendor, T&M Protection Resources, which included data mining activities and active investigations. They are investigating a whistleblower allegation and have reviewed 1300 of 1500 documents. However, no credible cases of fraud have been identified as yet.

b) Review revised FWA Policy and Procedure

Ms. Larmer presented the revised FWA policy explaining that the revisions reflect the interaction between Compliance and the vendor. She noted the major change is it leaves it to the discretion of the Chief Compliance Officer as to whether a case is sent to the vendor for investigation or whether the Plan does the investigation.

Ms. Larmer asked for an approval of the substance of the policy and noted the format will be updated.

A **motion** was made to approve the Fraud, Waste and Abuse Report and the FWA Policy; the motion was **seconded and unanimously approved**.

9. Adjournment

The meeting was adjourned at 2:07 pm.

Compliance Department Activity
September – Mid-November 2018

2018 CMS Program Audit of CMC

CMS issued a preliminary audit report on September 7, 2018. There were findings in each of the audit areas. Following final submission of root cause and impact analyses, on October 3, 2018, CMS issued an Immediate Corrective Action Required (ICAR) Notification letter, identifying 7 conditions requiring immediate corrective action. These were in the areas of Part D Formulary and Benefit Administration (FA), Part D Coverage Determinations, Appeals, and Grievances (CDAG), and Service Authorization Requests, Appeals and Grievances (SARAG). The Corrective Action Plans were due three days after the notification. The ICARs were submitted and have recently been accepted. The Plan is now awaiting its draft final audit report.

DMHC Audit(s)

The Department of Managed Health Care (DMHC) preliminary report regarding its findings was due on or before August 6. However, as of today, the audit report is still pending.

On October 19, 2018, DMHC notified the plan that it would be conducting a Routine survey of the Plan starting on March 18, 2019. The agency has requested a large volume of documents to cover the audit period of November 1, 2016 through October 31, 2018. Compliance is working with the business units to collect the information, which is due to DMHC by Monday, November 19, 2018.

2018 DHCS Audit

The Department of Health Care Services (DHCS) issued the final audit report from its April 2018 audit on September 11, 2018. DHCS requested corrective action plans for 7 findings. CAPs were submitted in early October. Currently DHCS is requesting additional documentation for some of the CAPs.

DHCS has confirmed that rather come out in April 2019 for its annual audit, it will conduct a joint audit with DMHC in March 2019. The practical reality is that we will have two separate audits at the same time, although we anticipate that DHCS and DMHC will jointly staff on the various contract and regulatory requirements. DHCS will issue a data request in early 2019.

Delegate and Internal Corrective Actions Plans Issued:

- Premier Care:
  - 1 for the Annual Audit (HIPAA breach reporting w/in 24 hours of identification, no indication of board-certification for staff making medical necessity determinations, Incorrect NOA letter)

  CAP due November 9, 2018.

- Physicians Medical Group:
  - 1 for the Claims Audit (accurate claims processing, PDR processing)
  - 1 for the Annual Audit (wait time and accessibility of services monitoring)

  CAP responses received and business unit reviewing.

- CHME
  - 1 for Annual Audit (FWA Training and HIPAA breach reporting within 24 hours of identification, use of clinical criteria for UM decisions, Encounter data submission/resubmission, and eligibility file processing)
  - CAP issued (CMC & MC) for untimely delivery of DME Supplies
  - Focus Audit and monthly Monitoring:
    - Timeliness of UM Decision making (all LOB)
    - Call Center Operations (all LOB)
    - Notice of Action Letters

  CAP responses under review by Business Units.

- Claims Department
  - Claims faxes and PDRs were being routed to the wrong email box (junk email box) and this was not identified for two months because PDRs and claims were still coming through.
  - 660 PDRs came in. 250 were out of compliance for the timeframe for processing. The majority of the cases were Medi-Cal. All cases have been resolved at this time. Claims recently submitted a corrective action to ensure this does not happen in the future. It is currently under review by Compliance.

  Corrective Action Plan accepted.

- Docustream
  - Annual audit findings:
    - FWA Training
    - System Breach Process

  CAP responses under review by Business Units.

- Language Line
  - Annual Audit findings:
    - Availability of Interpreter Services 24/7
    - No documentation of C&L Training
    - No documentation of language self-assessment

  Vendor wants to discuss findings and CAP further. Call to be scheduled.

Operational Compliance Report – Corrective Actions

- Enrollment's CAP appears to be working with improvement of the two measures to 100% compliance.
- Customer Service's measures have shown a positive trend upward, however, they remain below goal. **Customer Service will be asked to provide an updated Corrective Action Plan.**
- Case Management continues an upward trend for CMC HRA and ICP completion. However, they do not have numbers for SPD HRAs. **Case Management will be asked to submit a work plan on how they will bring this element into compliance.**
- Claims measures dropped in August but have returned to 100%.

- Grievance and Appeals rates tend to fluctuate greatly for CMC and Medi-Cal with a negative trend downward for several of the elements. **Grievance and Appeals will be asked to update their work plan for how they plan to achieve compliance in 2019.**
- New hire training within 10 days was not met because General Compliance training was not implemented until August 1, 2018. New hires have been receiving the training since.
- Key Personnel Filings continue to be out of compliance due to inability to obtain required documents from Board members within 5 days of appointment. The Compliance Department is working on strategies to improve the process and outcomes.

Joint Operations Committee Meetings

The following Joint Operations Committee Meetings were held:

September:

County Mental Health, Kaiser, PMG, Premier Care, VHP, and HealthLOGIX,

October:

Carenet, Liberty Dental, MedImpact, VSP, Docustream, Language Line

November:

Advanced Health, CHME, Premier Care, T&M Protection Services and scheduled PMG, VHP

December:

There are 4 JOCs scheduled for December.

Cal MediConnect

- CMS Audit CAPs have kept everyone busy.
- No other Notices of Non-Compliance were received from CMS.
- CMT Calls
    - September 2018 – CMT asked questions regarding the CMC Consumer Advisory Committee (e.g. strategies for recruitment, membership, how orient, what do you ask members for feedback on, etc.)
    - October 2018 – CMT inquired about the difference between Q1 and Q2 Core 3.2 data regarding the % of members documented as "unwilling to complete a care plan" and about strategies to improve performance on quality withhold measures.
    - November 2018 – CMT and Plan discussed CY 2019 Readiness and Behavioral Health Integration Coordination.

Medi-Cal

- DHCS issued Contract Amendment 26 for signature. It was missing rates and DHCS will be issuing a subsequent amendment to reflect Final SFY16/17 rates as submitted to CMS on 9/20/17 in Package 48.
- DHCS issued the 2019 Auto Assignment calculations. SCFHP will receive 67% of the members who have not selected a health plan when enrolling in Medi-Cal and Anthem Blue Cross will receive 33%.
- Children enrolled in the Pediatric Palliative Care Waiver will be receiving their palliative care services through the managed care plans effective 1/1/2019. Currently, SCFHP does not have any members in the Pediatric Palliative Care waiver program.
- Work continues for implementation of the Health Homes Program in Santa Clara County in July 2019

- DHCS published two key All Plan Letters: an updated "Blood Lead Screening of Young Children" and "Diabetes Prevention Program". These will be pushed out to providers.

DMHC

- 19 DMHC Complaints have been received from September to present. Currently only 1 case has gone to IMR.

HIPAA Disclosures

There have been 5 potential disclosures between September and mid-November that were reported to DHCS and required investigation.

- ID card to the wrong member
- Wrong member information in transportation portal. However, it was a test using the member name but no other identifying information.
- Grievance PHI bin was emptied by janitorial staff and had copies of some member PHI.
- PMG sent an auth letter to the wrong member.
- Website search function reconfigured incorrectly allowing claims dispute documents to be searchable by the public.

FWA Activities

T&M provided an updated summary report detailing its recent SIU activities. The activities included:

- Datamining Activities:
  - Reviewed hospice HCPCS codes (Q5001 – Q5010), awaiting contracts of several providers from SCFHP.
  - Reviewed 2 dermatologists pharmacy claims data.
  - Reviewed home blood glucose monitor (E0607) recipients and DME providers.
  - Reviewed P9603 and P9604 – Travel allowance for specimen collection
  - Reviewed SCFHP's exposure to Professional Clinical Laboratory (ProLab). OIG recently found ProLab to be non-compliant with Medicare requirements for billing phlebotomy travel allowances.
  - Reviewed medical and pharmacy claims data concerning members in hospice possibly receiving curative drugs.
  - Reviewed HCPCS codes: A9274 (External Ambulatory Insulin) and E0784 (Infusion pumps)

- Upcoming Activities:
  - Review of Community-Based Adult Services/Adult Day Health Care claims
  - Review of Hospitals claims data
  - Review of Skilled Nursing Facility providers

- Active Investigations:
  - 1 Active investigation that should be completed next week.

- 5 provider investigations for potential E&M upcoding and CPT Code 95004 Top Biller requiring collection of medical records and contact of members to verify services rendered.
- 1 hospital investigation for upcoding requiring collection of medical records and further review
- 2 durable medical equipment (DME) providers investigated for inappropriate CPAP billing. Overpayment notices to be mailed to the providers.
- 1 transportation provider investigated for potential billing discrepancies. Further review requires collection of medical visit data evaluated against billing.
- 6 clinic investigations, 4 of which resulted in overpayment notices being mailed. 2 clinic investigations require collection of medical records and further review.
- 1 ADHC Center with member attendance 93% or higher. Review records from provider and send overpayment notice if necessary.
- Mobile Diagnostic provider – review billings based on CMS directive of pro-rated billings based on the number of patients seen at a location.
- 3 ABA Providers – payments made in excess of contracted rates. Overpayment notice to be mailed.

Santa Clara Family Health Plan

SCFHP 2018 CMS Audit Actions Tracker

Last Updated: 11/15/2018

ID #	Lead	Workstream	Task Description	Previous Updates	Next Steps	Due Date	Status
ICAR CDAG 3.12 Task-1	Darryl	G&A	Hire temporary staff to support workload prior to implementing Beacon HCS Virtual Appeals Manager	•Temp G&A coordinator positions posted on or before 10/15	•Task complete. Currently reevaluating staffing needs due to unexpected loss of Supervisor.	10/19/2018	Task Complete
ICAR CDAG 3.12 Task-2	Darryl	G&A	IRE Auto-forward training	•Autoforward training designed, posted, and delivered		9/17/2018	Task Complete
ICAR CDAG 3.12 Task-3	Darryl	G&A	Create and implement interim appeals monitoring process/dashboard to track due dates	•Example case tracker dashboard created	•Case tracker implemented. Monitoring to begin on or before 11/15/2019.	10/29/2018	Task On Track
ICAR CDAG 3.12 Task-4	Darryl	G&A	Beacon HCS Virtual Appeals Manager Implementation	•Implementation kickoff meeting occurred 10/4	•Finalize workplan, finalize business requirements; on track for targeted go-live date of 1/1/2019.	1/1/2019	Task On Track
ICAR CDAG 3.12 Task-All	Darryl	G&A	Sponsor did not auto-forward coverage determinations and/or redeterminations (standard and/or expedited) that exceeded the CMS required timeframe to the Independent Review Entity (IRE) for review and disposition. Of the five cases that were required to be auto-forwarded to the IRE, four cases were non-compliant for failure to be auto-forwarded to the IRE due to inadequate staffing	•On track to implement 4 corrective actions, no significant risks or barriers		1/1/2019	ALL
ICAR FA 2.35 Task-1	Johanna	Pharmacy	Coding was updated to allow drugs on the B versus D drug list (543741) to process as intended.	•SAC06 Part B Main Table Drug List -- corrected and posted		7/20/2018	Task Complete
ICAR FA 2.35 Task-2	Johanna	Pharmacy	Called pharmacies to reprocess denied claims. All active members were able to obtain drug.	•Paid claims reviewed to verify access and payment, report produced to verify		8/6/2018	Task Complete
ICAR FA 2.35 Task-3	Johanna	Pharmacy	PBM provided monitoring report for August 2018 to confirm that drugs on the B versus D drug list were not inappropriately denied as non-covered drugs.	•SAC06 monitoring report produced for August 2018		9/12/2018	Task Complete
ICAR FA 2.35 Task-4	Johanna	Pharmacy	PBM provided monitoring report for September 2018 to confirm that drugs on the B versus D drug list	•SAC06 monitoring report produced for Sept 2018		10/2/2018	Task Complete
ICAR FA 2.35 Task-5	Johanna	Pharmacy	PBM will continue to provide monthly monitoring reports through June 2019 to confirm that drugs on the B versus D drug list are not inappropriately denied as non-covered drugs.	•Implemented and recurring monthly (monitoring)		10/15/2018	Task Complete
ICAR FA 2.35 Task-6	Johanna	Pharmacy	PBM to develop testing and validation process document and communicate standard process to Configuration Services for addressing potential configuration issues and reinforce adherence to PBM's Quality Assurance process.			10/19/2018	Task Complete
ICAR FA 2.35 Task-All	Johanna	Pharmacy	Sponsor failed to properly administer its CMS-approved formulary by inappropriately rejecting formulary medications.	•On track to implement 6 corrective actions, no significant risks or barriers		7/20/18 -- 10/19/2018	ALL

ID #	Lead	Workstream	Task Description	Previous Updates	Next Steps	Due Date	Status
ICAR SARAG 7.01 Task-1	Lily & Jana	UM	The plan conducted UM (Medical, Behavioral Health, Pharmacy, and LTSS) staff training on oral notification process for all expedited determinations to members and providers.	•Workflow for notification for expedited determinations documented and trained		8/31/2018	Task Complete
ICAR SARAG 7.01 Task-2	Lily & Jana	UM	The plan implemented oral notification process for all expedited determination to members and providers.	•Workflow for notification for expedited determinations implemented		8/31/2018	Task Complete
ICAR SARAG 7.01 Task-3	Lily & Jana	UM	The plan updated the UM procedure to include a weekly quality monitoring process for all aspects of the authorization process including timeliness of expedited service authorizations.	•UM quality monitoring process updated and implemented		8/31/2018	Task Complete
ICAR SARAG 7.01 Task-4	Lily & Jana	UM	Weekly, Monthly and quarterly audits including timeliness of expedited service authorizations will be conducted by UM Manager and reported to UM committee quarterly.	•UM quality monitoring process updated and implemented		9/4/2018	Task Complete
ICAR SARAG 7.01 Task-5	Pam	Support Services	The plan will update the mailroom policy and procedure to print and send the member letters within the same day within a specific cut off time.	•Mailroom policy updated, training delivered, new P&P in effect		10/4/2018	Task Complete
ICAR SARAG 7.01 Task-6	Pam	Support Services	The plan implemented the updated mailroom workflow of printing and sending UM member letters the same business day for letters created by 4:30 PM that business day	•Mailroom policy updated, training delivered, new P&P in effect		10/1/2018	Task Complete
ICAR SARAG 7.01 Task-7	Lily & Jana	UM	The plan will conduct staff training regarding the updated mailroom policy and procedure	•UM staff trained on new mailroom P&P		10/8/2018	Task Complete
ICAR SARAG 7.01 Task-8	Lily & Jana	UM	UM will develop a policy and procedure for managing member notification after the mailroom cutoff time, on weekends, or on holidays.	•UM developed updated policy for member notification, posted		10/8/2018	Task Complete
ICAR SARAG 7.01 Task-9	Lily & Jana	UM	UM will conduct staff training on the policy and procedure for managing member notification after the mailroom cutoff time, on weekends, or on holidays.		•Validate successful training on new notification P&P	10/15/2018	Task Complete
ICAR SARAG 7.01 Task-All	Lily & Jana	UM	Sponsor did not notify its MMP-California enrollees, and providers if the providers requested the services, of its decisions within 72 hours of receipt of expedited service authorization requests.	•On track to implement 9 corrective actions, validating staff training on new P&P for member notification after mailroom cutoff time		10/15/2018	ALL
ICAR SARAG 7.05 Task-1	Darryl	G&A	Task - Automated case due date tracker	•Example case tracker dashboard created	•Case tracker dashboard implemented on schedule.	10/29/2018	Task Complete
ICAR SARAG 7.05 Task-2	Darryl	G&A	Task - Hire temporary staff to support workload prior to implementing Beacon HCS Virtual Appeals Manager	•Due date changed from 11/5 to 10/15 •Temp G&A coordinator positions posted on or before 10/15	•Task complete. Currently reevaluating staffing needs due to unexpected loss of Supervisor.	10/15/2018	Task On Track
ICAR SARAG 7.05 Task-3	Darryl	G&A	Task - Beacon HCS Virtual Appeals Manager Implementation	•Implementation kickoff meeting occurred 10/4	•Finalize workplan, finalize business requirements; on track for targeted go-live date of 1/1/2019.	1/1/2019	Task On Track
ICAR SARAG 7.05 Task-4	Darryl	G&A	Task - Implement new mailroom policies	•Mailroom training sheet, incoming and outgoing mail policy, and overall mailroom policies updated and staff trained		10/1/2018	Task Complete

ID #	Lead	Workstream	Task Description	Previous Updates	Next Steps	Due Date	Status
ICAR SARAG 7.05 Task-All	Darryl	G&A	Finding: Sponsor did not notify enrollees, and providers when appropriate, of its determinations within 72 hours of receipt of expedited appeals requests.	•On track to implement 4 corrective actions, no significant risks or barriers		1/1/2019	ALL
ICAR SARAG 7.10 Task-1	Lily & Jana	UM	Task - The plan updated the UM procedure to include a weekly quality monitoring process for all aspects of the authorization process including timeliness of standard service authorizations.	•Completed, new UM Quality Monitoring process developed, posted, and implemented		8/31/2018	Task Complete
ICAR SARAG 7.10 Task-2	Lily & Jana	UM	Task - Weekly, Monthly and quarterly audits, including timeliness of standard service authorizations, will be conducted by UM Manager and reported to UM Committee quarterly	•Completed, new UM Quality Monitoring process developed, posted, and implemented		9/4/2018	Task Complete
ICAR SARAG 7.10 Task-3	Pam	Support Services	Task - The plan has updated the mailroom policy and procedure to print and send the member letters within the same day within a specific cut off time.	•Completed, new policy posted, training administered, and in effect		10/4/2018	Task Complete
ICAR SARAG 7.10 Task-4	Pam	Support Services	Task - The plan implemented the updated mailroom workflow of printing and sending UM member letters the same business day for letters created by 4:30 PM that business day.	•Completed, new policy posted, training administered, and in effect		10/1/2018	Task Complete
ICAR SARAG 7.10 Task-5	Lily & Jana	UM	Task - The plan will conduct staff training regarding the updated mailroom policy and procedure	•Completed, new policy posted, training administered, and in effect		10/8/2018	Task Complete
ICAR SARAG 7.10 Task-6	Lily & Jana	UM	Task - UM will develop a policy and procedure for managing member notification after the mailroom cutoff time, on weekends, or on holidays.	•Completed, new policy posted, training administered, and in effect		10/8/2018	Task Complete
ICAR SARAG 7.10 Task-7	Lily & Jana	UM	Task - UM will conduct staff training on the policy and procedure for managing member notification after the mailroom cutoff time, on weekends, or on holidays.	•Pending validation		10/15/2018	Task Complete
ICAR SARAG 7.10 Task-All	Lily & Jana	UM	Finding: Sponsor did not notify its MMP-California enrollees, and providers if the providers requested the service, of its decisions within 14 calendar days of receipt of standard authorization requests.	•All 7 tasks implemented and monitoring ongoing on new UM staff training and policy implementation		10/15/2018	ALL
ICAR SARAG 7.21 Task-All	Lily, Jana, Darryl	UM, G&A	Did not demonstrate sufficient outreach to providers or to enrollees to obtain additional information necessary to make appropriate clinical decisions. Sponsor did not attempt outreach to a provider prior to denying an authorization requests because sponsor's process did not address requests where supplemental information was missing or insufficient.	•On track to implement 7 corrective actions		1/1/2019	ALL
ICAR SARAG 7.21 Task-1	Lily & Jana	UM	The Plan will fully implement the HPMS memo (Feb 22, 2017) and initiate best practices for request for clinical information	•UM updated and posted P&P		9/30/2018	Task Complete
ICAR SARAG 7.21 Task-2	Lily & Jana	UM	Staff training and implementation of all UM personnel (Medical, Behavioral Health, Pharmacy, and LTSS) Evidence of Mandatory Attendance, training presentation documents, and sign-in sheets will be kept.	•Trained staff in mandatory education session(s), with sign-in evidence		9/30/2018	Task Complete
ICAR SARAG 7.21 Task-3	Lily & Jana	UM	Evidence of the appropriate outreach will be documented in QNXT system	•Process to document outreach in QNXT implemented		9/30/2018	Task Complete

ID #	Lead	Workstream	Task Description	Previous Updates	Next Steps	Due Date	Status
ICAR SARAG 7.21 Task-4	Lily & Jana	UM	Weekly, Monthly and quarterly audits will be conducted by UM Manager and provided to the UM Committee on a regular basis.	•UM quality monitoring process updated and implemented		9/30/2018	Task Complete
ICAR SARAG 7.21 Task-5	Darryl	G&A	Retrained staff on existing Job aid regarding provider outreach for Reconsiderations	•Training developed and delivered		9/7/2018	Task Complete
ICAR SARAG 7.21 Task-6	Darryl	G&A	Augment department resources with consulting support and/or temporary staff to handle current caseloads and support quality monitoring	•Validating that staffing updates meet the work volume requirements	Task complete. Currently reevaluating staffing needs due to unexpected loss of Supervisor.	10/22/2018	Task Complete
ICAR SARAG 7.21 Task-7	Darryl	G&A	Implement new Beacon Health System G & A system to eliminate variation from documented policies and procedures (including outreach to providers), and increase visibility of timeliness and documentation of outreach attempts.	•Implementation kickoff meeting occurred 10/4	Implementation on track for targeted 1/1/2019 go-live date	1/1/2019	Task On Track
ICAR SARAG 7.25 Task-All	Darryl	G&A	Sponsor failed to ensure that appropriate health care professionals reviewed appeals for all fully or partially adverse medical necessity decisions.	•On track to complete 2 corrective actions		1/1/2019	ALL
ICAR SARAG 7.25 Task-1	Darryl	G&A	Proof of revised medical record sheet, training and staff attestation.	•Revised medical record sheet completed, staff trained, documentation of updates to MR and proof of training posted		9/24/2018	Task Complete
ICAR SARAG 7.25 Task-2	Darryl	G&A	Beacon HCS Virtual Appeals Manager Implementation	•Implementation kickoff meeting occurred 10/4	Implementation on track for targeted 1/1/2019 go-live date	1/1/2019	Task On Track

POLICY

Policy Title:	Fraud, Waste and Abuse	**Policy No.:**	CP02
Replaces Policy Title (if applicable):	Fraud, Waste, and Abuse Policy	**Replaces Policy No. (if applicable):**	CP002_2
Related Policies:	N/A	**Applicable Procedure:**	CP02.01
Issuing Department:	Compliance	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Policy Statement

Santa Clara Family Health Plan (SCFHP) requires its staff (employed, temporary or contracted), board members and first tier, downstream and related entities (FDRs) to exercise due diligence in the prevention, detection and correction of fraud, waste and abuse. SCFHP promotes an ethical culture of compliance with all state and federal regulatory requirements, and mandates the reporting of any suspected fraud, waste and abuse to the Compliance Officer by any means including the use of an anonymous hotline.

II. Purpose

To ensure SCFHP has a comprehensive plan to prevent, detect and correct fraud, waste and abuse as required by state and federal regulatory provisions governing SCFHP's operations.

III. Definitions

Abuse: Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

California Department of Health Care Services (DHCS): The California State Agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq. and California Welfare and Institutions Code § 14000 et seq.

Centers for Medicare and Medicaid Services (CMS): An agency within the U.S. Department of Health and Human Services that is responsible for directing the Medicare program.

Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Medi-Cal: California's Medicaid program, serving low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women, and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS.

Medicare: The national health insurance program for:

- People 65 or older,
- People under 65 with certain disabilities, or
- People of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Member: An eligible beneficiary who enrolls in one of the health care coverage programs offered by SCFHP including, but not limited to, Medi-Cal, Healthy Kids and Cal MediConnect.

NBI MEDIC: The National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

OIG: The Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.

Related Entity: Any entity that is related to an MAO or Part D sponsor by common ownership or control and

1) Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;

2) Furnishes services to Medicare enrollees under an oral or written agreement; or

3) Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

Special Investigations Unit (SIU): An internal or externally delegated investigation unit responsible for conducting investigations of potential FWA for SCFHP.

Waste: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

IV. Responsibilities

SCFHP maintains ultimate responsibility for the effectiveness of its compliance program, including FWA detection, correction and prevention. As part of this responsibility, SCFHP requires all health care providers and business partners to adhere to and maintain policies to address the following principles which are further outlined in SCFHP's procedure CP02.01:

- Monitor for fraud, waste, and abuse;
- Comply with any monitoring or auditing requests from SCFHP;
- Develop and implement monitoring and auditing work plans for any functions supporting SCFHP's government programs;
- Develop, implement and monitor reporting mechanisms, including appropriate notification to regulatory agencies; and
- Provide ongoing education relating to FWA schemes.

V. References

18 U.S.C. § 1347
42 CFR 422 and 423
42 C.F.R. § 423.501
42 CFR 438.608
42 CFR 455.2
CA W. & I. Code Section 14043.1(a).
Medicare Managed Care Manual, Chapter 21
Prescription Drug Benefit Manual, Chapter 9

VI. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Revision Date	Activity Type (Initial; Updated; Retired; Annual Review-No Change)	Adoption Date	Final Approval By	Board Action/Date (Approve or Ratify)
v1	**7/28/99**	**Retire LC-05-05; replaced with CP002_2**			
v2	**2/2005**	**Updated**			
v3	**3/2006**	**Updated**			
v4	**5/2009**	**Updated**			
v5	**2/2011**	**Updated**			
v6	**11/2014**	**Updated**			
v7	**8/2015**	**Updated**			
v8	**4/2018**	**Updated**	**11/15/2018**		

PROCEDURE

Procedure Title:	Fraud, Waste and Abuse	**Procedure No.:**	CP02.01
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Compliance	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To establish guidelines that aid in the prevention and detection of fraud, waste, and abuse and to ensure that SCFHP is compliant with all regulatory requirements pertaining to the Special Investigations Unit (SIU) and FWA program.

II. Procedure

A. Cal MediConnect – Delegated Functions

SCFHP's Compliance Department manages the oversight of its delegated vendor on all SIU responsibilities established by CMS, DHCS or DMHC in connection with the Cal MediConnect program, as well as any contractual obligations. These responsibilities include but are not necessarily limited to:

1. Data mining of SCFHP's claims, encounter data, and prescription drug events for potential FWA schemes (e.g., upcoding, unbundling, fraud alert activities, newly excluded providers/prescribers, etc.);
2. Medical record reviews to ensure accuracy of coding and billing for suspected claims;
3. Conducting surveillance, interviews and other investigation relating to FWA;
4. Recovering overpayments;
5. Notifying SCFHP of any underpayments;
6. Providing SCFHP with a list of repeat offenders to allow for provider relations to follow-up with education; and
7. Notifying SCFHP of cases that required reporting to regulatory agencies (e.g., MFCU, NBI MEDIC, etc.).

B. Cal MediConnect – Issues Identified or Reporting within SCFHP

Upon the identification or reporting of any potential FWA issues within SCFHP, SCFHP's Compliance Department will initiate a baseline investigation of the issue within 5 business days of the

PROCEDURE

identification or reporting of such potential FWA issue. The following actions are taken upon completion of the baseline investigation:

1. If the baseline investigation does not reveal that the reported incident implicates FWA, then the Compliance Department will document its investigation results for reporting to the Compliance Committee. Upon approval of the Compliance Committee, the case will be closed.
2. If the baseline investigation reveals legitimate grounds for proceeding with the case as confirmed FWA, then the Compliance Department will initiate or, at the discretion of the Compliance Officer, direct its delegated SIU vendor to initiate, the following actions:
    a. Additional investigation against prior claims, encounter data or prescription drug events to identify the full scope and financial impact of the FWA;
    b. Report the case to the NBI MEDIC within the mandated thirty (30) days from the identification of the FWA; and
    c. Begin the recoupment/takeback process to ensure federal program monies are recovered.
3. In the event of a delay in submitting a suspected FWA incident to the Compliance Department or a delay in the commencement of the required investigation within 5 business days of identifying the issue, SCFHP's Compliance Department may submit a suspected case directly to the NBI MEDIC simultaneously with its actions pursuant to Section 2, above, in order to comply with CMS requirements for the referral of such cases to the NBI MEDIC.
    a. Referrals to the NBI MEDIC directly from SCFHP include the following details:
        i. Name of Compliance Officer or SIU Investigator;
        ii. Name of the organization;
        iii. Contact information for follow-up purposes;
        iv. Summary of the issue (e.g., who, what, when, where, how and why);
        v. Identification of the potential legal violations;
        vi. Specific statutes and allegations;
        vii. List of civil, criminal, administrative code or rules violations (state and federal);
        viii. Detailed description of allegations or pattern of FWA;
        ix. Incidents and issues associated with the allegations;
        x. Background Information (perpetrator/subject of investigation, member(s) involved, pharmacies, providers, other entities);
        xi. Additional background information (e.g., witnesses, geographic locations, websites, networks, etc.);
        xii. Interested parties;
        xiii. Data sources (e.g., claims, encounter data, PDE, graphs/trending, financial impact estimates);

PROCEDURE

xiv. Recommendations (next steps, special considerations, cautions).

b. SCFHP (or its delegated SIU vendor) will make its referral to the NBI MEDIC using one or both of the following mechanisms:

i. Calling the NBI MEDIC at 1-877-772-3379; and/or

ii. Complete a referral form located at: http://www.healthintegrity.org/html/contracts/medic/case_referral.html

c. In the event the NBI MEDIC requires follow-up documentation, SCFHP supplies those responses or materials within thirty (30) calendar days of the request, unless the NBI MEDIC establishes an earlier deadline.

4. SCFHP will maintain a tracking summary of all potential and confirmed FWA cases to identify trends. If repeat, suspected but unconfirmed FWA behavior is identified, the provider/prescriber at issue receives a warning letter from SCFHP that continued non-compliant behavior may result in:

a. SCFHP reporting the provider/prescriber to the appropriate state or federal agency for further disciplinary action; and/or

b. Termination of SCFHP's contract with the provider/prescriber.

5. Employees who have concerns or suspect fraud are directed to promptly report the situation, with supporting documentation if available, through one of the following mechanisms:

a. Anonymously through the Compliance Hotline

b. Using the secure Compliance E-mail;

c. Directly to the Chief Compliance Officer; or

d. To their department director. The department supervisor who is informed by an employee of a potential FWA case **must** forward the case promptly to the Compliance Department's Chief Compliance Officer of the Compliance Director.

In no event may the employee contact the suspected individual to determine facts or disclose or discuss the case, facts, suspicions, or allegations with anyone other than identified investigators.

C. Medi-Cal

The Compliance Officer or, at the Compliance Officer's discretion, SCFHP's delegated SIU vendor reports potential FWA issues directly to DHCS' Medi-Cal Fraud Unit using form MC 609 (Confidential Medi-Cal Complaint Report (Attachment B)) within 10 working days of when SCFHP becomes aware of, or has received notice of, potential fraud. The MC 609 report form can be sent to DHCS through email at IB.PAU.INTAKE@dhcs.ca.gov.

1. Case Referral Documentation and Investigation

a. The Compliance Director has the primary responsibility for the following:

PROCEDURE

i. Documenting and tracking the potential FWA issue in the current referral log
ii. Examining all records and documentation of the case to determine if the FWA is credible
iii. For FWA cases involving filed claims, verifying that the appropriate delay notice has been sent to the member and/or provider within 45 days (as required by the Health and Safety Code, §1371). Additional delay notices may be generated if the investigation of the claim continues more than the 45 days.
iv. Closing the cases that are not fraudulent.
v. If the potential FWA case indicates a credible allegation of fraud, preparing a formal report of the case and forwarding the documentation to the Compliance Committee, the Chief Executive Officer (CEO) and the Chief Operations Officer (COO), and/or to DHCS.
vi. The formal report and/or MC 609 report form must be submitted with the following, as applicable:
    1) Police report
    2) Background information
    3) Investigation report
    4) Interviews
    5) Member information
    6) Confirmation of services
    7) Items or services supplied by the Provider
    8) Pharmaceutical data
    9) Any other pertinent information
vii. Recording and tracking the final decision on the disposition of the potential FWA case made by the Compliance Committee, CEO, COO, and DHCS, if applicable.
viii. Filing validated or suspected FWA case(s) with the appropriate law enforcement agency, as applicable.
ix. Providing a quarterly and an annual report to the Compliance Committee, CEO, COO, and DHCS, if applicable on the status of any validated or suspected potential FWA and the outcome of any prosecuted cases.

D. Good Faith Reporting and Non-retaliation

SCFHP has a strict no-tolerance policy for retaliation or retribution against any employee or FDR who in good faith reports suspected FWA. Employees and FDRs are also protected from retaliation for False Claims Act complaints, as well as any other applicable anti-retaliation protections.

E. Record Retention

PROCEDURE

In accordance with federal law, SCFHP maintains all books, records, contracts, documents, communications, computer or other electronic systems (including medical records and documentation of SCFHP's FDRs) associated with its federally-funded health care programs for ten (10) years and makes such records available for inspection and audit upon request by state or federal regulators or their designees.

III. Policy and Regulatory References

CP02 – Fraud, Waste and Abuse Policy
CP05 – Records Retention Policy
CP06 – False Claims Act Policy
42 CFR § 422.504(i)(2)(i) and (ii)
42 C.F.R. §§ 422.503(b)(4)(vi)(D), 423.504(b)(4)(vi)(D)
Medicare Managed Care Manual, Chapter 21
Prescription Drug Benefit Manual, Chapter 9

IV. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Revision Date	Activity Type (Initial; Updated; Retired; Annual Review-No Change)	Adoption Date	Final Approval By	Board Action/Date (Approve or Ratify)
v1					

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, October 10, 2018

Voting Committee Members	Specialty	Present Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	Y
Jimmy Lin, MD	Internist	Y
Ria Paul, MD, Chair	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	N
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Jeffrey Arnold, MD	Emergency Medicine	N
Christine Tomcala, CEO	N/A	N

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Lily Boris, MD	Medical Director	Y
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	Y
Shawna Cagle	Manager, Case Management	Y
Jamie Enke	Manager, Process Improvement	Y
Darryl Breakbill	Manager, Grievance and Appeals	Y
Caroline Alexander	Administrative Assistant	N
Eric Tatum	Director of Provider Network Management	Y
Carmen Switzer	Provider Network Access Manager	Y (via telephone)
Mai Chang	Manager of Quality Improvement	Y
Chris Turner	Chief Operating Officer	Y
Tiffany Franke	Social Work Case Manager Lead	Y
Renee Rodriguez	Supervisor, Grievance and Appeals	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:35 p.m. Quorum was established at this time.			
Review and Approval of August 8, 2018 minutes	The minutes of the August 8, 2018 Quality Improvement Committee meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the August 8, 2018 meeting were approved as presented.		
Public Comment	No public comment.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
CEO Update	Ms. Turner presented the CEO Update on behalf of Ms. Tomcala, CEO. Healthy Kids membership is 3,217, Medi-Cal enrollment at 244, 493, Cal MediConnect 7, 601. Continue to see decline in enrollment in Medi-Cal line of business. Outreach team is working on improving Cal MediConnect enrollment working with providers doing outreach on Cal MediConnect. Plan relocated to new location. CMS audit activities have been keeping the plan busy.			
Action Items A. Email response evaluation	Ms. Enke presented the Email response evaluation on behalf of Ms. Nguyen. Annually monitor timeliness and quality of emails sent to members. Only one email received from CMC line of business. May be due to older population using phone more than internet/email. Reviewed four different measures: • Email turnaround time • Response comprehensiveness • Spelling errors • Member services contact information provided 100% goal met. Meeting NCQA requirements and will continue to do this analysis annually. Dr. Paul inquired as to if members know where to send emails to. Ms. Enke indicated on portal there is a generic email address. Ms. Breakbill indicated there is an area on website that members can submit questions regarding grievances.	Approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
B. Accessibility of Services Analysis	Ms. Switzer presented the Accessibility of Services Analysis. The purpose of the Santa Clara Family Health Plan's (SCFHP) annual timely access report is to demonstrate how the Plan has monitored compliance and non-compliance of timely access regulations during Measurement Year (MY) 2018. SCFHP's Timely Access & Availability Work Group and Quality Improvement Committee monitor timely access and reporting activities to ensure members receive timely access to services and care. SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser survey results. The following surveys and assessments are included in this report: • Provider Appointment Availability Survey and After-hours Survey • CAHPS • Provider Satisfaction Survey • Member Grievances **Conclusion - Timely Appointment Access:** Survey results showed that PCPs are able to meet non-urgent/routine appointment standards; however, as noted they continue to show non-compliance with urgent care appointments. The Plan believes that PCPs are challenged with urgent appointment standards due to the stringent requirement to schedule appointments within a 48-hour timeframe, coupled with providers not having an adequate understanding of regulatory requirements. The PCP after-hours access compliance resulted in 100% in 2018, up from 88% in 2017, which is a marked improvement. However, it is clear that PCP providers will require training/education on meeting timeliness compliance, as only 44% were compliant out of 401 surveyed.	Approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	For High Volume/High Impact Specialists, only 1 specialist type (Ophthalmology) out of 4 met the urgent appointment standard and 2 met the non-urgent/routine appointment standards, which concludes that provider training on access standards is necessary. The least amount of survey participants were from behavioral health providers; thus, it may be difficult to identify trends; however, the results did indicate that all respondents were not able to meet the non-life threatening emergency within 6-hours. Training for behavioral health providers is needed across all standards with a focus on the non-life threatening emergency within 6-hours standard. Dr. Paul inquired as to when the training will take place for providers that were non-compliant. Ms. Switzer indicated letters were sent to providers with corrective action plans. Will re-survey these providers throughout the first part of November. Provider relations team will conduct outreach efforts and provide training the last two weeks of November to the providers identified as non-compliant. If still non-compliant after training, will continue to educate and work with providers. **Conclusion – CAHPS (Member Satisfaction Survey):** SCFHP is pleased to acknowledge 4 out of 6 measures show a marked improvement from 2017. The overall rating on satisfaction with the Health Plan improved by 4.8 percentage points, which may be attributed to the Plans on-going efforts to improve operational procedures and member/provider communications. SCFHP's Provider Network Management, Quality Management, Provider Relations and Contracting departments will continue to develop and improve initiatives to address timely access issues with PCPs, specialists and behavioral health providers. SCFHP has developed a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. SCFHP has taken a more active			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	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. **Conclusion - Provider Satisfaction:** SCFHP met both stated standards and thresholds for provider satisfaction for 2018. The threshold standard for overall satisfaction is a new measure; therefore, 2018 results will be used as a benchmark for 2019. While the Plan is pleased that both threshold goals were met, the prior authorization and referral process results indicated a 9% decrease on satisfaction from 2017; thus there is room for improvement. As a result of the new questions added to the survey in MY 2018, the Plan will further assess the results that show a high level of dissatisfaction and determine steps to address and improve in those areas. SCFHP will work with staff members from Utilization Management, Contracting, Provider Relations, Customer Service and Claims to find ways to improve service to our providers. In addition, SCFHP will look at ways to increase awareness of timely appointment access standards. Dr. Paul asked which question is new on the survey. Ms. Switzer indicated it was the question regarding patient access to covered services. **Conclusion - Member Access Grievances:** The raw data on member complaints demonstrate that SCFHP is able to resolve complaints made by members expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. SCFHP continues to re-direct members to network and/or out-of-network specialists to ensure timely access to care is met.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Opportunities: Identified some barriers and documented some opportunities and interventions. Focus on provider training and explore contracting opportunities to fill in any gaps.			
C. Continuity and Coordination Between Medical and Behavioral Healthcare	Ms. Franke presented the Continuity and Coordination Between Medical and Behavioral Healthcare. Santa Clara Family Health Plan collects data on the following factors: • Exchange of Information-Medical Record Review of Behavioral Health and Primary Care Practitioners. Goal of 80% of total number of samples meet the timeliness standards. Goal was not met in this area. Sample size of 58 records, 15 met timeliness. Dr. Paul inquired about how this analysis is done. Ms. Franke indicated this was done by chart reviews. • Diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care (AMM HEDIS measure). Goal to maintain a rate in the HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures. While achieving goal for the continuation phase, plan was 5.88 percentage points behind the 75th percentile for the acute phase. Results are based on HEDIS data and claims data. • Appropriate Use of Pyschotropic Medications-Primary Care Practitioners and Antidepressant Medication Prescriptions. Goal to have 75% of antidepressant medication prescriptions be provided by Primary Care Practitioners and 25% of antidepressant medication	Approved as presented		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	prescriptions be provided by Psychiatrists. Analysis shows Primary Care Practitioners are prescribing 54.4% of the total antidepressants and Psychiatrists are prescribing 45.6%. For calendar year 2018, goal will be Primary Care Physicians prescribing at 59.4% and psychiatrists at 40.6%. Dr. Lin asked what kind of incentives Primary Care Physicians have to see psychiatric patients. Dr. Paul suggested that training would be helpful in this area to Primary Care Physicians. Dr. Paul asked what is the plan's strategy in this area, incentives or training? Dr. Franke indicated training will be one of the items the plan will move forward with. Dr. Paul suggested if primary care physicians had access to a psychiatrist to consult with for guidance, this would be helpful. Dr. Liu suggested looking at number of unique members for data rather than total number of prescriptions. Dr. Alkoraishi suggested using F codes ICD-10. Has levels as far as severity. Dr. Lin asked how this compares to other plans. Ms. Franke indicated there are no measures for comparison with other plans. • 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. Goal of 75% of CMC members identified with diagnoses of Schizophrenia and Diabetes Mellitus Type II to have attended at least one annual Primary Care Visit for ongoing physical health monitoring. Identified 135 members for this data set. Did not meet CY 2017 goal by 15.8 percentage points. Focus will be on educating members on importance of seeing primary care physician once a year. One of the barriers is			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	homelessness in terms of reaching out for appointments. Dr. Alkoraishi mentioned Alexian Brothers has a homeless medical clinic that includes behavioral health services. Suggested possibly can use as a resource to get medical and behavioral health care for homeless CMC members. • Secondary Preventative Behavioral Healthcare Program Implementation. Goal of 80-100% of CMC members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment. 3,127 Cal MediConnect members identified, only 127 completed the PHQ-9 assessment. 42% of Cal MediConnect members identified showed signs of depressive symptoms. Goal was not met. Only 5.47% had a PHQ-9 assessment. Create automated trigger in Essette on when to do 6 month follow up. • Special Needs of Members with severe and persistent mental illness-HEDIS measure of Cardiovascular Monitoring for people with Cardiovascular Disease and Schizophrenia. Goal to fall within the 75th percentile of members following treatment care with their providers. Goal was met as 100% of members completed follow up care as indicated by their PCP. Despite meeting goal, this measure will not be an ongoing factor the Health Plan will continue to monitor due to its low impact on the CMC member population.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
D. Annual Assessment of Experience with UM Process	Ms. Enke presented the Annual Assessment of Experience with UM Process. Presented the barriers and opportunities as result of provider satisfaction survey. Barrier #1: Providers and office staff are not familiar with SCFHP UM processes (turnaround times, appeal process, authorization grid). Opportunity: Make information regarding SCFHP UM processes more available and accessible to providers and office staff. Intervention: Add information regarding key UM processes to SCFHP's provider portal. Engage providers through additional education efforts. When providing verbal notification for authorization determinations, include the required time frame in the verbal message. Evaluate location of information on scfhp.com to make it more easily located by providers. Barrier#2: Office staff are completing the surveys over actual providers, who may be more familiar with SCFHP's UM processes. Opportunity: Develop alternative survey methods to reach more Providers vs. Office Staff. Intervention: Use a larger provider sample size in future provider satisfaction surveys. In addition to phone survey, publish future survey links to the provider portal and provider e-newsletters. Interventions will be initiated in 2018. Also presented barriers and opportunities as result of member satisfaction survey. Barrier #1: Members do not understand SCFHP's transportation benefits. Opportunity: Educate members on how to obtain transportation assistance for appointments. Intervention: Member transportation needs are assessed within the required Health Risk Assessment. Identified needs will be addressed by Case Management staff during the member's individual care planning process.	Approved as presented		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Barrier #2: PCP and Specialist access issues. Opportunity: SCFHP will evaluate and monitor all access and availability complaints. Intervention: Members will be educated through periodic newsletters to call SCFHP to inform of any provider access issues. Barrier#3: Members may not understand when an urgent appointment is needed. Opportunity: Educate members on the difference between urgent and routine appointments and when both are needed. Intervention: Train case management staff to educate members on SCFHP's Nurse Advice Line (NAL) when members report lack of access to appointments. Barrier #4: SCFHP's approval and denial letter language is not sufficiently member friendly. Opportunity: Improve denial and approval language. Intervention: Update denial language template grid to be more member-friendly. Conduct staff trainings on the importance of and guidelines for using member friendly language in all member correspondence.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
E. Assessment of Physician Directory Adequacy	Ms. Enke presented the Assessment of Physician Directory Adequacy. Five measures were monitored for aspects of physician directory accuracy: • Accuracy of office locations • Accuracy of phone numbers • Accuracy of hospital affiliations • Accuracy of accepting new patients • Awareness of physician office staff of physician's participation in the organization network Goal is 100% for all measures. Accuracy percentages were as follows: Accuracy of office locations 97% Accuracy of Phone Numbers 93% Accuracy of hospital affiliations 97% Accuracy of accepting new patients 98% Awareness of physician office staff of physician's participation in the organization network 79% (possibly a bit low due to confusion by office staff of question) Barriers and opportunities were identified. Barrier #1: Delays in receiving changes from providers through their delegates Opportunity: Provide additional avenues for submitting provider changes Intervention: Ensure that timeliness of provider changes is discussed at quarterly joint operation committees. Continue to build out electronic attestation solutions available via the provider portal. Barrier #2: Rapidly changing provider data due to frequent staff changes. Opportunity: Inform providers of importance of submitting timely information	Approved as presented		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Intervention: Ensure that timeliness of provider changes is part of provider orientation onboarding. Continue to build out electronic attestation solutions available via the provider portal.			
F. Member Experience Analysis	Deferred to next Quality Improvement Committee meeting in December.			
G. Assessing Member Understanding of Marketing Information Analysis	Ms. Enke presented the Assessing Member Understanding of Marketing Information Analysis. Call report was generated from an internal call reporting system for calls received between January 1, 2018 and April 5, 2018. The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to help focus the analysis. Next the analysis focused on the members that called within 90 days of their enrollment date with the CMC plan. Individual call records were grouped and assessed by issue type and their descriptions. Benefit Inquiry was the highest occurrence in individual call records at 55.47%. The calls were then ranked by prevalence. The top four most frequent descriptions were: • Pharmacy 12.17% • Case Management 6.47% • Specialist 5.55% • Dental 4.31% In summary, calls related to pharmacy, case management, and specialists were diverse and specific to each member. In many cases, the appropriate course of action for the member to take is to call the plan to resolve a specific issue. Volume of call records specific to issue type "Inquiry Benefit" and description "INQ Benefit Dental Services" identified opportunity to improve communication to new members about their dental benefits.	Approved as presented		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	New members were unaware that their dental benefits are provided through Denti-Cal. They were unsure how to find a provider. Content was subsequently developed for Summer 2018 Cal MediConnect member newsletter to communicate this information.			
Discussion Items				
A. Access and Availability	Ms. Switzer presented the Access and Availability report. Conducted a re-survey for those providers that were found to be non-compliant for measurement year 2017. The resurvey results are reviewed by the Provider Network Access Manager, who will list the providers who show continued non-compliance on a provider outreach matrix. The provider outreach matrix is submitted to the provider relations team who will make contact with the providers and offer training/education on timely access standards. As instructed, the provider relations team documents all outreach efforts and completed training sessions within the matrix. Resurvey results are also reviewed in the Joint Operation Committee meetings with our delegated provider groups, and they are advised that a corrective action plan must be submitted to the Plan, and that access training will be required. The findings showed some improvement in PCPs meeting the urgent appointment within 48 hours at 61% and a marked improvement in meeting the appointment within 10 days at 84%, with an average improvement of 73%. Findings on specialists providing access to urgent appointments within 96-hours and appointments within 15-days only showed an average improvement of 40%. The Provider Network Access Manager has submitted the provider outreach matrix to the Provider Relations team to ensure that notification of continued non-compliance, timely access training and education is completed and documented. A resurvey report (specific to the group) was presented at the Joint			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Operating Committee meetings for both Physicians Medical Group of San Jose and Premier Care of Northern California on September 13, 2018. To ensure SCFHP policies and procedures are met, both groups were advised to submit a CAP to SCHP by September 28, 2108. The CAP will be reviewed and the group (s) will be notified if SCFHP accepts the proposed CAP, or if additional information is required. Both groups were also advised that SCFHP's provider relations team will make contact to schedule access training. SCFHP maintains provider corrective action plans and access training sign-in sheets to document actions taken to improve patient access in accordance with regulatory requirements.			
B. Appeals and Grievances	Mr. Breakbill presented the Appeals and Grievances report. Reviewed regulatory reporting. Submitted the following regulatory reports in Q2: • CMC Complaints & Resolution • CBAS Report • DHCS BHT Report • DHCS Grievance Report • Mental Health Report • DMHC Grievance Report Bundle • Monthly NMT/NEMT reports Submitted the following JOC reports: • Premier Care of Northern California (PCNC) • Physicians Medical Group (PMG) • Valley Health Plan (VHP) Increase in Medi-Cal line of business cases attributed to issue with DME vendor. Increase in Medi-Cal appeals from Valley Health Plan from February to March. No real increase in Pharmacy appeals. Attributed to language change in initial			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	review notice. Providers are submitting all documentation needed with requests. Q2 2018 Medical Appeals by Determinations: 65% Upheld, 31% Overturned, 4% Dismissed Q2 2018 Pharmacy Appeals by Determinations: 36% Upheld, 52% Overturned, 12% Partially Favorable In November, an increase in CMC Appeals attributed to claims appeals. Increase in CMC Grievances was attributed to CHME appliance delivery issues. Increased education to members by CHME regarding deliveries. Q2 2018 Reconsiderations by Determination: 52% Overturned; 31% Upheld; 15% Dismissed; 2% Auto-Forward IRE Q2 2018 Redeterminations by Determination: 56% Upheld; 37% Overturned; 5% Withdrawn; 2% Dismissed Volume of CHME Grievances Rate per 1,000 increased for Medi-Cal and also CMC.			
C. Experience with Case Management	Ms. Cagle presented Experience with Case Management. The case management department evaluates member's experience with Complex Case Management (CCM) Services by obtaining feedback from members and analyzing member complaints for the purpose of identifying opportunities for improvement. 100% of members enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Specific feedback measured: Information about the overall program, the program staff, member's ability to adhere to the recommendations, percentage of members indicating that the program helped them achieve health goals and complaints. Members who were enrolled in CCMS for 60 days or more are provided telephonic outreach by coordination staff not directly involved in their care. Survey responses are collected on an			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	ongoing basis and reported monthly. Responses are analyzed and interpreted as part of Evaluating PHM Strategy Effectiveness on an annual basis. Feedback data is documented in and reported from the CM software platform Essette. Questions are scored on a 0-5. Highest score possible is 44. Overall goal is to have members respond "agree" or "strongly agree" for questions 1-8 and "satisfied" or "very satisfied" for question 9 for a total score of 35 or better or 90% overall satisfaction. Members are also encouraged to provide comments and feedback. Members do have the right to refuse to participate in all or parts of the survey. Overall 100% of members stated they were overall satisfied or somewhat satisfied resulting in meeting the 90% goal for this measure. 100% of members believe that their assigned case manager treated them with respect and listened to what they had to say. 100% of members felt their assigned case manager returned phone calls in a timely manner. 71% of members believe that their case manager helped them find the services they needed. 29% stated they were unsure. 71-72% of members responded that they better understand their disease or condition, are better able to manage their health and their situation is better because of their case manager's help. 14% were not sure, and another 14% disagreed. SCFHP did not meet the 90% performance goal in four areas: • Help in finding services needed (71%) • Increased understanding of the members' condition (71%) • Improved ability to manage own health (72%) • Improved overall health situation (72%) However, in areas 2-4, only one person answered that they "disagreed." In area 1, two people answered "not sure" which equated to 28% outlier status. Although the majority of people surveyed expressed satisfaction, the performance rates indicate			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	possible areas of improvement within the CCM program. Dr. Alkoraishi asked if this included those with heart problems, strokes. Also asked who is responding to the survey, members or authorized representatives of the members. Potential barriers identified: Of the 14 members enrolled for 60 days or more, 7 were reached and 7 were unable to be reached. Provide a paper survey to mail to members. Opened the floor to discussion about possible barriers identified. Ms. Franke indicated behavioral health members may have difficulty giving valid information if they are experiencing symptoms. Possibly have behavioral health department connect with case management to better capture survey results from behavioral health members. As population grows, possibly outsource survey to vendor.			
D. Continuity and Coordination of Medical Care	Ms. Enke presented the Continuity and Coordination of Medical Care report. Santa Clara Family Health Plan monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Reviewed four data measures associated with member movement between practitioners and member movement between settings. Movement across settings: • Ambulatory Care Follow-Up Visit 30 Days Post Discharge • HEDIS: Plan All-Cause Readmissions (PCR) Movement Across Practitioners: • PCP Experience Survey • HEDIS: Comprehensive Diabetes Care-Eye Exam Rate (CDC) Quarterly, SCFHP monitors CMC members that have been discharged from an acute inpatient hospital stay and			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	subsequently had an ambulatory care follow-up visit within 30 days of discharge. Required measure for Medicaid-Medicare Plans (MMPs) participating in the duals demonstration-CA 1.11 SCFHP's UM Management team determined the performance goal to be 90%. Rigorous goal considering member non-compliance, however will ensure that we are constantly reassessing our interventions for continued improvement. For 2017 ended with a rate of 78% on measure of 30 day follow-up post discharge. The 2017 cumulative rate of 78% shows that SCFHP is 12 percentage points away from meeting the goal of 90%. This gap indicates opportunities for improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay. Opened the floor for discussion with QIC providers regarding barriers to consider as to why our members cannot seek ambulatory follow up care within 30 days. One barrier identified is that physicians are not always notified of admissions. Dr. Lin indicated follow up is very important for medication reconciliation. Follow up within one week after discharge rather than waiting one month. Dr. Paul inquired as to when the health plan receives reports on admissions. Schedule appointment with primary care physician for follow up as part of discharge process. Possibly send home health out to see member. Do a trial with one hospital and have case managers do outbound calls to members discharged. HEDIS: Plan All-Cause Readmissions (PCR) SCFHP monitors all-cause acute readmission annually as part of HEDIS reporting and as part of the Quality Withhold data set. Included are members 18 years of age and older with an inpatient acute hospital stay within the measurement year, followed by an unplanned acute readmission for any diagnosis,			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	within 30 days of discharge. Performance goal is CMS 2018 Benchmark of 11%. Went from 13.49% in 2017 to 14.79%, which is above CMS Benchmark. Goal was not met. SCFHP missed the performance goal of 11% by 2.5 percentage points in 2017, and 3.8 percentage points in 2018. The slight decrease in 2017 indicates and opportunity to improve existing processes in place to prevent unplanned acute readmissions. Opened the floor to discussion with our QIC providers. Asked if any barriers to consider as to why our members may experience unplanned acute readmissions within 30 days of discharge from the hospital. Identified internally that SCFHP Transition of Care (TOC) program focused on Regional Hospital only. Opportunities for improvement identified: increased collaboration between SCFHP UM and CM departments to identify transitions of care. Expand scope of TOC calls. PCP Experience Survey: SCFHP conducts an annual PCP survey to assess experience with continuity and coordination of care between primary care and specialty care. Survey Sample of 59 PCPs selected from a universe of 428 claims from Q2 2018 where a PCP-assigned member visited a Specialist. Conducted telephonically in September 2018. Three call attempts made over a span of two weeks. PCPs were given the option to complete telephonically, via fax or online (using surveymonkey.com). Two areas where goal of 90% was not met: • Frequency of receiving information about patients from Specialty Care 53% • Effectiveness of information received about care patients received from Specialty Care 84% 100% of PCPs surveyed were generally satisfied with their patients' continuity and coordination of care and the process for			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	hand-off between specialty and primary care. 100% of PCPs reported that information from Specialty Care was generally useful, and 94% reported that the information was generally timely. Opened the floor for general discussion with QIC providers. Potential know barriers included lack of HER integration between providers and referring providers not always specific in identifying the reason for specialty referrals. CDC Eye Exam Rate: SCFHP monitors the CDC Eye Exam HEDIS rate to assess the movement of diabetic patients between practitioners. Measures the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. Time frame is from 1/1/2017 to 12/31/2017 and reported for year 2018. The performance goal set by Quality Improvement is to meet or exceed the previous year rate. In Measurement Year 1 (MY) 2016, a performance goal of 47.41% was set and in MY2 2017, the target goal was to maintain or exceed the rate of 62.53% achieved from MY1 2016. Performance goal was met for both measurement years.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Committee Reports				
A. Credentialing Committee	Dr. Boris presented the August 15th Credentialing Committee meeting minutes. No providers were terminated, all passed credentialing. .	Minutes of the August 15th, 2018 Credentialing Committee meeting were approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the June 21st Pharmaceutical and Therapeutics Committee meeting minutes. New drugs were presented during generic pipeline presentation. Reviewed formulary changes. Prior authorization criteria presented for approval on Diabetic Supplies, Androgel, Humira, and Enbrel.	Minutes of the June 21st, 2018 Pharmaceutical and Therapeutics Committee meeting were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the July 18th, 2018 Utilization Management Committee minutes. Updated care coordinator guidelines for wheelchair replacement. Care Coordinator can approve if wheelchair is 3 years old or less. Presented procedure for documentation requirements when no clinical notes are attached to an authorization request. Reviewed Nurse Advice Line Stats. Highest volume for Triage Guidelines used for call types were: • Medi-Cal information only, abdominal pain, chest pain, allergic reactions • Healthy Kids-information only, bites and stings • Cal MediConnect-information only, abdominal pain	Minutes of the July 18th, 2018 Utilization Management Committee meeting were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
D. Compliance Report	Ms. Larmer presented the Compliance Report. Medicare Data Validation audit took place. Field audit took place. Working on corrective action plans. Preliminary report issued. Total of seven conditions requiring immediate corrective action plans. Working on systems and staffing. Moving towards integration of business units. Working on NCQA submissions.			
E. Quality Dashboard	Dr. Liu presented the Quality Dashboard. FSR is for Medi-Cal and IHA is Medi-Cal. IHA is stable and FSR continues to be 100%. Re-evaluating metrics in all departments.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Ria Paul at 8:44 p.m.			
Next Meeting	Wednesday, December 5, 2018- 6:30 PM	Calendar and attend.	All	

Reviewed and approved by:

Ria Paul Date 12/5/18

Ria Paul, MD
Quality Improvement Committee Chairperson

SCFHP Personalized Information on Health Plan Services:

2018 E-mail Response Evaluation

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee (QIC) on October 10, 2018

I. Overview

Providing accurate and timely personalized information of member health plan services is central to the promotion of member engagement and self-management. SCFHP has a responsibility to provide accurate, quality information on health plan services to members through the website, over the telephone, and through e-mail.

In an effort to make this information readily available, SCFHP ensures that members can contact the organization through e-mail for any reason and receive responses within one-business day.

Personal information on health plan services may change periodically throughout the year; therefore, SCFHP has an obligation to be sure the information submitted via e-mail to members is accurate, current and timely. This is accomplished by measuring and evaluating the quality and accuracy of the information. SCFHP audits e-mail response annually to identify any opportunities to improve interactions with the members.

II. Methodology: E-mail

The Call Center collects all member e-mails through Microsoft Outlook and documents the contact in the QNXT Call Tracking system. Data included in this analysis was captured from July 1, 2017 through June 30, 2018.

A dedicated staff in Customer Service checks the e-mail inbox intermittently throughout each business day. The staff will respond to the member's inquiry with a thorough answer to the member's question within one-business day.

Once a complete reply is sent to the member, the request is documented in the QNXT call tracking system using appropriate contact codes. The call note includes the question and inquiry received from the member and the response provided.

SCFHP audits the information on e-mail turnaround time and the quality of the email response on a quarterly basis to be able to identify opportunities to improve based on data collected and analyzed. This data is then rolled up into an annual rate for comparison year over year.

Measure 1: Email Turnaround-Time

- **Numerator:** Number of emails received from Q3-2017 through Q2-2018 that were responded to within one business day
- **Denominator:** Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails are collected, reviewed and responded to within one-business day.

Measure 2: Response Comprehensiveness

- **Numerator:** Number of emails received from Q3-2017 through Q2-2018 where the response adequately addressed the member request
- **Denominator:** Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails comprehensively address the member's request

Measure 3: Spelling Errors

- **Numerator**: Number of emails received from Q3-2017 through Q2-2018 where zero spelling errors were identified
- **Denominator**: Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of emails were responded to with zero spelling errors

Measure 4: Member Services Contact Information Provided

- **Numerator**: Number of emails received from Q3-2017 through Q2-2018 where the Member Services contact information was provided
- **Denominator**: Number of emails received from Q3-2017 through Q2-2018
- **Goal**: 100% of email responses contained Member Services contact information

III. Analysis

a. Results

Table 1: Timeliness and Quality of E-mail Responses

Measure	Goal	Q3-2017.	Q4-2017	Q1-2018	Q2-2018	Goal Met Y/N
M1: Responses sent to Member within one-business day	100%	NA	NA	NA	100%	Y
Information is legible, complete and allows the member to understand:						
M2: The response comprehensively addresses the member request	100%	NA	NA	NA	100%	y
Other items that may also reflect the quality of the e-mail response:						
M3: No spelling errors identified	100%	NA	NA	NA	100%	y
M4: Member Services contact information provided	100%	NA	NA	NA	100%	y

b. Quantitative Analysis

No emails were received in Q3-Q4 2017 or Q1 of 2018. There was one e-mail contact for Q2 2018 and the response met turnaround time quality and accuracy standards. Overall, the volume of e-mail inquiries for the Cal MediConnect line of business is low. This is most likely due to several factors that affect the specific population we serve. These factors can prevent members from accessing electronic devices required to submit emails. Factors include: language barriers, multiple chronic medical conditions, education levels, and economic background.

c. Qualitative Analysis

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
NA	NA		NA	

IV. Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan
Accessibility of Services
MY2018

Medicare - Cal-MediConnect

Prepared by: Carmen Switzer, Provider Network Access Manager
For review and approval by the Quality Improvement Committee
October 10, 2018

INTRODUCTION

The purpose of the Santa Clara Family Health Plan's (SCFHP) annual timely access report is to demonstrate how the Plan has monitored compliance and non-compliance of timely access regulations during Measurement Year (MY) 2018. SCFHP's Timely Access & Availability Work Group and Quality Improvement Committee monitor timely access and reporting activities to ensure members receive timely access to services and care. SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser survey results.

When access is identified as not being met, per SCFHP, the Centers of Medicare and Medicaid Services (CMS) and/or other regulatory agencies, an analysis of findings and corrective action plan are required. The Provider Network Management Department regularly monitors and reports access activities to the Timely Access & Availability (TAA) Work Group and Quality Improvement Committee (QIC). The TAA work group and QIC review, evaluate, and make recommendations as needed.

Description of Line of Business: Cal MediConnect is a dual eligible plan for members who qualify for both Medicare and Medi-Cal. Cal MediConnect members have access to case managers to help with transition of care, coordination of health services, community resources and other support.

Annually the health plan conducts surveys to determine the ability of network providers to provide appointments to members according to SCFHP, federal, state and/or other agency standards. SCFHP monitors and reports on timely access to appointments on primary care, specialists, behavioral health and ancillary services on an annual basis.

Primary Care Providers are defined as physicians, nurse practitioners, certified nurse midwifes, and physician assistants licensed in the areas of General Practice, Family Medicine, Internal Medicine and Geriatrics.

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 gynecology, cardiology and ophthalmology.

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 (BH) providers are defined as Behavioral Health providers 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 as prescribing - Psychiatry and non-prescribing-Psychology, Licensed Clinical Social Workers and Marriage/Family Counselors. High volume behavioral health providers are identified by analyzing claims and encounter data for a 12-month period.

Data collection includes assessment of access to appointments through member and/or provider surveys and an analysis of member complaints and appeals. Member complaints and appeals are tracked and trended in our QNXT and Grievance and Appeals database. Appointment access complaints and appeals are categorized as access complaints or appeals. Member complaints from January to June of 2018 are assessed in this report relative to appointment access.

Santa Clara Family Health Plan contracted with an external survey vendor, Center for the Study of Services (CSS), to administer access surveys for MY2018. This report provides an overview and analysis of SCFHP's provider timely access results. The Plan's goals, objectives, methodologies and results are included in each report section within this report.

The following surveys and assessments are included in this report:

1. Provider Appointment Availability Survey and After-Hours Survey
2. CAHPS
3. Provider Satisfaction Survey
4. Member Grievances

1. PROVIDER APPOINTMENT AND AVAILABILITY SURVEY AND AFTER-HOURS SURVEY

GOALS

To ensure that SCFHP meets the provider appointment access standards established by DMHC and other regulatory agencies and to meet the needs of its members.

OBJECTIVES

- Measure primary care, specialist and behavioral health provider's timely appointment access, at least annually.
- Measure primary care after-hours access at least annually.
- Evaluate SCFHP's timely access performance in comparison to goals.
- Identify areas to improve timely appointment access.
- Develop interventions as appropriate to address deficiencies and/or gaps in care.

METHODOLOGY- PROVIDER APPOINTMENT AND AVAILABILITY SURVEY (All Providers)

SCFHP provided Cal-MediConnect provider rosters to CSS for the following provider types: primary care, high volume, high impact specialty and behavioral health providers. These files followed the DMHC MY2018 PAAS Provider Contact List Templates. CSS reviewed the contact lists for missing and duplicate provider records (according to DMHC MY 2018 PAAS de-duplication rules) before considering the contact lists final. CSS worked with SCFHP to modify the DMHC's survey tools to incorporate new measure questions pertaining to language assistance services and finalized the survey questionnaire tool.

CSS surveyed all providers in the final sample. Sixty percent (60%) of providers were surveyed in the first wave from June 14 - June 29, 2018, with the remaining providers surveyed three weeks later from July 19 – August 3, 2018. The survey was 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 provided a unique login code) with a telephone follow-up. Three call attempts were 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 was limited to 48 hours from the time of the message.

All data received was checked for accuracy and completeness by at least two CSS staff working on the project. The data was then systematically cleaned and transformed for reporting. At least two CSS staff checked that data was de-duplicated, that it reflected calculating compliance, and that it was standardized and formatted correctly. CSS then used raw data and results templates to deliver survey results to SCFHP.

METHODOLOGY - AFTER-HOURS (PCP Only)

The after-hours survey was administrated by CSS survey vendor. The survey was conducted between June 25 – June 29, 2018 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 (N=469), and behavioral health (N=153) providers. SCFHP provided CSS a provider contact list, which they were responsible for de-duplicating to ensure each provider was surveyed once.

Providers who shared the same phone numbers were combined into groups of up to five (5) providers for a unique survey administration and the survey results were then attributed to all the providers. If twenty (20) providers share the same phone number, then these providers would be grouped into four (4) separate sample units for one dialing.

If a live person (provider or answering service) was reached, the respondent was asked the same questions from the survey questionnaire tool, and if the call went directly to an automated recording, the interviewer collected the response based on the message. If the automated recording provided an option to connect to a live person (by pressing a button or staying on the line), the interviewer selected that option and also recorded the answers the person gave. The interviewer did not leave a voice message during any of the telephone attempts.

The Plan requires providers to direct patients with a life-threatening emergency to hang up and dial 911 and compliance for this measure is determined through questions Q2 and Q5. The Plan determines if the provider meets the Timeliness measure (provider call back within 30-minutes) through questions Q3 and Q4 or Q6, Q7, Q9 and Q10 (are blank) or Q9 and Q10. The survey tool in Appendix A includes the survey questions related to after-hours.

The following measures table includes the provider types that were included in the survey and the standards for each provider type.

MEASURES TABLE

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care	After-Hours Care
Family Practice	48 hours	10-days	NA	NA	24-hours / 7-days a week
General Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Internal Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Geriatrics	48 hours	10-days	NA	NA	24-hours / 7-days a week
Oncology (High Impact)	96 hours	15-days	NA	NA	NA
Gynecology (High Volume)	96 hours	15-days	NA	NA	NA
Cardiology (High Volume)	96 hours	15-days	NA	NA	NA
Ophthalmology (High Volume)	96 hours	15-days	NA	NA	NA
Behavioral Health - Prescribers	48 hours	10-days	6-hours	30-days	NA
Behavioral Health – Non-Prescribers	48 hours	10-days	6-hours	30-days	NA

RESULTS

Table I: Primary Care Provider

A. Standard: Urgent Care Appointment within 48-hours (PCP providers combined)

# of Providers Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
175	161	108	90%	No	67%	72%	-5%

B. Standard: Urgent Care Appointment within 48-hours (PCP provider break down)

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Family Medicine	77	70	48	90%	No	69%	NA	NA
General Practice	11	10	9	90%	Yes	90%	NA	NA
Geriatrics	1	1	1	90%	Yes	100%	NA	NA
Internal Medicine	86	80	50	90%	No	63%	NA	NA

Quantitative Analysis (Tables I - A and B)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for the PCP urgent care appointment measure. As shown in Table 1A, which includes all PCP provider types, the urgent appointment measure fell short of the goal by 23 percentage points at 67%, and there was a decrease of 5 percentage points from 2017. Table 1B, shows the PCP breakdown by provider type, which concludes that General Practice and Geriatric providers met the goal at 90% and 100% respectively. There are very few General Practice and Geriatric providers within the SCFHP network, which explains why the total surveyed was only 14. Family practice and internal medicine providers did not meet goal with an outcome of 69% and 63% respectively. SCFHP did not break down PCP provider types in 2017, thus there is no comparison data available.

C. Standard: Non-Urgent/Routine Appointment within 10-days (PCP providers combined)

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
175	172	156	90%	Yes	91%	91%	No Change

D. Standard: Non-Urgent/Routine Appointment within 10-days (PCP provider break down)

Provider Type	# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Family Medicine	77	77	70	90%	Yes	91%	NA	NA
General Practice	11	10	9	90%	Yes	90%	NA	NA
Geriatrics	1	1	0	90%	No	0%	NA	NA
Internal Medicine	86	84	77	90%	Yes	92%	NA	NA

Quantitative Analysis (Tables I - C and D)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for the PCP non-urgent/routine care appointment measure. As shown in Table 1C, PCP providers met goal at 91% and there was no change from 2017. Table 1D, shows the PCP breakdown by provider type, which concludes that all PCP types with the exception of Geriatrics met or exceeded the goal. As stated above, there are very few General Practice and Geriatric providers within the SCFHP network, which explains why the total surveyed was only 14. SCFHP did not break down PCP provider types in 2017, thus there is no comparison data available.

E. After-Hours – Access Compliance: 911 Information

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Primary Care Provider (PCP)	401	401	90%	Yes	100%	88%	+12%

F. After-Hours – Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Primary Care Provider (PCP)	401	176	90%	No	44%	74%	-30%

Quantitative Analysis (Tables I - E and F)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for after-hours measures. The after-hours survey measure on whether appropriate instructions relative to life-threatening emergency situations were provided to members calling after-hours was met at 100%, and improved by 12 percentage points from 2017. However, the timeliness standard to return the members call within 30-minutes or less, was not met with an outcome of 44% and there was a decrease from 2017 by 30 percentage points.

Qualitative Analysis (Tables I - A thru F)**:** For MY2018, the Plan used a new methodology for sampling and a vendor was used to conduct the survey. The number of PCP's who were surveyed provide a statistically valid sample size from which conclusions could be drawn. The raw data report showed that Palo Alto Medical Foundation failed to meet the urgent appointment standard by 21%, Physician Medical Group by 12% and directly contracted providers and Premier Care by less than 1% collectively. It appears that the stringent requirements regarding scheduling urgent appointments within a 48-hour timeframe and the after-hours standard to return a patient call within 30 minutes or less continue to be a challenge for providers.

The after-hours results for call backs within 30-minutes showed the following rate of compliance outcomes for each group of providers: Direct (N=21) at 19%, Palo Alto Medical Foundation (N=241) at 44%, Physicians Medical Group (N=112) at 45%, and Premier (N=27) at 52%. Provider education on timely appointment access and after-hours call backs within 30-minutes, should be a focus point for interventions this year.

Table II: High Impact and High Volume Specialist

A. Standard: Urgent Care Appointment within 96-hours

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	34	24	90%	No	71%	73%	-2%
Oncology (N=73)	16	9	90%	No	56%	New Measure	NA
Opthamology (N=95)	28	28	90%	Yes	100%	New Measure	NA
Gynecology (N=138)	21	17	90%	No	81%	New Measure	NA

B. Standard: Non-Urgent/Routine Appointment within 15-days

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	40	28	90%	No	70%	72%	-2%
Oncology (N=73)	16	8	90%	No	50%	New Measure	NA
Opthamology (N=95)	28	27	90%	Yes	96%	New Measure	NA
Gynecology (N=138)	21	19	90%	Yes	90%	New Measure	NA

Quantitative Analysis (Tables II - A and B)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for specialist urgent care and non-urgent/routine care appointment measures. The urgent appointment goal was met by ophthalmology and non-urgent/routine appointment goal was met by ophthalmology and gynecology. The other specialists fell short of the goal for urgent and non-urgent/routine care appointments. Compared to 2017, cardiology results decreased for urgent care and non-urgent/routine care by 2 percentage points. These metrics are new for gynecology, oncology and ophthalmology; thus, results will be used as a benchmark for 2019.

Qualitative Analysis (Tables II - A and B)**:** While attempts were made to increase the number of respondents within each of the specialty areas, the actual results were such that it is difficult to draw any conclusions as it relates to responsiveness on gaining appointments either on an urgent or non-urgent/routine basis. While the results showed that the targeted goal of 90% was not reached, you have to look at the actual number of respondents to judge the validity of the percentages. SCFHP experiences nearly no survey participation from Stanford Medical Group and 43% of network specialists are within this group. SCFHP has reached out to Stanford leadership to request participation, and the Plan reported low-participation by Stanford Medical Group to the Department of Health Care Services. The raw data showed that the majority of Cardiologists that did not meet the urgent or non-urgent/routine access standards were directly contracted providers (14), followed by Palo Alto Medical Foundation (4) and Physicians Medical Group (3). Oncologists that did not meet the urgent or non-urgent/routine access standards were directly contracted providers (1), followed by Palo Alto Medical Foundation (15). The gynecology providers that did not meet the urgent access standard were directly contracted providers (3).

SCFHP sends corrective action letters to providers who do not meet access standards and a resurvey is completed within 60 days from sending the corrective action letter. Resurveyed providers who show continued non-compliance are required to submit a corrective action plan and to complete timely appointment access training with SCFHP provider relations staff members. SCFHP's provider relations staff members will focus on provider outreach to train providers on timely appointment standards and document these efforts.

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Table III: Behavioral Health

A. Psychiatry (N=57)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	6	4	90%	No	67%	New Measure	NA
Urgent Care within 48-hours	4	1	90%	No	25%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	0	90%	No	0%	New Measure	NA
Follow-up Routine Care within 30-days	6	6	90%	Yes	100%	New Measure	NA

B. Psychology (N=1)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	1	1	90%	Yes	100%	New Measure	NA
Urgent Care within 48-hours	0	NA	90%	NA	NA	New Measure	NA
Non-Life Threatening Emergency within 6-hours	1	0	90%	No	0%	New Measure	NA
Follow-up Routine Care within 30-days	1	1	90%	Yes	100%	New Measure	NA

C. Non-Physician Mental Health (N=63)

Standard	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Initial Routine Visit within 10-days	7	3	90%	No	43%	New Measure	NA
Urgent Care within 48-hours	5	4	90%	No	80%	New Measure	NA
Non-Life Threatening Emergency within 6-hours	6	1	90%	No	17%	New Measure	NA
Follow-up Routine Care within 30-days	8	8	90%	Yes	100%	New Measure	NA

Quantitative Analysis (Tables III – A thru C)**:** SCFHP's Timely Access and Availability work group set a target goal of 90% for behavioral health measures. Only one measure across all provider types was met (follow-up routine care within 30-days). Psychology met all but one measure (non-life threatening emergency within 6-hours) and the raw data report showed that the psychologist did not answer the "urgent care within 48-hours survey question. The other measures across all behavioral health provider types fell short of the 90% goal. These are new measures; thus, there is no comparison data available, and MY2018 results will be used as a benchmark for 2019.

Qualitative Analysis (Tables III – A thru C)**:** SCFHP 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. Appointment access is always an important metric in monitoring our providers for quality of care and service. SCFHP will continue to expand its behavioral health network in order to provide better access to its members, as well as identify additional health systems that can join the Plan in 2018/2019.

Conclusion - Timely Appointment Access:
Survey results showed that PCPs are able to meet non-urgent/routine appointment standards; however, as noted they continue to show non-compliance with urgent care appointments. The Plan believes that PCPs are challenged with urgent appointment standards due to the stringent requirement to schedule appointments within a 48-hour timeframe, coupled with providers not having an adequate understanding of regulatory requirements. The PCP after-hours access compliance resulted in 100% in 2018, up from 88% in 2017, which is a marked improvement. However, it is clear that PCP providers will require training/education on meeting timeliness compliance, as only 44% were compliant out of 401 surveyed.

For High Volume/High Impact Specialists, only 1 specialist type (Ophthalmology) out of 4 met the urgent appointment standard and 2 met the non-urgent/routine appointment standards, which concludes that provider training on access standards is necessary.

The least amount of survey participants were from behavioral health providers; thus, it may be difficult to identify trends; however, the results did indicate that all respondents were not able to meet the non-life threatening emergency within 6-hours. Training for behavioral health providers is needed across all standards with a focus on the non-life threatening emergency within 6-hours standard.

2. MEMBER EXPERIENCE SURVEY (CAHPS)

METHODOLOGY

Questionnaire: SCFHP uses a vendor to annually administer the CAHPS survey. The survey results are then officially published by CMS. At the time of this analysis, the final CMS CAHPS report was unavailable. Additionally, many of the questions of interest have historically been "NA" on the final CMS report. Therefore, for purposes of this report SCFHP has used DSS' unofficial CAHPS report for SCFHP, which provides the plan's rates in comparison to DSS' entire book of business.

The survey instrument is a booklet with a cover letter explaining the importance of completing the survey. This was mailed, along with a business reply envelope addressed to DSS, to the sample beneficiaries using first class postage. A copy of the survey is provided in Appendix F.

Data Collection: A Synopsis of the methodology is outlined below:

Survey protocol	Date
Pre-notification letter	3/6/2018
First questionnaire mailed	3/13/2018
Second questionnaire mailed	4/4/2018
Initiate follow-up calls to non-responders	4/20/2018
Last day to accept completed surveys	6/1/2018
Data submission to CMS	6/20/2018

Item	Volume
Total mailed	1,600
Ineligibles	133
Total completed surveys	431
Mail completes	351
Phone completes	80
Adjusted response rate	29.38%

Staffing of the toll-free help line. DSS staffed a toll-free phone line for beneficiaries to call if they had any questions.

Sample design.

•**Qualified respondents.** Beneficiaries eligible for the survey were those 18 years and older (at the time of the sample draw) who were enrolled in the Cal-MediConnect plan and had been continuously enrolled for six months or longer.

•**Sample type.** A simple random sample of eligible beneficiaries was drawn.

•**Sample size/sampling error.** A sample of 431 beneficiaries was obtained, for which the overall sampling error is +/-4.7% at the 95% confidence level, using the most pessimistic assumption regarding variance (p=0.5).

Data processing and analysis. DSS processed all completed surveys and analyzed the results. The results in this report have not been case-mix adjusted.

Comparison averages. Most measures are compared to the 2017 National Average from CMS (2017) Nat'l Avg.), and the DSS Book of Business is made up of 182 MA plans with a total of 93,685 beneficiaries.

Spanish surveys. Respondents were given the option of completing the survey in Spanish. English and Spanish materials were mailed to 210 members who were identified by the plan as Spanish-speaking. A telephone number was also provided on the survey cover letter for all members to call to complete the survey in Spanish. There were 67 surveys completed in Spanish.2018 final results were not received as of the date of this report. The tables below show 2017 results relevant to member satisfaction in Timely Access and Rating of Health Plan measures through the 2017 CAHPS survey.

RESULTS

Composite Rating & Questions	# Surveyed	Total N (those who responded)	Goal	Goal Met	Always and Usually (2018)	Always and Usually (2017)	Change
Rating of Health Plan	391	344	90%	No	87.98%	83.18%	+4.8%
Ease of getting tests or treatments (Q10)	394	311	90%	No	78.93%	81.74%	-2.81%
Received appointment to see a **specialist** as soon as needed (Q29)	224	161	90%	No	71.88%	63.93%	+7.95%
Got **urgent** care as soon as needed (Q4)	159	118	90%	No	74.21%	75.29%	-1.08%
Got check-up or **routine** appointment as soon as needed (Q6)	313	244	90%	No	77.96%	73.48%	+4.48%
Getting seen within 15min of your appointment (Q8)	320	194	90%	No	60.63%	48.26%	+12.37%

Quantitative analysis: 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 2017 and 2018. As shown in the table above, the goal was not met for any measures; however, member satisfaction improved in 4 out of 6 measures, which is a marked improvement from 2017. The measure most improved was "getting seen within 15min of your appointment" (Q8) with an increase of 12.37 percentage points. The measure for "got urgent care as soon as needed" (Q4), showed a decrease in satisfaction by 1.08 percentage points, and it appears that this result is trending across survey outcomes.

Qualitative analysis: SCFHP has identified that member/enrollee overall low satisfaction on the timely urgent care measures are due to the following factors:
- 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 due to clinic scheduling staff not fully understanding provider scheduling protocols. ***For example,*** *providers have contacted SCFHP following the receipt of a corrective action letter, and will explain that his or her scheduling protocols are aligned with timely access/appointment standards and that the staff misinformed the survey interviewer.*

- Stringent requirements regarding scheduling urgent appointments within a 48-hour time-frame continue to be a challenge for providers.

Conclusion - CAHPS:
SCFHP is pleased to acknowledge 4 out of 6 measures show a marked improvement from 2017. The overall rating on satisfaction with the Health Plan improved by 4.8 percentage points, which may be attributed to the

Plans on-going efforts to improve operational procedures and member/provider communications. SCFHP's Provider Network Management, Quality Management, Provider Relations and Contracting departments will continue to develop and improve initiatives to address timely access issues with PCPs, specialists and behavioral health providers. SCFHP has developed a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. 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.

3. PROVIDER SATISFACTION SURVEY

GOALS:
To ensure that SCFHP providers have a positive experience with health plan services.

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.

STANDARDS AND THRESHOLDS FOR PROVIDER SATISFACTION:

-Eighty percent (80%) of provider's will be satisfied
-Seventy percent (70%) of providers will be satisfied with authorization/referral process

METHODOLOGY

In MY2018, SCFHP utilized CSS as the survey vendor to administer the PSS. The survey was administered with a fax-only methodology to all of the PCPs (N= 401), Specialists (N=528), and Behavioral Health (N=123) providers. SCFHP provided CSS a provider contact list consisting of 1052 records and CSS identified a total of 495 unique fax numbers to administer the survey. Since the same fax numbers were shared among multiple providers in the same medical groups, one unique survey was faxed to each distinct fax number and the results were attributed to all providers sharing the same fax number. The surveys were distributed in four waves. The first wave began on June 27, 2018 and surveys were faxed to all available (495) fax numbers. Subsequent waves were limited to non-respondents from the previous wave and so on until the 4th wave was completed. Providers were instructed to complete the survey by rating how satisfied they are with various service areas of SCFHP. The returned surveys were captured using manual data entry. Each returned survey was identified by the original tracking identification number that was created by CSS.

Note: *In 2017, SCFHP did not break out provider types, such as PCPs, Specialists and BH. The 2018 survey was revised significantly; thus, there are very few 2017 comparisons available and the results will be used as a benchmark for 2019. Where noted, 2017 survey data reflects the combined responses of all providers not broken out by PCP, Specialist and BH. Please see Appendix B & C, which includes the provider satisfaction survey tools for 2018 and 2017. The analysis below will include notations that will reference the questions on the 2018 survey tool, i.e., Q4a, Q5a and etc.*

RESULTS

Table I: Overall Satisfaction

A. Overall Satisfaction with SCFHP Services

Provider Type	Goal	Goal Met	Very Satisfied/Satisfied (1 & 2)	Dissatisfied/Very Dissatisfied (3 & 4)	Not Applicable/No Experience (5)
PCPs (N=56)	80%	Yes	88%	11%	1%
Specialists (N=86)	80%	No	79%	15%	6%
Behavioral Health (N=15)	80%	Yes	92%	3%	5%
Total	**80%**	**Yes**	**86%**	**10%**	**4%**

Survey Question: 7a

Quantitative Analysis (Table I - A)**:** The combined satisfaction level across all three types of providers surveyed was 86%; thus, the goal was met. The satisfaction level across all surveyed providers came in at 6% above SCFHP's goal. The highest result was with behavioral health providers at 92% and the lowest with specialist providers at 79%. These are new measures; thus, there is no comparison data available, and MY2018 results will be used as a benchmark for 2019

B. Overall Satisfaction with Prior Authorization/Referral Process

Question	Goal	Goal Met	Very Satisfied/Satisfied (2018)	Very Satisfied/Satisfied (2017)	Change from 2017
Prior Authorization and Referral Process	70%	Yes	77%	86%	-9%

Survey Question: 1a-b

Quantitative Analysis (Table I – B)**:** The combined satisfaction level with the Prior Authorization/Referral Process across all providers surveyed was 77%; thus, the goal was met. However, provider satisfaction decreased by 9 percentage points from 2017. The 2018 raw data reports showed that PCP satisfaction with the prior authorization and referral process was at 82%, specialist providers at 78% and behavioral health providers at 70%.

C. Overall Satisfaction by Primary Care Providers (N=98)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1&2)	Very Dissatisfied/ Dissatisfied (3&4)	Not Applicable/ No Experience (5)	Very Satisfied/ Satisfied (1&2) 2017	Change from 2017
*Utilization Management	80%	Yes	82%	7%	11%	NA	NA
*Claims/Appeals	80%	No	75%	17%	8%	NA	NA
**Timely Access	80%	No	75%	9%	16%	78%	-3%
*Customer Service	80%	Yes	87%	13%	0%	NA	NA
*Provider Relations	80%	Yes	81%	18%	1%	NA	NA
*SCFHP Provider Network	80%	No	66%	30%	4%	NA	NA

*Denotes new measure
**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – C)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the goals were exceeded with an outcome of 88%, and 81%. In 2017, the very satisfied/satisfied result across the provider network on prior authorizations and referrals was at 86% respectively. PCP's very satisfied/satisfied results did not meet the goal with an outcome of 75% on timely appointment access questions (Q3a-f), and in 2017, the results across the provider network was at 78%. However, as stated in the methodology for this section, SCFHP did not breakdown provider types in previous years, and the Plan added a new measure in 2018 on timely access (Q3f). The PCPs very satisfied/satisfied rating of SCFHP's provider network (Q6a-c) was the lowest with an outcome of 66%. There is no other comparison data, as all other measures are new for MY2018.

Qualitative Analysis (Tables I – A, B, C): The raw data report showed that PCP satisfaction ratings on non-urgent behavioral health appointments (Q3e) and availability of behavioral health providers (Q6c) had the highest level of dissatisfaction at 33%; which is an average percentage based on questions Q3e and Q6c. As referenced in the availability of provider network analysis (presented in the QIC meeting on August 8, 2018), a study of mental health shortages in California by the Office of Statewide Health Planning and Development (OSHPD) indicated mental health shortages across many rural areas of the state. Additionally, according to data from the California Employment Development Department, demand for mental health and substance abuse social workers, and substance abuse and behavioral disorder counselors shortages has grown by 22.8 percent through 2017. As also noted in the availability of provider network analysis, there are known provider shortages and recruitment challenges with behavioral health providers in the North West and/or South East areas of Santa Clara County, which are within rural communities. SCFHP continues to monitor recruitment activities and contractual opportunities in this area, as well as other areas of the county as necessary to ensure CMC members have timely access to health care providers. The raw data reports also show that customer service staff relevant to knowledge about questions (Q4b) had the highest level of satisfaction at 91%, and no PCP's responded with an answer of not applicable/no experience. The same question (Q5b) was answered relevant to provider relations staff and the level of satisfaction was at 68%. One area that SCFHP can focus on is collecting additional data from providers concerning issues with behavioral health access; i.e., behavioral health provider types and services that are difficult to access. The Plan can also focus on providing additional training to customer service and provider relations staff members to ensure representatives have the knowledge and tools available to assist with provider questions.

D. Overall Satisfaction by Specialist Providers (N=105)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1&2)	Dissatisfied/Very Dissatisfied (3&4)	Not Applicable/ No Experience (5)	Very Satisfied/ Satisfied (1&2) 2017	Change from 2017
*Utilization Management	80%	No	75%	11%	14%	NA	NA
*Claims/Appeals	80%	No	60%	12%	28%	NA	NA
**Timely Access	80%	No	60%	3%	37%	78%	-3%
*Customer Service	80%	No	78%	14%	8%	NA	NA
*Provider Relations	80%	No	79%	12%	9%	NA	NA
*SCFHP Provider Network	80%	No	66%	14%	20%	NA	NA

*Denotes new measure
**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – D)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the first goal was not met by 1 percentage point with an outcome of 79%, and the second goal was exceeded by 8 percentage points with an outcome of 78%. In 2017, the very satisfied/satisfied result across the provider network on prior authorizations and referrals was at 86% respectively. Results on appointment access questions (Q3a-f) showed that the goal was not met with an outcome of 60% and in 2017, the results across the provider network was at 78%. However, as stated in the methodology for this section, SCFHP did not breakdown provider types in previous years, and the Plan added a new measure in 2018 on timely access (Q3f). Thirty seven percent (37%) of specialists answered not applicable/no experience with appointment access and only 3% were very dissatisfied/dissatisfied; thus, if more specialists had experience with timely access, results may have shown a higher rating on very satisfied/satisfied. Results on claims/appeals questions (Q2a-c) did not meet the goal with an outcome of 60%. However, 28% answered not applicable/no experience, therefore it appears that the persons completing the survey were unable to give an adequate rating on this measure. There is no other comparison data, as all other measures are new for MY2018.

Qualitative Analysis (Table I – D): All areas measured did not meet the goal of 80%. However, customer service and provider relations missed the goal by only 1 or 2 percentage points. The raw data report shows that 12% of specialists were very dissatisfied/dissatisfied with claims/appeals (Q2a-c), and although 28% answered not applicable/no experience, the Plan did have a claims system conversion in 2017 that may have contributed to a lower percentage of satisfaction. Following the Plan's system conversion, it has worked diligently to improve claims processing and is confident that claims survey results in measurement year 2019 will reflect those efforts.

The raw data reports show that the ratings relevant to SCFHP's provider network is with availability of behavioral health providers (Q6c), and appointment access is with availability of behavioral health providers (Q3e), with an average dissatisfaction rating of 11%. As indicated above in the PCP qualitative analysis, this result is likely due to behavioral health provider shortages. As stated above, SCFHP will continue to assist its members to receive timely behavioral health care as needed.

The raw data report also showed that provider relations relevant to friendliness and helpfulness had the highest level of satisfaction at 85%. Customer service and provider relations "ability to resolve concerns/issues" had the highest level of dissatisfaction at 21%. SCFHP has courteous and friendly customer service and provider relations team members and continuously strive to improve service to our providers. One area that SCFHP can focus on is working to improve training and documentation utilized by the provider relations staff to enhance our provider training programs.

E. Overall Satisfaction by Behavioral Health Providers (N=28)

Question	Goal	Goal Met	Very Satisfied/Satisfied (1 & 2)	Very Dissatisfied/ Dissatisfied (3 & 4)	Not Applicable /No Experience (5)	Very Satisfied/ Satisfied (1 & 2) 2017	Change from 2017
*Utilization Management	80%	No	66%	2%	32%	NA	NA
*Claims/Appeals	80%	No	69%	4%	27%	NA	NA
**Timely Access	80%	No	30%	0%	70%	78%	-3%
*Customer Service	80%	No	73%	2%	25%	NA	NA
*Provider Relations	80%	Yes	94%	3%	4%	NA	NA
*SCFHP Provider Network	80%	Yes	81%	0%	19%	NA	NA

*Denotes new measure

**Denotes that the very satisfied/satisfied rating for 2017 includes all provider types across the network and excludes Q3f (this question is a new measure for 2018).

Quantitative Analysis (Table I – E)**:** Of the two threshold goals of overall provider satisfaction of 80% and satisfaction on the prior authorization and referral process at 70%, the first goal was met with an outcome of 92%, and the second goal was met with an outcome of 70%. In 2017, the only question under the "UM" section was relevant to satisfaction with prior authorizations and referrals, and as noted above, the Plan did not breakdown provider types in previous surveys; thus the very satisfied/satisfied result across the provider network on prior authorizations and referrals in 2017 was at 86% respectively. The behavioral health providers answered not applicable/no experience more often than PCPs and specialists with an average outcome of 30%. The very satisfied/satisfied rating on timely access (Q3a-f) was the lowest with an outcome of 30%; however, very dissatisfied/dissatisfied was at 0% and the not applicable/no experience had an outcome of 70%; thus, if more BH providers had experience with timely access, results may have shown a higher rating on very satisfied/satisfied. The outcomes on utilization management (Q1a-d) and claims/appeals (Q2a-c) were also rated below the goal by behavioral health providers; however, the very dissatisfied/dissatisfied average rating was 3% and the not applicable/no experience average rating was 30%, which indicated that with additional responses, it could swing the percentage of satisfaction upward or downward.

Qualitative Analysis (Table I – E): Compared to PCP's and specialists, the behavioral health providers had a much lower number of participation in the survey, likely due to circumstances where several BH providers manage their own schedules between patients, coupled with non-standard office hours. Although the behavioral health providers rated the lowest in satisfaction with timely access to appointments (Q3a-f), 70% answered not applicable/no experience. It should also be noted that with a relatively small number of respondents (28), the responses of additional BH providers could swing the percentages by ~20% one way or the other.

Conclusion - Provider Satisfaction:
SCFHP met both stated standards and thresholds for provider satisfaction for 2018. The threshold standard for overall satisfaction is a new measure; therefore, 2018 results will be used as a benchmark for 2019. While the Plan is pleased that both threshold goals were met, the prior authorization and referral process results indicated a 9% decrease on satisfaction from 2017; thus there is room for improvement. As a result of the new questions added to the survey in MY 2018, the Plan will further assess the results that show a high level of dissatisfaction and determine steps to address and improve in those areas. SCFHP will work with staff members from

Utilization Management, Contracting, Provider Relations, Customer Service and Claims to find ways to improve service to our providers. In addition, SCFHP will look at ways to increase awareness of timely appointment access standards.

4. MEMBER ACCESS GREVIENCES

Table A: Member Complaints (January - June 2018)

Provider Type	Case Description	# of Complaints
Primary Care	Untimely Non-Urgent/Routine Appointment	3
Primary Care	In-office Wait Times/Other	5
Physical Therapist (PT)	Untimely Non-Urgent/Routine Appointment	2
Urologist	Untimely Non-Urgent/Routine Appointment	1

Quantitative Analysis (Table A): There were a total of eleven (11) member complaints regarding access in Q1 and Q2 of 2018. Review of member complaints showed that there were none reported relevant to Geriatrics, Addiction Medicine, Clinical Social Workers (HVP) or any other high volume/impact providers. A total of three (3) members reported timely appointment access issues with specialists; Urologist (1) and PT (2).

The member seeking an appointment with a Urologist resides in the city of Sunnyvale, where there are no Urology providers. The distance to the closest Urologist from Sunnyvale is 5.8 miles or 4.53 minutes in the city of Mountain View, where there are a total of eight (8) Urologists, and the farthest from the distance standard is 14.5 miles or 12.8 minutes in the city of San Jose, where there are a total of ten (10) Urologists. SCFHP has thirty five (35) contracted Urologists, of which thirty four (34) are open to new patients. The provider to member ratio is met a 1:214.

The members seeking an appointment with a Physical Therapist (PT) reside in San Jose, where there are six (6) PT providers, all of which are open to new patients. Follow up with the PT providers confirmed an approximate wait of sixty (60) days for a new patient appointment. The provider to member ratio is met a 1:682. The data show that standards for geographic time and distance was met for Physical Therapy.

The other PCP complaints were relevant to timely appointments, in-office wait times and the desire to be assigned to a primary care provider closed to new patients.

Qualitative Analysis: SCFHP has identified that some of the member PCP complaints were related to lack of extended office hours, hours of operation not suiting the patient and members desired PCP is not in network. As shown in the member complaints record, complaints are resolved expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. As referenced in the availability of provider network analysis, a study in California by the Office of Statewide Health Planning and Development (OSHPD) indicated that California had only 38.6 physical therapists per 100,000 persons compared to 56.8 physical therapists per 100,000 persons nationwide. Results from a California Hospital Association survey came to similar conclusions. According to that study, vacancies in Physical Therapy have a negative impact on hospital efficiency and access to care.

Conclusion - Member Access Grievances:
The raw data on member complaints demonstrate that SCFHP is able to resolve complaints made by members expeditiously. For example, if a member must be seen before a provider is able to schedule the member, the Plan will contact the provider office and request that the member is scheduled within the established access standards. SCFHP continues to re-direct members to network and/or out-of-network specialists to ensure timely access to care is met.

OPPORTUNITIES

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
Timely access—PCP urgent appointments within 48-hours	• Improve access to urgent care appointments	• Improve training materials • Conduct provider outreach(Training)	Yes	TBD
Timely Access—Behavioral Health non-life threatening emergency within 6-hours	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards	• Explore contracting opportunities to expand BH network • Improve training materials • Conduct provider outreach (Training)	Yes	TBD
After-Hours Access (return call within 30min or less)	• Improve after-hours access	• Improve training materials • Conduct provider outreach (Training)	Yes	TBD

PARTICIPANTS:

Provider Network Access Manager
Timely Access and Availability Work Group
Behavioral Health
Quality Improvement
Grievances and Appeals
Provider Relations
Customer Service

Attachments:
Appendix A: After-Hours Survey Tool
Appendix B: Provider Satisfaction Survey Tool (2018)
Appendix C: Provider Satisfaction Survey Tool (2017)

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		

Appendix A: After-hours Survey Tool

After-Hours Survey 2018

Q1. Hello, my name is _____. Is this the after-hours service for Provider1, Provider2, Provider3, Provider4, and Provider5?

{DO NOT READ ANSWER OPTIONS.}

1) Yes, for all → Go to **INTRO 2**
2) Yes, for some→ Select **Final Disposition then go to INTRO 2**
3) No, this survey cannot be completed for all (Interviewer select reason) → Select **Final Disposition**
4) No, this is not the after-hours service → Reschedule call +2 hours
5) Reached a recording or auto attendant → Go to **Question 5**
6) No Answer → Go to **END CALL**

(Programming Note: Include a dropdown field of disposition codes next to each provider so final dispositions can be chosen for providers who are ineligible. If at least one provider is eligible, the survey should be continued.

Selections should include:

- Phone number is disconnected or non-working (P31)
- Provider not known at this number (P30)
- Provider is retired or deceased (P20)
- Provider has moved or left the office for other reasons (P20)
- Provider does not participate in health plan (P24)
- Phone number not a healthcare provider office (P30)
- Provider refused to participate (P40)
- Respondent (or auto-attendant) does not speak English (P30)
- Respondent asked to be placed on DNC list (DNC)

>>INTRO 1<<
Hello, my name is _____. Is this the after-hours service for Provider1, Provider2, Provider3, Provider4, and Provider5?

1) Yes → Go to **INTRO 3**
2) Yes, for some → Select **Final Disposition then go to INTRO 3**
3) No for all or Refusal → Select **Final Disposition**

(Programming Note: Include a dropdown field of disposition codes next to each provider so final dispositions can be chosen for providers who are ineligible. If at least one provider is eligible, the survey should be continued.)

>>INTRO 2<<

This call may be monitored and recorded for quality assurance and training purposes. I'm calling from CSS Research on behalf of [SCFHP], of which Provider1, Provider2, Provider3, Provider4, and Provider5 are affiliated. We are conducting an after-hours access survey and would like to ask you a few questions regarding whether Provider1, Provider2, Provider3, Provider4, and Provider5 are available to his/her/their patients after hours. For record keeping purposes, may I have your name?

{RECORD INTERVIEWEE NAME}

Interviewee Name: _____ → Go to **Question 1b**

>>INTRO 3<<

This call may be monitored and recorded for quality assurance and training purposes. I'm calling from CSS Research on behalf of [SCFHP], of which Provider1, Provider2, Provider3, Provider4, and Provider5 are affiliated. We are conducting an after-hours access survey and would like to ask you a few questions regarding whether Provider1, Provider2, Provider3, Provider4, and Provider5 are available to {his/her/their} patients after hours. For record keeping purposes, may I have your name?

{RECORD INTERVIEWEE NAME}

Interviewee Name: _____ → Go to **Question 9**

Q1b. (INTERVIEWER RECORD: Are you speaking with one of the named providers?)

1) Yes
2) No or Not Sure

Q2. What would you tell a caller who states he/she is dealing with a life-threatening emergency situation?

{DO NOT READ ANSWER OPTIONS. CHOOSE ALL THAT APPLY.}

a) Go to the nearest emergency room.
b) Hang up and dial 911.
c) Leave your name and number, someone will call you back.
d) Go to an urgent care center.
e) The doctor or an on call physician can be paged or called at another number.
f) Transfer to a PCP, advice/triage nurse, or urgent care center.
g) Don't know or not specified
h) Other: {TYPE ANSWER}

{INTERVIEWER NOTES}

An example of an emergency situation is a sudden onset of chest pain. For the purposes of this survey, the caller is a patient, not a doctor or pharmacist.

(Programming Note: If Q1b = 1, skip Q3 and Q4 and go to **CLOSE**)

Q3. If a patient expresses an urgent need to speak with a clinician, is there a way you can put them into contact with the provider, an on-call provider or a health care professional such as an advice nurse tonight?

{DO NOT READ ANSWER OPTIONS.}

3) Yes
4) No or Not Ascertained → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Yes" if you are speaking to the health care provider directly. If you are unsure whether the patient can be put into contact with a provider tonight, ask follow up questions such as: (If the respondent can contact the provider) Will the patient speak to the provider if called? (If a message can be left) Will they call back?

Q4. In what timeframe can the patient expect to hear from the provider or on-call provider?

{DO NOT READ ANSWER OPTIONS.}

1) Immediately (can cross connect/transfer) → Go to **CLOSE**
2) 30 minutes or less → Go to **CLOSE**
3) More than 30 minutes → Go to **CLOSE**
4) Not specified → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Not specified" if the respondent says "As soon as possible". Choose "Immediately" if you are speaking to the health care provider directly, or if the call can be transferred immediately.

Q5. {INTERVIEWER RECORD} What does the recording or auto attendant tell a caller who states he/she is dealing with a life-threatening emergency situation? **(Select all that apply.)**

a) Go to the nearest emergency room.
b) Hang up and dial 911.
c) Leave your name and number, someone will call you back.
d) Go to an urgent care center.
e) The doctor or an on call physician can be paged or called at another number.
f) Transfer to a PCP, advice/triage nurse, or urgent care center.

g) No emergency instructions provided.
h) Other: {TYPE ANSWER}

Q6. {INTERVIEWER RECORD} Were any of the following options given by the recording or auto attendant? **(Select all that apply.)**

a) The caller is given the option to page the provider through the recording
b) A phone number or pager number is given to reach the provider, an on call provider, or an after-hours service
c) The caller is able to leave a message
d) None of the above

{INTERVIEWER NOTES}
Choose option A if the option (such as stay on the line/press extension number) is given to connect immediately to a health care provider - which includes a physician, nurse, therapist, etc.
For option B, a nurse advice line is an example of an after-hours service. A cell phone or home phone number is an example of a different phone number.
For Option C, the message must specify that the call will be returned.

(Programming Note: If options A or D are chosen, end the survey.)

Q7. {INTERVIEWER RECORD} In what timeframe can the patient expect to hear from the provider or on-call provider?

1) Immediately (can cross connect/transfer)
2) 30 minutes or less
3) More than 30 minutes
4) Recording does not specify

Interviewer Note: Choose "Recording does not specify" if the recording states they will call back "As soon as possible". Choose "immediately" if the option is given to connect to a provider (stay on the line/press extension) or after hours service (i.e. nurse advice line).

Q8. {INTERVIEWER RECORD} Does the recording/auto-attendant offer an option to speak with a live person?

1) Yes (INTERVIEWER: choose option to connect to live person) → Go to **Intro 1**
2) No → Go to **END CALL**

{INTERVIEWER NOTES}
Choose option 1 if you can speak to an operator or a named person. Only record option 1 after a live person is on the line, otherwise choose option 2.

(Programming Note: Display Question 8 only if option A on Question 6 is NOT marked.)

Q9. If a patient expresses an urgent need to speak with a clinician, is there a way you can put them into contact with the provider, an on-call provider or a health care professional such as an advice nurse tonight?

{DO NOT READ ANSWER OPTIONS.}

1) Yes
2) No or Not Ascertained → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Yes" if you are speaking to the health care provider directly.

Q10. In what timeframe can the patient expect to hear from the provider or on-call provider?

{DO NOT READ ANSWER OPTIONS.}

1) Immediately (can cross connect/transfer) → Go to **CLOSE**
2) 30 minutes or less → Go to **CLOSE**
3) More than 30 minutes → Go to **CLOSE**
4) Not specified → Go to **CLOSE**

{INTERVIEWER NOTES}
Choose "Not specified" if the respondent says "As soon as possible". Choose "Immediately" if you are speaking to the health care provider directly, or if the call can be transferred immediately.

>>CLOSE<<
Thank you very much for your time. Have a nice day/evening.

>>END CALL<<

Santa Clara Family Health Plan™

Appendix B: Provider Satisfaction Survey Tool (2018)

Dear Provider:

Santa Clara Family Health Plan is committed to improving the services we offer to our contracted providers. As part of this commitment, we ask you to complete this short survey on your satisfaction with our services. Your responses will help us identify areas of improvement. Various members of your administrative and medical staff may be best qualified to provide input on questions based on their areas of expertise. Please take a few minutes to complete this survey and return by fax to 800-205-3745.

Santa Clara Family Health Plan is working with the Center for the Study of Services (CSS), an independent research organization, for this survey. If you have any questions, please contact CSS at providerfeedback@cssresearch.org.

How satisfied are you with each of the following?

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	No Experience
1. Utilization Management					
a. Timeliness of the prior authorization process	☐1	☐2	☐3	☐4	☐5
b. Timeliness of the ready referral process	☐1	☐2	☐3	☐4	☐5
c. Efficiency of the UM appeals process	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness of staff	☐1	☐2	☐3	☐4	☐5
2. Claims/Appeals					
a. Timeliness of clean claims processing	☐1	☐2	☐3	☐4	☐5
b. Promptness of answers to claims inquiries	☐1	☐2	☐3	☐4	☐5
c. Efficiency of the claims appeals process	☐1	☐2	☐3	☐4	☐5
3. Patients' Timely Access to…					
a. Urgent care	☐1	☐2	☐3	☐4	☐5
b. Non-urgent primary care	☐1	☐2	☐3	☐4	☐5
c. Non-urgent specialist care	☐1	☐2	☐3	☐4	☐5
d. Non-urgent ancillary diagnostic and treatment	☐1	☐2	☐3	☐4	☐5
e. Non-urgent behavioral health	☐1	☐2	☐3	☐4	☐5
f. Covered services	☐1	☐2	☐3	☐4	☐5
4. Customer Service Staff's…					
a. Ability to answer calls promptly	☐1	☐2	☐3	☐4	☐5
b. Knowledge about my questions	☐1	☐2	☐3	☐4	☐5
c. Ability to resolve my concerns/issues	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness	☐1	☐2	☐3	☐4	☐5
5. Provider Relations Staff's…					
a. Ability to respond to questions promptly	☐1	☐2	☐3	☐4	☐5
b. Knowledge about my questions	☐1	☐2	☐3	☐4	☐5
c. Ability to resolve my concerns/issues	☐1	☐2	☐3	☐4	☐5
d. Friendliness and helpfulness	☐1	☐2	☐3	☐4	☐5
6. SCFHP's Provider Network					
a. Quality of SCFHP's provider network	☐1	☐2	☐3	☐4	☐5
b. Availability of medical health providers	☐1	☐2	☐3	☐4	☐5
c. Availability of behavioral health providers	☐1	☐2	☐3	☐4	☐5
7. Overall Satisfaction					
a. Overall experience with Santa Clara Family Health Plan	☐1	☐2	☐3	☐4	☐5

Thank you for your feedback!

Please fax the completed survey back to 800-205-3745.

Santa Clara Family Health Plan™

Appendix C: Provider Satisfaction Survey (2017)

PROVIDER SATISFACTION WITH ACCESS SURVEY
FACSIMILIE TRANSMITTAL – ACTION REQUESTED WITHIN 5 BUSINESS DAYS
FAX YOUR RESPONSES TO: (408) 376-3537

Dear Provider:

The **State of California Timely Access to Non-Emergency Health Care Services Regulation** (§1300.67.2.2, Title 28, California Code of Regulations) requires service plans to maintain an adequate provider network to ensure patients receive timely access to care as appropriate for their condition, and to solicit provider's perspective and satisfaction with the patient's ability to receive access to care within the timelines set forth under California law.

Please check your Provider Type: PCP ☐ Specialist ☐

IPA/Medical Group Affiliation: Direct/Independent Providers ☐ PAMF ☐ PMGSJ ☐ Premier Care ☐

Please check all of the above that apply to you.

Please tell us your satisfaction level with each of the below:

HOW SATISFIED ARE YOU WITH:	**1. Very Satisfied**	**2.Satisfied**	**3. Dissatisfied**	**4.Very Dissatisfied**	**Not Applicable/ Unknown**
The referral and/or prior authorization process necessary for your patients' to obtain covered services?	☐	☐	☐	☐	☐
Your patients access to:					
urgent care	☐	☐	☐	☐	☐
non-urgent primary care	☐	☐	☐	☐	☐
non-urgent specialty services	☐	☐	☐	☐	☐
non-urgent ancillary diagnostic and treatment services	☐	☐	☐	☐	☐
behavioral health non-urgent care	☐	☐	☐	☐	☐
Your satisfaction with the language assistance program:					
coordination of appointments with an interpreter	☐	☐	☐	☐	☐
availability of appropriate range of interpreters	☐	☐	☐	☐	☐
training and competency of interpreters	☐	☐	☐	☐	☐

Please fax your responses to (408) 376-3537 within 5 days of receipt.

THANK YOU!

Santa Clara Family Health Plan (SCFHP)

Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Quality Improvement Committee: October 10, 2018

Factor 1: Exchange of Information – Medical Record Review of Behavioral Health and Primary Care Practitioners (PCPs)

I. The Santa Clara Family Health Plan (SCFHP) collects data on exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

Commented [JE1]: One you abbreviate this once, you don't have to spell out Santa Clara Family Health Plan again in the rest of the document

II. 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 2017. To qualify for this data pull, the member had to have an established PCP relationship identifiable from our claims system database.

From this data set, we identified 385 unique members. We calculated a statistically valid sample by using a 90% confidence interval and a margin of error of 10. The total sample size came out to 58. We randomly selected the 58 from the population of 385. For the 58 members, the BH Team coordinated a medical record review with Santa Clara County BH Services to measure the timeliness of BH Practitioner and Primary Care Practitioner (PCP) communications regarding medication updates as found within each BH file.

For timeliness, we checked for records documented within the BH Practitioner chart that BH medications were communicated to the PCP at minimum once per year; the factor of timeliness has been defined as such to state that if a BH Provider communicated member BH medications to the PCP within the Calendar Year of 2017 this is a pass. Many of our BH specialists serve our members through the County of Santa Clara Behavioral Health Department or through county contracted providers, which means that both the BH specialist and the PCP have access to the member medical records using an EMR (Electronic Medical Records) system. These scenarios automatically meet the timeliness criterion as both BH specialist and PCP are able to access the same records.

a. **Goal:** 80% of the total number of samples meet the timeliness standards.

III. Analysis

a. Results

Of the SCFHP unique sample of 58 Members, 15 Members were granted automatic credit for the timeliness standard of Medical Record Review as both PCP and BH Providers are 1) located through the same Valley Health Clinic for BH and PCP services, and 2) the PCP and BH Providers share the same Electronic Medical Record system, with the ability to view each provider's notes, medications, and diagnoses.

The current information shows that at this time, 15 out of 58 Members meet our timeliness standard, with a Pass rate of 26% and a Do Not Pass rate of 74%.

We did not meet our goal that 80% of the total number of samples meet the timeliness standards.

Commented [TF2]: Reworded this sentence per JE request to make more sense.

b. Quantitative analysis

The Health Plan found that 43 of our total 58 files Do Not Pass do not meet the established timeliness standard.

The current information shows that at this time, 15 out of 58 Members meet our timeliness standard, with a Pass rate of 26% and a Do Not Pass rate of 74%.

c. Qualitative analysis

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of medical records indicating Member Behavioral Health medications were communicated at least once within the previous year to the PCP. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist [consultant]), Quality Improvement staff (internal), Provider Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

2017 Barrier and Opportunity Analysis Table (Factor 1 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
HIPPA/Privacy Information (Deficit of Knowledge) – difficult for PCPs and Psychiatrists to cross-communicate regarding medical and Behavioral Health diagnoses & medications as frontline staff are under the impression that they cannot provide any information to Provider without a consent from the Member.	Educate members on the importance of signing a release to allow sharing of medical record information between member providers.	Article within SCFHP Newsletter stating importance and benefits of signing a release to allow sharing of medical record information between member providers	N	n/a
Access to Medically Relevant information (PCP and Psychiatrist)	Increase communication paths between PCPs and	Include Member lab results and medications filled through the	N	n/a

Commented [JE3]: Are we going to update this for the final report? Not sure if we can keep this in and get it approved if we still have additional review we need to do.

Commented [JE4]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

Commented [JE5]: Since we are focusing on timeliness, want to make sure that the barrier addresses that. Does this make sense?

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
	Psychiatrist in order to support relevant exchange of member information (e.g. medications)	SCFHP Physician Portal.		

Commented [JE6]: I am not sure how much control over our disclosure forms? If not we don't have as much, maybe providing lab data through the portal would be more feasible/actionable.

Factor 2: Diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care (AMM HEDIS measure)

I. SCFHP looks at the results of the HEDIS measure Antidepressant Medication Management (AMM) year over year to monitor that members with a behavioral health disorder/diagnosis of depression are being appropriately treated.

II. **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 2017. The rates measure the following:

Commented [JE7]: Add tech specs to exhibit.

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).

a. **Goal**: To maintain a rate in the HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures.

III. **Analysis**

a. Results

i. Effective Acute Phase Treatment: % of members who remained on an antidepressant medication for at least 12 weeks

	False	True	Grand Total
Count of Effective Acute Phase	31	87	118
	26.27%	73.73%	100.00%

ii. Effective Continuation Phase Treatment: % of members who remained on an antidepressant medication for at least 180 days

	False	True	Grand Total
Count of Effective Continuation Phase	45	73	118
	38.14%	61.86%	100.00%

Rate Description	Mean	P10	P25	P50	P75	P90
AMM - Rate - Effect.Acute Phase Tx	69.41	58.82	63.5	69.51	75.39	79.61
AMM - Rate - Effect.Continuation Phase Tx	54.42	41.12	47.53	54.11	60.32	66.55
Eligible Population per 1000 MY	27.13	14.45	19.45	24.98	32.23	41.68

b. Quantitative analysis

SCFHP scored in the 50th HEDIS percentile for the AMM Effective Acute Phase Rate. For the AMM Effective Continuation Phase Rate, SCFHP scored in the 75th HEDIS percentile. The goal was to achieve 75th percentile for both rates. While achieving our goal for the continuation phase, we were 5.88 percentage points behind the 75th percentile for the acute phase. Thus, we must conclude that there is room for improvement when it comes to CMC members maintaining their antidepressant medication treatment over a twelve week period. Our goal for the year 2018 will be to increase the percentage points of the Acute Phase rate high enough to achieve 75th percentile for our 2017 data, while maintaining our rate in the continuation phase.

c. Qualitative analysis

The quantitative analysis shows that during the first 12 weeks, or 180 days, of taking an antidepressant medication, SCFHP CMC Members are less **likely** to continue taking the medications during this Acute Treatment Phase than Members associated with other CMC Health Plans.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the rate of Members Antidepressant Medication compliance. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], an Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist [contractor]), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

Commented [JE8]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

The analysis identified these specific barriers:

2017 Barrier and Opportunity Analysis Table (Factor 2 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	Selected for 2018?	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	N	n/a

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
		conversation request)		
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

Factor 3: Appropriate Use of Psychotropic Medications - Primary Care Practitioners (PCPs) and Antidepressant Medication Prescriptions

I. 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 that not only are adherence to prescribing guidelines (for all prescribing providers) concerning antidepressant medications vital to providing members with direct access to care, but also that PCP comfort level in using their medical skills to prescribe antidepressants needs to be addressed.

II. **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).

SCFHP analyzed Calendar Year (CY) 2017 along with available CY HEDIS NCD codes for antidepressant medications, along with the diagnostic codes for Mild-to-Moderate diagnoses (Mild-to-Moderate based on level of functioning/county clinic placement as well as DSM-V diagnostic code) are used to determine:

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

    a. The antidepressant medication had to have been filled by the member's PCP/Internal Medicine Doctor or a Psychiatrist

a. Goal = to have 75% of antidepressant medication prescriptions to be provided by Primary Care Practitioners and 25% of antidepressant medication prescriptions to be provided by Psychiatrists.

3. This metric will be used to indicate an increase in access to care 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 medications falls within different PCP comfort levels – the Health Plan has begun to

Commented [TF9]: Correct place to state this? Helps to explain more thoroughly the why as to what we are measuring and will feed into the ideas for future monitoring and improvement measures.

Commented [JE10R9]: This is good here. I would also just mention that it is not just PCPs adhering to the guidelines, it is also having them feel comfortable enough prescribing the meds, right?

Commented [JE11]: Add in CY 2017 measurement year

Commented [TF12R11]: Sufficient that stated in Body Paragraph? CY 2017?

Commented [TF13]: Need define – but need to include here?

outline as well as implement means to improve PCP awareness of antidepressant guidelines as will be discussed further along within this Factor.

III. Analysis

CY 2017 data

Of the Total Number of individual prescriptions (N = 7739)

- 3791 were prescribed by psychiatrists
- 3182 were prescribed by PCPs (Internal Medicine, Family Practice, General Practice, Geriatric medicine)
- Of the total, 766 were prescribed by other types of medical professionals (e.g. Neurologists, Cardiologists, Urologists, etc).

For the purposes of analyses we will not include practitioners which do not fit into these categories.
N = 3791+3182= 6973.

PCPs prescribing antidepressants for M2M (Mild to Moderate) Members = 54.4%
(Total Number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant medications = 3791 / 6973 = 54.4%)

Psychiatrists prescribing antidepressants for M2M (Mild to Moderate) Members = 45.6%
(Total Number of Psychiatrist antidepressant prescriptions / total number of prescriptions for antidepressant medications = 3182 / 6973 = 45.6%)

Results (Prescriptions written):

-PCPs prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant) = (3791 / 6973 = 54.4%)

PCPs prescribing antidepressants for M2M (Mild-to-Moderate) Members (total number of Psych antidepressant prescriptions / total number of prescriptions for antidepressant) = (3182 / 6973 = 45.6%)

a. Results

SCFHP found that of the 6973 prescriptions written for antidepressant medications, 3791 were prescribed by PCPs (as defined, those Physicians providing services as Internal Medicine, Family Practice, General Practice, Geriatric medicine) & 3182 were prescribed by Behavioral Health Providers (as defined, those BH Providers noted as Psychiatrists).

4. 54.4% of Antidepressant medications were thus prescribed by PCPs
5. 45.6% of Antidepressant medications were thus prescribed by BH Providers.

b. Quantitative Analysis

The SCFHP obtained our baseline data; of the total number of prescriptions for antidepressant medications, 54.4% were written by PCPs and 45.6% were written by BH Practitioners. From our data collected, SCFHP did not meet our goal of 75% antidepressant prescriptions by PCPs and 25% antidepressant prescriptions by Psychiatrists.

Of the scripts written, there were *208 unique PCPs* identified and *83 unique BH Practitioners* identified.

With more PCPs available in a multitude of settings (Geriatric clinics, Internal Medicine clinics, Private Practice Practitioners, etc.) than Psychiatrists (predominantly through County/County Contracted Agencies), it is apparent that **despite** a near 50/50 split in Antidepressant medication prescriptions, PCPs are an ongoing, useful component to address antidepressant medication needs within the County.

There are more PCP providers available than Psychiatrists, and this indicates that it would be more likely for a member to obtain a PCP appointment (and thus a prescription) than a BH appointment. Many of the county Psychiatrists are also associated specifically with mental health clinics, many of which only serve those with more severe mental illness, such as Schizophrenia.

Our CY 2018 goal is suggested to be incremental in increase to continue to show improvement, with a goal increase of 5 percentage points for PCP antidepressant medication prescriptions (PCPs = 59.4% and Psychiatrists = 40.6%).

Commented [JE14]: Perfect

c. Qualitative Analysis

The quantitative analysis shows currently of our identified population, PCPs are prescribing 54.4% of the total antidepressants and Psychiatrists are prescribing 45.6%.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to improve the number of PCPs

prescribing antidepressants for this population by 5 percentage points. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], , an Adult Psychiatrist [Consultant]), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

Commented [JE15]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

The analysis identified these specific barriers:

2017 Barrier and Opportunity Analysis Table (Factor 3 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Provider perception between referral and consultation distinction.	Identify Members in maintenance stage of medication versus modifying medications for symptom management – PCPs more inclined to manage "ongoing" prescriptions than polypharmacy Members or Members undergoing BH medication changes	Upon implementation of consultation access line with Santa Clara County BH Services, send out letter to Providers informing of line availability and clarifying distinction between consultation and referral.	N	n/a
PCPs lack knowledge and/or comfort level required to manage/prescribe their members' antidepressant medications	Improve comfort levels of PCPs prescribing antidepressant medications by providing access to consultants	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	N	n/a

Commented [JE16]: I reworded this so that the different between barriers/opportunities/intervention is clear

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
		antidepressant medications, general prescribing guidelines and considerations (3/2018)		

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

I. The Santa Clara Family Health Plan collects data on Members identified as having dual diagnoses of Schizophrenia as well as Diabetes Mellitus II.

II. **Methodology**

SCFHP collects data 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. For the purposes of this initial year, the Health Plan will determine the percentage of Members who had a Primary Care/Internal Medicine visit within CY 2017 (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.

a. 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.

III. **Analysis**

a. Results

Total number of Members with diagnoses of Schizophrenia and Diabetes Mellitus Type II were identified through claims data in CY 2017 (**N = 130**). Of these Members, 77 were identified as having had a Primary Care Practitioner (PCP) annual visit (59.2%) and 53 were identified as not having has a Primary Care Practitioner (PCP) visit (40.8%).
We did not meet our CY 2017 goal by 15.8 percentage points.

b. **Quantitative Analysis**

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 2017 (77 members of a total of 130, or 59.2%) number to be low. This is baseline data collected for ongoing analyses year over year.

c. **Qualitative Analysis**

The baseline data indicates 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. Members with Severe Mental Illnesses, 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. SCFHP identifies this population as vulnerable to factors which may limit Member ability to follow up in an ongoing manner for medical care.

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to increase the number of CMC Members dually diagnosed with Schizophrenia and Diabetes Mellitus 2 who have met with their Primary Care Provider at least once every year. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist consultant), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

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2017 Barrier and Opportunity Analysis Table (Factor 4 – Baseline Year Data CY 2017):

Barrier	Opportunity	Intervention	**Selected for 2018?**	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 remind Member: Schedule PCP Annual Wellness exam + Have A1c blood testing completed	Y	10/2018
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

The barrier analysis completed in the baseline year CY 2017 identified that PCPs and Psychiatrists are in need of increase in communication methods – it was

suggested at 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 (family, case management if connected to a mental health clinic, group attendance/addressing mental health symptoms, etc.). An intervention to increase Member awareness of the importance of follow up care with PCP regarding Diabetes Mellitus 2 management within this subpopulation has been implemented as of October 2018. Outreach to the entire population involved 3 calls to each member to offer assistance in scheduling of Annual Wellness Exam for Diabetes Mellitus 2 follow up care and assistance with SCFHP transportation to and from this appointment. This intervention will remain in place for the measurement cycle to determine if the performance goal is attainable.

Factor 5: Secondary Preventative Behavioral Healthcare Program Implementation – PHQ-9

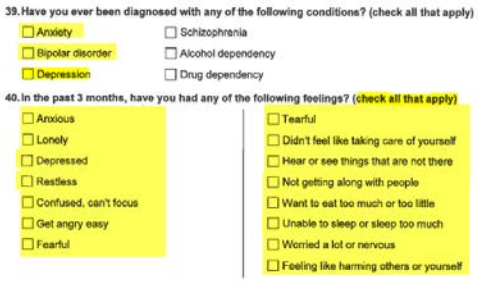
I. SCFHP collects data on members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions. Data pulled from the Health Plans annual Health Risk Assessment (HRA) identified Members who have self-reported a diagnosis of depression 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, and thus the subpopulation of Santa Clara Family Health Plan Members, coupled with treatment needs/considerations for health wellness, the Health Plan has collected data concerning levels of Member identified depression and the data address the need for a secondary behavioral health program to connect members, as based on their current 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.

II. **Methodology**

The SCFHP collects data on CMC as identified within the HRA, completed annually by Members, to identify the population of members currently self-indicating diagnoses and/or symptoms of depression.

Health Risk Assessments completed between July 1, 2017 and June 30, 2018 were reviewed for responses on HRA mental health questions:


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

a. Goal = 80-100% of CMC Members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment.

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.

III. Analysis

a. Results

Within our specified timeframe of 12 months (July 2017 – June 2018):

3127 Unique Members had identified symptoms and/or a diagnosis of Depression on their Health Risk Assessment.

Of the 3127 Members, 171 Members had completed a PHQ-9.

5.47% had a PHQ-9 assessment.

Total HRA Members with BH indicator on HRA	Total HRA Members with PHQ9	
3,127	171	5.47%

This assessment measure is useful in guiding interventions and thus *supports* the need for a PHQ-9 Program – assessment scores may be used to help guide treatment and resources to those most in need.

b. Quantitative Analysis

SCFHP acknowledges that there are many CMC members who had indicated depressive symptoms/diagnosis of depression.

Of these 3127 members (of whom account for 42 % of the SCFHP CMC total member population as calculated based on total CMC population June 2018 = 7503), 5.47% had a PHQ-9 assessment.

Our goal to meet for our specified timeframe was 80-100% of sample Member's to have completed a PHQ-9; the total number of completed surveys is low considering the prevalence of depressive symptoms and depression within our population. SCFHP did not meet our goal. As a baseline year these data support the need for a PHQ-9 and/or depression program for CMC Members.

c. Qualitative Analysis

In an effort to meet the performance goal for 2018, an initial barrier analysis was completed to identify opportunities and interventions to increase the number of completes PHQ-9 assessments and communication of appropriate interventions/treatment for all CMC Members who have indicated a diagnosis of depression and/or depressive symptoms as identified on the Member's Health Risk Assessment (HRA); we would like to retain the objective of 80-100% PHQ-9 percentage completion rate for these Members. SCFHP conducted a Behavioral Health Workgroup on September 25, 2018 to review root cause/barrier analysis with an interdisciplinary team which included Doctoral staff (Medical MD [internal], Adult and Child Psychiatrist [Quality Improvement Committee Member], an Adult Psychiatrist consultant), Quality Improvement staff (internal), Access and Availability staff (internal), Medical Social Work Case Manager (internal), and Behavioral Health Director (internal).

Commented [JE18]: Dr Alkoraishi is an Adult and Child Psych according to the QIC meeting minutes. He is also not a consultant (as far as I know?) so we may want to remove that and replace it with "Quality Improvement Committee Member"

Barrier and Opportunity Analysis Table (Factor 5 – Baseline Year Data CY [July 2017 – June 2018]):

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
Case Managers not always completing a PHQ-9 for 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	Y	10/2018
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	Submit PHQ-9 for translation and send	N	n/a

Barrier	Opportunity	Intervention	**Selected for 2018?**	Date Initiated
	preferred language	by mail to member when requested		

The barrier analysis completed in the baseline year (Baseline Year Data [July 2017 –June 2018]) identified that there are many members currently experiencing symptoms of depression and are in need of treatment interventions; this supports the need for a PHQ-9 Program to allow for addressing such symptoms through a specific, monitored program. 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. 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 follow up was implemented in 10/2018; also ongoing initial as well as annual training on the PHQ-9 program will continue to take place (stated start date of 10/2018). The intervention will remain in place for the measurement cycle to determine if the performance goal is attainable.

Factor 6: Special Needs of Members with severe and persistent mental illness – HEDIS measure of Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

I. 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.

II. **Methodology**

SCFHP utilized the SMC 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. For our baseline data we reviewed HEDIS rates for AMM in 2017. The rates measure 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/

a. Goal = to fall within the 75th Percentile of Members following treatment care with their providers.

III. **Analysis**

a. Results

SCFHP's HEDIS vendor identified only 4 Members who met this very specific criteria. Of the 4 Members, 100% followed up for cardiovascular care with their Provider in 2017

b. **Quantitative Analysis**

The suggested goal was to achieve 75th percentile the total rate. The Santa Clara Family Health Plan met this goal – 100% of Members completed follow up care as indicated by their PCP.

SCFHP acknowledges that a total population size of 4 members for this HEDIS measure is quite small. We believe this may be due to the strict eligibility criteria for this specific measure (footnote[iii]). Despite meeting our goal (100%) this measure will not be an ongoing factor the Health Plan will continue to monitor due to its low

impact in the CMC member population. For 2018, SCFHP will identify a measure the Health Plan may follow up with and utilize for better assisting the Severe Mental Illness population in maintaining their physical and mental health.

c. **Qualitative Analysis**

There is no qualitative/barrier analysis at this time. SCFHP met the stated goal, and will be measuring a new goal for 2018.

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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.

[iii] HEDIS SMC technical specifications link:
http://icat/initiatives/ncqa_first_survey/Shared%20Documents/1.%20Project%20Management/Workgroups/QI6A/Data/Factor%206%20-%20SMC%20HEDIS%20Measure/SMC%20HEDIS%202018%20Tech%20Specs.docx

Santa Clara Family Health Plan (SCFHP)

Member and Practitioner Satisfaction with the UM Process: 2018 Analysis

Quality Improvement Committee: October 10, 2018

I. Introduction

SCFHP monitors experience with the utilization management (UM) process to ensure adequate satisfaction is achieved. Annually, SCFHP completes an analysis which incorporates practitioner & member survey questions, member complaint categories related to processes for UM, and CAHPS data. This analysis allows the organization to formulate an action plan addressing low member and provider satisfaction with (UM) functions within SCFHP.

Practitioner Satisfaction with UM Processes

Practitioner Survey Results for Satisfaction with UM

II. SCFHP monitors Practitioner Satisfaction with the UM Processes by conducting a satisfaction survey.

III. Methodology

SCFHP collects and tracks provider satisfaction from survey responses. SCFHP Personal Care Coordinators (PCCs) administer a phone survey to both primary care and specialty practitioners. The survey is conducted during the month of July and all practitioners are called at least twice. The practitioners are chosen from a random sample of 50 members that had completed authorizations (outpatient and inpatient) with a received by the health plan UM department in the month of June 2018. The 50 members had a combined total of 65 authorizations received during this time frame. Each referring provider from those authorizations was surveyed on their UM experience with that authorization. In total, 28 unique providers responded regarding their experience with a total of 38 authorizations. By surveying practitioners on authorizations from the previous month, we are able to capture more accurate responses as the practitioner will be more familiar with the request.

The denominator for the survey is the number of responses received for each question for each authorization. The numerator for the survey is calculated for each question as follows:

1. **Question 1:** Rate your level of satisfaction with obtaining precertification and/or authorization for requested services for Health Plan members.
    a. Numerator: The number of providers who answered that they were “Completely satisfied” or “Partially satisfied” for each authorization they were surveyed on

2. **Question 2:** Did you receive a determination letter for this authorization within the appropriate timeframe? (14 days with routine requests, 72 hours for Expedited requests)
    a. Numerator: The number of providers who answered that answered “Yes” for each authorization they were surveyed on

3. **Question 3:** Are you familiar with where to find SCFHP’s prior authorization grid for Cal MediConnect members?
    a. Numerator: The number of providers who answered that answered “Yes” for each authorization they were surveyed on

4. **Question 4:** If applicable for a denial determination, were you able to understand the information included to explain SCFHP's Appeal process?
    a. Numerator: The number of providers who answered that answered "Yes" for each authorization they were surveyed on

IV. Results:

SCFHP collects and tracks provider satisfaction from our practitioner satisfaction survey responses regarding satisfaction with the UM process. The survey questions used to measure satisfaction are listed in the table below.

Provider Response Rates

	Reponses Received	Refused	Unable to Contact	Total	Response Rate
# of Authorizations	34	25	6	65	52%
Distinct Providers	28	6	27	61	46%

Measurement Year & Practitioner Type	Numerator	Denominator	Performance Rate	Performance Goal	Goal Met? (y/n)
Satisfaction with process for obtaining pre-certification/referrals/authorization information	33	34	97%	90%	Y
Timeliness of obtaining pre-certification/referrals/authorization information	30	34	88%	90%	N
Familiarity with SCFHP's prior authorization guidelines/grid	28	34	82%	90%	N
Ease of understanding SCFHP's appeal process after a denial determination	25	34	74%	90%	N
Overall Satisfaction	29	34	85%	90%	N

V. Analysis:

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve the member and provider satisfaction with the UM process. The quantitative analysis process includes a review of results and compares those results against an established performance goal. In future analyses, we will compare results year over year. 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 three year period.

a. Quantitative analysis

The performance goal for all provider satisfaction questions was set at 90%. This was only met for one question: Satisfaction with the process for obtaining pre-certification/referrals/authorization information. Two questions had a satisfaction rate within 5 percentage points of the performance goal: "Timeliness of obtaining pre-certification/referrals/authorization information" at 88% and "Ease of understanding SCHP's prior authorization guidelines/grid". The lowest favorable response rate was regarding the ease of understanding SCFHP's appeal process after a denial determination. Only 75% of responses per authorization answered that the process was easily understandable. The overall satisfaction rate with SCFHP's UM process landed 5 percentage points below our performance goal of 90%.

b. Qualitative analysis

The results of the satisfaction survey were discussed at the August 8, 2018 Quality Improvement Committee. This committee includes internal staff representing Quality Improvement, Provider Network Management, Compliance and Health Services staff. Additionally, external committee physicians were present. Multiple barriers and root causes were discussed for those areas in which SCFHP did not meet the performance goal. The barriers discovered impact all of the missed performance goals.

a. Individuals responding to the survey did not understand the required regulatory turnaround time frames, as an internal systems review of the actual authorizations for which the individuals were speaking to has been properly processed within the required timeframes. CMS protocols include a turn-around time (TAT) of 14 days for routine authorization requests as compared to Medi-Cal regulations which specify a 5 day TAT. These survey findings reflect that Providers selecting the choice of "Unsure" resulted in lower performance rates for this measure. All four of these authorizations were actually completed within 72 hours of receipt of the request.
    i. Root causes:
        1. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand the regulatory time frame requirements.
            a. Providers do not have enough time to participate in phone surveys
b. Responders were not familiar with SCFHP's prior authorization grid because of the location of the grid and the types of office staff responding to the survey
    i. Root causes:
        1. Providers/staff cannot find the prior authorization grid because it is not easily accessible, and/or the SCFHP website location is not intuitive and/or confusing
        2. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand the prior authorization grid
            a. Providers do not have enough time to participate in phone surveys
c. Responders did not understand SCFHP's appeal process after a denial determination
    i. Root causes:

1. Existing SCFHP materials regarding the appeal process is not sufficient in educating providers about the appeal process
2. Actual providers are difficult to get a hold of in a phone call survey, many survey responders are office management staff who may not understand or be familiar with SCFHP's appeal process
    a. Providers do not have enough time to participate in phone surveys

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Providers and office staff are not familiar with SCFHP UM processes (turnaround times, appeal process, authorization grid)	Make information regarding SCFHP UM processes more available and accessible to providers and office staff	Add information regarding key UM processes to SCFHP's provider portal Engage providers through additional education efforts When providing verbal notification for authorization determinations, include the required time frame in the verbal message Evaluate location of information on scfhp.com to make it more easily located by providers	Yes	11/01/2018 *after a revised prior authorization grid has been approved by UMC on 10/17/18.
Office staff are completing the surveys over actual providers, who may be more familiar with SCFHP's UM processes	Develop alternative survey methods to reach more Providers vs. Office Staff	Use a larger provider sample size in future provider satisfaction surveys In addition to phone survey, publish future survey links to the provider portal and	No	By end of Q2 2019

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
		provider e-newsletters		

Member Satisfaction with UM Processes

SCFHP measures Member Satisfaction with the Utilization Management Process through annual monitoring of complaints from members related to Utilization Management Processes and through the performance of a member satisfaction survey. The CAHPS survey is also conducted, however, the plan did not receive adequate response rates for the questions related to the UM process.

I. Methodology

SCFHP collects and tracks member complaints across the organization. While all departments may receive member complaints, a formal process exists to document complaints in the Grievance and Appeals (G&A) department. All complaints received in other departments are routed to G&A for documentation and tracking. Members may submit complaints through several methods: verbal complaints received via phone and written complaints received via fax, standard and electronic mail. Complaints gathered in G&A are documented in a central database repository in which they are categorized. Complaints are broken into multiple categories. The specific categories which may contain complaints regarding the Utilization Management (UM) process are as follows:

NCQA Category	Type	Sub-Type
Billing and Financial Issues	Grievance, Part C	Organization Determination/Reconsideration Process
Billing and Financial Issues	Grievance, Part D	Coverage Determination/Redetermination Process

Once complaints are categorized, they are reviewed monthly by a cross-functional team for trends and opportunities.

In addition to complaints, SCFHP conducts a member satisfaction survey regarding experience with the UM process. 50 random members were chosen from all authorizations received in the month of June 2018. The survey was conducted in July 2018. Members were asked about their experience with the UM process within one month of the request since the experience is fresher and more memorable. The members were called at least twice and their survey responses recorded in our case management system. Of the 50 members contacted, 19 distinct members provided responses, providing a 38% response rate. Only 2 members refused to answer the survey, and 29 members were unable to be contacted with the contact information on file.

The denominator for the survey is the number of responses received for each question. The numerator for the survey is calculated for each question as follows:

5. **Question 1:** In the last 6 months, how often was it easy to get the care, tests or treatment you needed?
    a. Numerator: The number of members who answered that it was “always easy” for them to get the care they needed

b. **Note**: A sub-question of Question 1 was asked of members that stated it was never or sometimes easy to get the care needed. This question gave three options to respond why it was not easy. There are no benchmarks for this question, as it is informational only.

6. **Question 3:** In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
   a. Numerator: The number of members who answered "Usually" or "Always"

7. **Question 4:** How easy is it for you to understand the approval or denial letter for the authorization decisions which you received from Santa Clara Family Health Plan?
   a. Numerator: The number of members who answered "Usually" or "Always"

II. Results:

Member Survey Results for Satisfaction with UM

SCFHP collects and tracks member satisfaction from relevant CAHPS survey responses regarding satisfaction with the UM process. The CAHPS survey questions used to measure satisfaction are listed in the table below.

a. Member Satisfaction Survey Results

Survey Question	MY 2018	Goal	Goal Met Y/N
Q1: Ease of getting needed care, tests or treatment	58%	90%	N
Q3: How often did patient get appointment as soon as needed	84%	90%	N
Q3: Ease of understanding approval or denial letters from authorization decisions	74%	90%	N

Member Complaints Related to UM Processes

The below grid describes the complaints captured with results for the July 2017 – June 2018.

b. Member UM Complaint Results

			2017						2018						
NCQA Category	**Type**	**Subtype**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Total**
Billing and Financial Issues	**Grievance Part C**	Org Determination /Reconsideration Process	2	1	0	0	2	1	0	2	3	3	1	2	17
	Grievance Part D	Coverage Determination /Reconsideration Process	0	0	0	0	0	0	0	0	2	1	1	2	6
Grand Total			**2**	**1**	**0**	**0**	**2**	**1**	**0**	**2**	**5**	**4**	**2**	**4**	**23**

Complaint Category	MY Jul 2017 – Jun 2018*	Goal	Goal Met Y/N
Org Determination /Reconsideration Process	2.26 per 1,000	< 3 per 1,000	Y
Coverage Determination /Reconsideration Process	0.80 per 1,000	< 3 per 1,000	Y

**Measure is calculated as complaints per 1,000. Calculation:*
7,532 (Total CMC Membership)/1,000 = 7.532
# of complaints/7.532 = Complaints per 1,000

III. Analysis:

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve member satisfaction with the UM process. 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 to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause.

a. Quantitative analysis

Since this was the first measurement year for the member satisfaction survey and the complaints analysis, SCFHP has only one measurement year of data. The survey and analysis will be re-run in the next measurement year to measure performance improvement. The UM complaints per 1,000 rate fell within SCFHP's performance goal of 3 complaints per 1,000. Because our goal was met, an action plan will not be developed. The member satisfaction survey results did not meet our performance expectation for any of the three questions asked. One limitation of this survey, which will be improved in the next measurement year, is to expand the sample size and complete more outreach attempts to increase the validity and quantity of responses. The performance goal for all questions was 90%. The question that had the lowest satisfaction rate was regarding the ease of getting needed care, tests or treatment. Only 58% of the members that responded that it was always easy to get the care needed. A sub-question was then asked to members that felt it was not easy to get the care needed. 4 members responded that it was because there were no

available appointment times. 2 members responded that they did not have transportation to the appointment. The second lowest satisfaction rate was regarding the ease of understanding approval or denial letters for authorization decisions. Only 74% of members found that it was usually or always easy to understand approval or denial reasons. The highest scoring question was regarding the rate at which patients were able to get an appointment as soon as needed. 85% of members answered that they were usually or always to get an appointment when needed.

b. Qualitative analysis

The results of the member satisfaction analysis were presented at the Quality Improvement Committee on August 8, 2018. This committee includes internal staff representing Quality Improvement, Provider Network Management, and Health Services staff. Additionally, external committee physicians were present. Multiple barriers and root causes were discussed for the areas in which SCFHP did not meet the performance goal.

1. Members did not feel it was easy to get the care, tests or treatment needed
    1. Root causes:
        a. Many PCPs and specialists have access issues and appointment scheduling is not flexible
        b. Members do not know how to get access to transportation needed to arrive at the appointment
2. Members felt that they did not get an appointment as soon as needed
    1. Root causes:
        a. Many PCPs and specialists have access issues and appointment scheduling is not flexible
        b. Members may not understand what constitutes an urgent appointment
3. Members do not easily understand the reason for an approval or a denial, which is distributed in the determination letter
    1. SCFHP's denial and approval language do not correspond to members' literacy levels

2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Members do not understand SCFHP's transportation benefits	Educate members on how to obtain transportation assistance for appointments	Member transportation needs are assessed within the required Health Risk assessment. Identified needs will be addressed by Case management staff	Y	11/1/2018

		during the members individual care planning process		
PCP and Specialist access issues	SCFHP will evaluate and monitor all access and availability complaints	?? Members will be educated through periodic newsletters to call SCFHP to inform of any provider access issues	N	By end of Q2 2019
Members may not understand when an urgent appointment is needed	Educate members' on the difference between urgent and routine appointments and when both are needed	Train case management staff to educate members on SCFHP's Nurse Advice Line (NAL) when members report lack of access to transportation	Y	11/01/2018
SCFHP's approval and denial letter language is not sufficiently member friendly	Improve denial and approval language	Update denial language template grid to be more member-friendly Conduct staff trainings on the importance of and guidelines for using member friendly language in all member correspondence	Y	10/01/2018

Member and Practitioner Satisfaction with the UM Process Reporting

Approval History:

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan Assessment of Physician Directory Accuracy: 2018 Analysis

Quality Improvement Committee : October 10, 2018

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 2018, 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 Year1 2018
    a. Quantitative analysis
    b. Qualitative analysis to include barriers, opportunities and recommended interventions to meet performance goals in measurement year 1.
    c. Implementation of interventions for measurement year 1.

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	590
Recommended Sample Size	61

Two provider relations staff made calls during the months of April through July using the 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 relations staff 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	58	56	58	59	47
Total Physician Responses	61	61	61	61	61
Accuracy Percentage (%)	97%	93%	97%	98%	79%
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 1 (MY1), 2018 of 100% was not met. The rate of accuracy of hospital affiliations and office locations was 97% which is three percentage points below the performance goal. The accuracy of accepting new patients was the highest, which was at 98%. The accuracy of the phone numbers was 93% and lowest accuracy level was for participation in the organization's network at 79%.

c. Qualitative analysis

In an effort to meet the performance goal for 2019, an initial 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. The analysis was completed by internal staff comprised of the PNM data analyst, Manager, Provider Database and Reporting, and the Manager, Process Improvement.

2018 Barrier and Opportunity Analysis Table 2.0

Barrier	Opportunity	Intervention	Selected for 2018?	Date Initiated
Delays in receiving changes from providers through their delegates	Provide additional avenues for submitting provider changes	Ensure that timeliness of provider changes is discussed at quarterly joint operation committees Continue to build out electronic attestation solutions available via the provider portal	Y	9/26/18
Rapidly changing provider data due to frequent staff changes	Inform providers of importance of submitting timely information	Ensure that timeliness of provider changes is part of provider orientation onboarding Continue to build out electronic attestation solutions available via the provider portal	Y	9/26/18

III. Reporting

Committee Approval Table 3.0

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	10/10/2018	

Exhibit A

SAMPLE PROVIDER ATTESTATION FORM

Santa Clara Family Health Plan
The Spirit of Care

Provider Directory Attestation

Date: xx/xx/xxxx

Santa Clara Family Health Plan is required to validate provider demographics every quarter in accordance with all our regulatory requirements. **Please review and complete the attestation below before xx/xx/xxxx and fax back to 408-376-3537.** If there are any changes, please write the updates below 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. If the field has nothing listed in it, SCFHP does not have any data for this field and is required to; therefore, please add that to the Changes Needed / Added column.

	No Change	Changes Needed / Added
Legal Name & Title (as listed on License)	☐	
Other Name(s) (recognized by patients)	☐	
Practitioner NPI #	☐	
CA State License #	☐	
CA State License Expiration Date	☐	
DEA #	☐	
DEA Expiration Date	☐	
Practitioner Gender	☐	
Practitioner Ethnicity	☐	
Languages Spoken by Provider	☐	
Practitioner Hospital Affiliations and effective date of affiliation	☐	
Practitioner Specialty (Include additional specialties as applicable)	☐	

Board Certified? (If yes, please list specialty and certifying board)	☐	
Board Certification Initial Certification and Expiration Date(s)	☐	
Academic Degree Description	☐	
Highest Level of Education attained	☐	
Name and NPI of Supervising Physician (if a Midlevel)	☐	
Has Practitioner Completed Cultural Competency Training? (List date and Name of training)	☐	

Additional Trainings/Certifications?

QASP Level	☐	**Homelessness**	☐
Substance Abuse	☐	**Deafness or hard of hearing**	☐
Trauma informed	☐	**Other**	☐
Physical Disabilities	☐	***Specify;***	
Chronic Illness	☐		
HIV/AIDS	☐		
Serious mental illness	☐		

Medical Group Name/ Practice Name	☐	
Practice Location Address	☐	
Practice City, State Zip	☐	
Practice Phone	☐	
After Hours Phone Number	☐	
Practice Fax	☐	
Practice Fax for Authorizations	☐	
Secure Email (for patient communication only)	☐	
Email (for Health Plan communication)	☐	

Website URL	☐	
Tax ID # (used for billing)	☐	
Organizational/Billing NPI	☐	
Languages Spoken by Office Staff	☐	
Does Practitioner participate in telehealth?	☐	

Proximity to Public Transport (Less than 1 Block, 1 block or more	☐	

Hours at this location:

Days		Hours
Monday	☐	
Tuesday	☐	
Wednesday	☐	
Thursday	☐	
Friday	☐	
Saturday	☐	
Sunday	☐	

Are you participating as a PCP at this location?	☐	
FTE Equivalent at this Location		
Age Limits (youngest/oldest)	☐	
Gender Limits	☐	
Does Practitioner see Children?	☐	
Accepting New Patients at this location	☐	

Is provider enrolled in Medi-Cal? ☐ Yes ☐ No

Please use the space below to provide additional information regarding this practitioner.

Attestation Completed By:

Print Name: _____

Print Title: _____

Signature: _____

Date Completed: _____

Assessment of Member Understanding of Policies & Procedures: Call Code Analysis

Date Analysis Conducted: 4/17/2018

By: Devdhar Patel, Communications Systems & Analytics Manager and Chelsea Byom, Manager, Marketing & Communications

Process:

Call report was generated from an internal call reporting system for calls received between January 1, 2018 and April 5, 2018.

CMC Call Reports contained information by the following list of fields:

Call_Date1
Create_User_ID1
Caller_ID
Type_Issue1
LOB
Member_Full_Name
Member_HPID
dob
Population_Type
Enroll_Coverage_Rate_Code
Provider_Name
Network_Name
PCP_Network
Provider_ID
Status
ClosedDate
TAT
Resolution
Resolnotes
CallNotes
Assigned_To

The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to help focus the analysis.

The resulting list contained the following types of issues and their descriptions:

Type_Issue1	Description
Access to Care	GRV
Administrative	Materials Request
Inquiry Auth	INQ Auth Member Call Medical
Inquiry Auth	INQ Auth Member Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Medical
Inquiry Benefit	INQ Benefit Case Management Support

Type_Issue1	Description
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 Specialist
Inquiry Benefit	INQ Benefit Vision Service
Inquiry Billing	INQ Billing Statement
Inquiry Claim	INQ Claim Status
Inquiry General	INQ General Assistance with obtaining appointment
Inquiry General	INQ General HRA
Inquiry General	INQ General Medi
Inquiry General	INQ General Provider/Network Information Inquiry
Quality of Serv	GRV
Referral Grv	GRV
Transportation	Member Communications Notice

Next, the analysis focused on the members that called within 90 days of their enrollment date with the CMC plan.

Member's health plan ID (HPID) was reported in the call report. HPID was used to source member's enrollment date from the internal enrollment data tables. Member's enrollment date was measured against the call date to identify if the member called within 90 days of his or her enrollment. The following pivot table outlines the frequency of calls members made by the type of issue (call codes) within 90 days of member's enrollment.

Row Labels	Count of Member_HPID	Count of Member_HPID2
⊞ Access to Care	2	0.31%
⊞ Administrative	42	6.47%
⊞ Inquiry Auth	17	2.62%
⊟ Inquiry Benefit	360	55.47%
INQ Benefit Case Management Support	42	6.47%
INQ Benefit Dental Service	28	4.31%
INQ Benefit DME, Enteral and Parenteral Service	27	4.16%
INQ Benefit Mental Health Service	16	2.47%
INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP	7	1.08%
INQ Benefit Other (need to specify)	101	15.56%
INQ Benefit Pharmacy	79	12.17%
INQ Benefit Specialist	36	5.55%
INQ Benefit Vision Service	24	3.70%
⊞ Inquiry Billing	8	1.23%
⊞ Inquiry Claim	13	2.00%
⊞ Inquiry General	144	22.19%
⊞ Quality of Serv	32	4.93%
⊞ Referral Grv	17	2.62%
⊞ Transportation	14	2.16%
Grand Total	649	100.00%

Individual call records were grouped and assessed by issue type and their descriptions. “Benefit Inquiry” was the highest occurrence in individual call records at 55.47%. Within calls of this type, the call descriptions were ranked by prevalence. The top four most frequent descriptions were:

1. Pharmacy	12.17%
2. Case Management	6.47%
3. Specialist	5.55%
4. Dental	4.31%

A sample of call notes were reviewed within these top four categories to identify noticeable trends and opportunities for improvement. Themes identified in the call notes are summarized in the table below.

Samples of Call Types:

Pharmacy	MedImpact claim reversal
	Confusion over medication changes
Case Management	Insurance changed, affecting coverage and benefits
	Help filling out HRA form
Specialist	Finding specialist according to member’s specific needs
	Inquiry on member’s share of cost
Dental	Dental benefit is provided by Denti-Cal through Medi-Cal FFS; SCFHP does not manage dental benefit

In summary, calls related to pharmacy, case management, and specialists were diverse and specific to each member. In many cases, the appropriate course of action for the member to

take is to call the plan to resolve a specific issue. The Plan determined that it would be difficult to address these areas in a broad and cost efficient manner that would be relevant to all membership. However, the Plan identified “INQ Benefit Dental Service” as an actionable opportunity to improve member understanding because the majority of the call notes indicated members were asking the same, specific questions about how dental services are covered and how to find a dentist. Member education via a mass communication vehicle would be an effective way to improve new member understanding of this benefit.

Conclusions: Volume of call records specific to issue type “Inquiry Benefit” and description “INQ Benefit Dental Services” identified opportunity to improve communication to new members about their dental benefits. New members were unaware that their dental benefits are provided through Denti-Cal. They were unsure how to find a provider. Content was subsequently developed for Summer 2018 Cal MediConnect member newsletter to communicate this information.

Santa Clara Family Health Plan Member Experience, Including Behavioral Health: 2017 Analysis

Quality Improvement Committee: October 10, 2018

Authors: Mariana Ulloa, QI Project Manager; Darryl Breakbill, G&A operations Manager; Tiffany Franke, Social Work Case Manager Lead

I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from their members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaint and appeal activity may impact overall member satisfaction, SCFHP tracks and trends this activity, in addition to identifying barriers and implementing interventions. The behavioral health member satisfaction survey is another means to monitor the member experience. Overall, the member experience approach is designed through the analysis to help meet the specific needs of SCFHP members. SCFHP reviews data associated with Complaint 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 CY2017, 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 information systems QNXT and the Grievance and Appeals database to 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 2017 (January 1-December 31). The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to the 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

Member Complaints/Grievances and Appeal Categories

Table 1. CMS Member Complaints/Grievances Categories

Complaint / Grievance Category	1Q-2017	2Q-2017	3Q-2017	4Q-2017	(Jan. 1-Dec. 31, 2017) Total Grievances	Grievances / per 1,000 members 7,482 = 2017 average
Quality of Care	4	3	11	7	25	3.341
Access	4	3	5	5	17	2.272
Attitude/Service	31	23	26	48	128	17.108
Billing/Financial	24	5	88	74	191	25.528
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	63	34	130	134	361	48.249

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 includes all member complaints/grievances and is not a sample. In 2017, the complaints/grievances analysis showed a significant increase in the second half of the year in two categories: Attitude/Service and Billing/Financial. Attitude and Service increased by 55% with a result of 31 in the first quarter and a result of 48 in the fourth quarter. The Billing and Financial category had the largest increase and more than tripled over the course of the year with a result of 24 in the first quarter and a result of 88 and 74 in the third and fourth quarters respectively. In addition, Attitude/Service had a result of 17 per 1000 members for the year and Billing and Financial had a result of 25.5 per 1000 members. The remaining three categories, Quality of Care, Access, and Quality of Practitioner Site had significantly lower numbers and remained flat throughout the year.

Table 2. CMS Member Appeal Categories

Appeals Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Appeals	Appeals / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	43	37	56	143	279	37.289
Quality of Practitioner Office Site	0	0	0	0	0	0.000

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 which include pre-service authorization appeals and post-service claims appeals filed by members or member representatives. The data as shown in Table 2 includes all member appeals and is not a sample. In 2017, the appeals analysis showed a significant increase in the second half of the year in the following category: Billing/Financial. The Billing and Financial category more than tripled over the course of the year with a result of 43 in the first quarter and a result of 143 in the fourth quarter. In addition, the results indicate 37 appeals per 1000 members. The remaining four categories, Quality of Care, Access, Attitude/Service and Quality of Practitioner Site had results of zero appeals.

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 & 2)

SCFHP convened a Grievance and Appeals workgroup on October 3, 2018 that included interdepartmental representatives from the following departments Behavioral Health Case Management, Grievance and Appeals Operations, Compliance, Quality Improvement, Customer Service, and the Executive Team to conduct and review a root cause analysis of the increased number of Attitude/Service and Billing/Financial complaints/grievances and the Billing/Financial appeals.

In analyzing the Attitude/Service complaints/grievances the following root causes were determined for the increase:

- There was an increase in the amount of transportation grievances from Yellow Cab. These complaints were related to not being picked up on time. In addition, because

the Transportation Services Program expanded in 2017, there was a corresponding increase in opportunities for related complaints and grievances.

- There were no other identified trends in the grievances received during Q4 2017. The concerns varied from the delay in processing authorizations to the attitude of Customer Service Representatives with SCFHP.

In analyzing the Billing/Financial complaints/grievances the following root causes were determined for the Q3 2017 increase:

- Quest Diagnostics inappropriately balance billed SCFHP members for lab services. This was due to a misunderstanding of the Cal MediConnect line of business in that both the primary and secondary payment comes from SCFHP. This was since corrected by working with the Provider Network Management and Customer Service Departments to relay the appropriate billing practices to Quest Diagnostic. This resulted in a reduction of those cases in Q4 2017.

In analyzing the Billing and Financial appeals the following root causes were determined for the increase:

- The Grievance & Appeals Department received a new body of work related to post-service claims denials. Effective 9/1/2017, claims reconsiderations transitioned from the Provider Dispute Resolution team to G&A. Additionally, Cal MediConnect members started to receive Integrated Denial Notices related to claims denials. This gave members the right to file an appeal on denied payment.

Behavioral Health Member Complaints/Grievances and Appeals

Table 3. Behavioral Health CMS Member Complaint/Grievance Categories

Behavioral Health Complaint / Grievance Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Grievances	BH Grievances / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	1	0	0	1	0.134
Attitude/Service	1	0	2	4	7	0.936
Billing/Financial	2	0	5	0	7	0.936
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	3	1	7	4	15	2.005

Quantitative Analysis: Behavioral Health Member Complaints/Grievances

SCFHP tracks and trends all member behavioral health 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 member and member representative initiated complaints from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those members were reviewed to verify whether or not a complaint was filed. The data as shown in Table 3 includes all member behavioral health grievances/complaints and is not a sample. In 2017, the complaints/grievances analysis showed a result of zero complaints/grievances in the following categories: Quality of Care, and Quality of Practitioner Site. The remaining three categories: Access, Attitude/Service and Billing/Financial had significantly low numbers and remained flat throughout the year.

Table 4. Behavioral Health CMS Member Appeals Categories

Behavioral Health Appeals Category	1Q2017	2Q2017	3Q2017	4Q2017	Jan. 1-Dec. 31, 2017 Total Appeals	B/H Appeals / per 1,000 members 7,482 = 2017 average
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	0	0	0	3	3	0.401
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	0	0	0	3	3	0.401

Quantitative Analysis: Behavioral Health Member Appeals

SCFHP tracks and trends behavioral health 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 member and member representative initiated appeals from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those members were reviewed to verify whether or not an appeal was filed. The data as shown in Table 4 includes all member behavioral health appeals and is not a sample. In 2017, the behavioral health appeals analysis showed a result of zero for the following categories: Quality of

Care, Access, Attitude/Service and Quality of Practitioner Site. The Billing and Financial category had significantly low numbers throughout the year.

2. Behavioral Health CMS Member Satisfaction Survey

Methodology:
SCFHP conducts an annual telephone, member satisfaction survey for all CalMediconnect members who receive behavioral health services. SCFHP identified all members that received behavioral health services between 12/01/2017 and 12/31/2017. The surveyor asked the member a total of 20 questions and recorded the answers in an on-line survey tool. A total of 230 members were identified and SCFHP staff attempted to reach each member via telephone to conduct the member satisfaction survey.

Quantitative Analysis: Behavioral Health Member Satisfaction Survey Results

The first 6 questions of the survey capture demographic information such as line of business, gender, age, race/ethnicity, and level of education **(Please See Figure 1).** Highlights and summarization of the demographic questions include:

- 57 or 25% of the 230 members identified actually completed the survey.
- The majority of non-responders did not participate because they never answered the phone.
- 24, or 10% of the total members refused to participate.
- The majority of the respondents were female, over 55, White or Hispanic with an education above the high school level.

***Figure 1*. Behavioral Health: Member Satisfaction Survey Results (Questions 1-6)**

Sample Size	230
Completed Survey	57
Did not complete survey	173
% complete	25%

Gender:	
Male	22
Female	35

Age:	
18-34	0
35-54	11
55+	46

Race/Ethnicity:	
American Indian/Native Alaskan	0
Asian	6
Black/African American	7
Hispanic/Latino	14
Native Hawaiian/Pacific Islander	1
White/Caucasian	26
I prefer not to answer	3

Level of Education:	
Less than High School	6
High School/GED	19
Post-Secondary Education	14
College Graduate	18

Reason for not completing:	
Deceased	14
Would not answer phone	93
No working phone #	19
Member/PR Refused	24
Member/PR Incapable	11
Member Termed/Disenrolled	11
Other	1
Total	**173**

Questions 7-20 of the survey are related to the quality of care and are as follows:

Q7) How often did you get an appointment as soon as you wanted?
Q8) How often did you see someone as you wanted when you needed help right away?
Q9) How often did you get the help or advice you needed over the phone?
Q10) How often did your counselor show respect for what you had to say?
Q11) How often did your counselor explain things in a way that you could understand? -
Q12) How often did your counselor listen carefully?
Q13) How often did your counselor spend any time with you? -
Q14) How often did you feel comfortable raising issues or concerns? -
Q15) Compared to 12 months ago, how would you rate your ability to deal with daily problems? -
Q16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations? -
Q17) Compared to 12 months ago, how would you rate your ability to Accomplish the things you wanted to do?
Q18) Compared to 12 months ago, how would you rate your ability to deal with social situations? -

Q19) What effect has your counseling had on your symptoms and problems?
Q20) What effect has your counseling had on the quality of your life?

Highlights and summarization of the quality of care questions include:

For Questions 7-14 included in **Table 1** below:

- Question 9, "How often did you get the help or advice you needed over the phone?", had a significant number of negative responses with 19 members (33%) stating "never" as their answer.

Table 1	**Never**	**Sometimes**	**Usually**	**Always**	**Total**
7) How often did you get an appointment as soon as you wanted?	3	6	17	31	57
8) How often did you see someone as you wanted when you needed help right away?	3	12	13	29	57
9) How often did you get the help or advice you needed over the phone?	19	12	9	17	57
10) How often did your counselor show respect for what you had to say?	2	5	7	43	57
11) How often did your counselor explain things in a way that you could understand?	3	3	11	40	57
12) How often did your counselor listen carefully?	0	6	9	42	57
13) How often did your counselor spend any time with you?	2	8	11	36	57
14) How often did you feel comfortable raising issues or concerns?	0	7	6	44	57

For Questions 15-18 included in **Table 2** below:

- Question 15, "Compared to 12 months ago, how would you rate your ability to deal with daily problems?", had the lowest result with 12 members stating their answer as "much worse" or "a little worse".

Table 2						
	Much Worse	**A Little Worse**	**About the Same**	**A Little Better**	**Much Better**	**Total**
15) Compared to 12 months ago, how would you rate your ability to deal with daily problems?	4	8	8	15	22	57
16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations?	1	3	16	15	22	57
17) Compared to 12 month ago, how would you rate your ability to accomplish the things you wanted to do?	2	6	12	23	14	57
18) Compared to 12 months ago, how would you rate your ability to deal with social situations?	3	2	17	16	19	57

For Questions 19 and 20 included in **Table 3** below:

- Question 19, "What effect has your counseling had on your symptoms and problems?", and Question 20, "What effect has your counseling had on the quality of your life?", most members answered positively with either "a little" or "much better" as their response.

Table 3					
	A Little or Very Harmful	**Not Helpful or Harmful**	**A Little Helpful**	**Very Helpful**	**Total**
19) What effect has your counseling had on your symptoms and problems?	1	2	24	30	57
20) What effect has your counseling had on the quality of your life?	0	5	18	34	57

SCFHP will use 2017 data as a baseline result. 2018 data will be compared to 2017 to identify trends and areas that need improvement.

3. Reporting

Committee Approval

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Assessment of Member Understanding of Policies & Procedures: Call Code Analysis

Date Analysis Conducted: 4/17/2018

By: Devdhar Patel, Communications Systems & Analytics Manager and Chelsea Byom, Manager, Marketing & Communications

Process:

Call report was generated from an internal call reporting system for calls received between January 1, 2018 and April 5, 2018.

CMC Call Reports contained information by the following list of fields:

Call_Date1
Create_User_ID1
Caller_ID
Type_Issue1
LOB
Member_Full_Name
Member_HPID
dob
Population_Type
Enroll_Coverage_Rate_Code
Provider_Name
Network_Name
PCP_Network
Provider_ID
Status
ClosedDate
TAT
Resolution
Resolnotes
CallNotes
Assigned_To

The records in the call report were filtered by specific call codes reported under the [Type_Issue1] field to help focus the analysis.

The resulting list contained the following types of issues and their descriptions:

Type_Issue1	Description
Access to Care	GRV
Administrative	Materials Request
Inquiry Auth	INQ Auth Member Call Medical
Inquiry Auth	INQ Auth Member Call Pharmacy
Inquiry Auth	INQ Auth Provider Call Medical
Inquiry Benefit	INQ Benefit Case Management Support

Type_Issue1	Description
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 Specialist
Inquiry Benefit	INQ Benefit Vision Service
Inquiry Billing	INQ Billing Statement
Inquiry Claim	INQ Claim Status
Inquiry General	INQ General Assistance with obtaining appointment
Inquiry General	INQ General HRA
Inquiry General	INQ General Medi
Inquiry General	INQ General Provider/Network Information Inquiry
Quality of Serv	GRV
Referral Grv	GRV
Transportation	Member Communications Notice

Next, the analysis focused on the members that called within 90 days of their enrollment date with the CMC plan.

Member's health plan ID (HPID) was reported in the call report. HPID was used to source member's enrollment date from the internal enrollment data tables. Member's enrollment date was measured against the call date to identify if the member called within 90 days of his or her enrollment. The following pivot table outlines the frequency of calls members made by the type of issue (call codes) within 90 days of member's enrollment.

Row Labels	Count of Member_HPID	Count of Member_HPID2
⊞ Access to Care	2	0.31%
⊞ Administrative	42	6.47%
⊞ Inquiry Auth	17	2.62%
⊟ Inquiry Benefit	360	55.47%
INQ Benefit Case Management Support	42	6.47%
INQ Benefit Dental Service	28	4.31%
INQ Benefit DME, Enteral and Parenteral Service	27	4.16%
INQ Benefit Mental Health Service	16	2.47%
INQ Benefit MLTSS Support: CBAS, IHSS, LTC, MSSP	7	1.08%
INQ Benefit Other (need to specify)	101	15.56%
INQ Benefit Pharmacy	79	12.17%
INQ Benefit Specialist	36	5.55%
INQ Benefit Vision Service	24	3.70%
⊞ Inquiry Billing	8	1.23%
⊞ Inquiry Claim	13	2.00%
⊞ Inquiry General	144	22.19%
⊞ Quality of Serv	32	4.93%
⊞ Referral Grv	17	2.62%
⊞ Transportation	14	2.16%
Grand Total	649	100.00%

Individual call records were grouped and assessed by issue type and their descriptions. “Benefit Inquiry” was the highest occurrence in individual call records at 55.47%. Within calls of this type, the call descriptions were ranked by prevalence. The top four most frequent descriptions were:

1. Pharmacy	12.17%
2. Case Management	6.47%
3. Specialist	5.55%
4. Dental	4.31%

A sample of call notes were reviewed within these top four categories to identify noticeable trends and opportunities for improvement. Themes identified in the call notes are summarized in the table below.

Samples of Call Types:

Pharmacy	MedImpact claim reversal
	Confusion over medication changes
Case Management	Insurance changed, affecting coverage and benefits
	Help filling out HRA form
Specialist	Finding specialist according to member’s specific needs
	Inquiry on member’s share of cost
Dental	Dental benefit is provided by Denti-Cal through Medi-Cal FFS; SCFHP does not manage dental benefit

In summary, calls related to pharmacy, case management, and specialists were diverse and specific to each member. In many cases, the appropriate course of action for the member to

take is to call the plan to resolve a specific issue. The Plan determined that it would be difficult to address these areas in a broad and cost efficient manner that would be relevant to all membership. However, the Plan identified “INQ Benefit Dental Service” as an actionable opportunity to improve member understanding because the majority of the call notes indicated members were asking the same, specific questions about how dental services are covered and how to find a dentist. Member education via a mass communication vehicle would be an effective way to improve new member understanding of this benefit.

Conclusions: Volume of call records specific to issue type “Inquiry Benefit” and description “INQ Benefit Dental Services” identified opportunity to improve communication to new members about their dental benefits. New members were unaware that their dental benefits are provided through Denti-Cal. They were unsure how to find a provider. Content was subsequently developed for Summer 2018 Cal MediConnect member newsletter to communicate this information.

Santa Clara Family Health Plan
Provider Appointment Availability
Non-Compliant Provider Resurvey Results
MY2017

Prepared by: Carmen Switzer, Provider Network Access Manager
For review by the Quality Improvement Committee
October 10, 2018

Santa Clara Family Health Plan™

INTRODUCTION

Santa Clara Family Health Plan ("SCFHP or "Plan") administers the Provider Availability Appointment Survey ("PAAS") on an annual basis. Per Plan policies, providers who show non-compliance are issued a corrective action plan ("CAP") letter. The CAP letter states that the provider is required to submit a corrective action plan, and that the Plan will repeat the survey within 60-days. This report includes the resurvey results for measurement year 2017.

METHODOLOGY

The Department of Managed Health Care ("DMHC") survey methodologies and tools were used to conduct the resurveys. SCFHP utilized a survey vendor, CSS, to administer the resurveys.

The resurvey results are reviewed by the Provider Network Access Manager, who will list the providers who show continued non-compliance on a provider outreach matrix. The provider outreach matrix is submitted to the provider relations team who will make contact with the providers and offer training/education on timely access standards. As instructed, the provider relations team documents all outreach efforts and completed training sessions within the matrix. Resurvey results are also reviewed in the Joint Operation Committee meetings with our delegated provider groups, and they are advised that a corrective action plan must be submitted to the Plan, and that access training will be required.

Note: To address survey results that state the provider is no longer in practice, non-respondents and/or telephone issues, the provider outreach matrix includes this information for follow-up by PNM staff to ensure our provider profiles are updated as required.

A. RESURVEY RESULTS - PROVIDER APPOINTMENT AVAILABILITY

Table I: ANCILLARY – Standard: Non-urgent appointment within 15-days

A. Individually Contracted Provider (N=2)

Provider Type	Provider	Compliant
Mammogram	Valley Radiology Medical Association	Y
Physical Therapy	San Jose Physical Therapy	Y

Table II A-C: PRIMARY CARE PROVIDER – Standard: Urgent appointment within 48-hours

A. Directly Contracted Providers (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	3	0	2	1	0	2
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	NA	NA	NA	NA	NA	NA
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	0	1	1	0	1

B. Palo Alto Medical Foundation (N=31)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	15	11	4	0	5	6
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	9	7	1	1	6	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	7	7	0	0	2	5

C. Physician Medical Group of San Jose (N=9)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	4	3	1	0	3	1
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	1	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	2	0	0	1	1

D. Premier Care of Northern California (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	2	2	0	0	2	0
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	1	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	NA	NA	NA	NA	NA	NA

Table III A-D: PRIMARY CARE PROVIDER – Standard: Non-urgent appointment within 10-days

A. Directly Contracted Providers (N=5)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	3	0	2	1	0	2
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	NA	NA	NA	NA	NA	NA
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	0	1	1	0	1

B. Palo Alto Medical Foundation (N=31)

Provider Group	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	15	11	0	4	8	3
General Practice	NA	NA	NA	NA	NA	NA
Internal Medicine	9	7	1	1	7	1
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	7	7	0	0	5	2

C. Physicians Medical Group of San Jose (N=9)

Provider Group	Total to Survey	Responded	Refused/ No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	4	3	1	0	2	2
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	2	0
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	2	2	0	0	2	0

D. Premier Care of Northern California (5)

Provider Group	Total to Survey	Responded	Refused/ No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Family Practice	2	2	0	0	2	0
General Practice	1	1	0	0	1	0
Internal Medicine	2	2	0	0	2	0
Geriatrics	NA	NA	NA	NA	NA	NA
Pediatrics	NA	NA	NA	NA	NA	NA

Table IV A-C: SPECIALITS – Standard: Urgent appointment within 96-hours

A. Directly Contracted Providers (N=38)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	9	3	5	1	1	8
Pediatric Cardiology	5	2	1	2	2	1
Endocrinology	14	2	11	1	1	13
Gastroenterology	6	1	4	1	0	5
Psychiatry	4	1	1	2	0	2

B. Palo Alto Medical Foundation (N=23)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	0	2	1	0	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	4	2	2	0	0	4
Gastroenterology	16	5	10	1	0	15
Psychiatry	NA	NA	NA	NA	NA	NA

C. Physician Medical Group of (N=13)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	2	1	0	1	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	3	2	0	1	2	0
Gastroenterology	7	5	1	1	2	4
Psychiatry	NA	NA	NA	NA	NA	NA

Table V A-C: SPECIALISTS – Standard: Non-urgent appointment within 15-days

A. Directly Contracted Providers (N=38)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	9	3	5	1	2	6
Pediatric Cardiology	5	2	1	2	0	3
Endocrinology	14	2	11	1	0	13
Gastroenterology	6	1	4	1	0	5
Psychiatry	4	1	1	2	0	2

B. Palo Alto Medical Foundation (N=23)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	0	2	1	0	2
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	4	2	2	0	1	3
Gastroenterology	16	5	10	1	1	14
Psychiatry	NA	NA	NA	NA	NA	NA

C. Physicians Medical Group of San Jose (N=13)

Specialty	Total to Survey	Responded	Refused/No Response	Retired/Ceasing to Practice/Phone Issue	Compliant	Non-Compliant
Cardiology	3	3	1	0	3	1
Pediatric Cardiology	NA	NA	NA	NA	NA	NA
Endocrinology	3	3	0	1	3	0
Gastroenterology	7	5	1	1	4	2
Psychiatry	NA	NA	NA	NA	NA	NA

Quantitative Analysis:
In Table I A, the resurvey results showed that the Ancillary groups (Valley Radiology Medical Association and San Jose Physical Therapy) were found to be compliant with access standards to schedule an appointment within 15-days.

In Table II A-D, the primary care provider ("PCP") results for the urgent appointment within 48-hours showed that out of the 50 resurveyed, there were 38 that responded and the results showed that 23 were compliant, which indicates that 61% of providers who responded to the survey now meet the standard. In Table III A-D, the PCP results for the appointment within 10-days showed that out of the 38 that responded, 32 were compliant, which indicates that 84% of providers who responded to the resurvey now meet the standard.

In Table IV A-C, the specialist provider results for the urgent appointment within 96-hours showed that out of the 65 resurveyed, there were 22 that responded and the results showed that 8 were compliant, which indicates that only 36% of the providers who responded to the resurvey now meet the standard. In Table V A-C, the specialist provider results for the appointment within 15-days showed that out of 27 that responded, 12 were compliant, which indicates that only 44% of providers who responded to the resurvey now meet the standard.

Conclusion:
The findings showed some improvement in PCPs meeting the urgent appointment within 48-hours at 61%, and a marked improvement in meeting the appointment within 10-days at 84%, with an average improvement of 73%. Findings on specialists providing access to urgent appointments within 96-hours and appointments within 15-days only showed an average improvement of 40%. The Provider Network Access Manager has submitted the provider outreach matrix to the Provider Relations team to ensure that notification of continued non-compliance, timely access training and education is completed and documented.

A resurvey report (specific to the group) was presented at the Joint Operating Committee meetings for both Physicians Medical Group of San Jose and Premier Care of Northern California on September 13, 2018. To ensure SCFHP policies and procedures are met, both groups were advised to submit a CAP to SCFHP by September 28, 2018. The CAP will be reviewed and the group(s) will be notified if SCFHP accepts the proposed CAP, or if additional information is required. Both groups were also advised that SCFHP's provider relations team will make contact to schedule access training.

SCFHP maintains provider corrective action plans and access training sign-in sheets to document actions taken to improve patient access in accordance with regulatory requirements.

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: August 15, 2018

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	11	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	21	
Number practitioners recredentialed within 36-month timeline	21	
% 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 07/31/2018	199	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
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	1551	972	704	700	383	105

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.

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

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.

Santa Clara Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, June 21, 2018
6:00 PM - 8:00 PM
210 E. Hacienda Avenue Campbell, CA 95008

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	Y
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	N
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	Y
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Lily Boris, MD	SCFHP Medical Director	N
Caroline Alexander	SCFHP Administrative Assistant, Medical Management	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:07 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	
	The SCFHP 1Q2018 P&T Minutes from March 15, 2018 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 1Q2018 P&T Minutes from March 15, 2018 were approved as

		submitted and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	Health Plan Updates Dr. Robertson presented the Health Plan Updates. Santa Clara Family Health Plan is moving to the new building on 6201 San Ignacio Avenue in July. Discussion was had and a vote taken regarding Pharmacy Committee meeting time on a move forward basis in the new building. Proposed start meeting at 6:30 p.m. or continue to meet at 6 pm. Committee voted and it was unanimous to continue meeting at 6 p.m. Health Plan is busy working towards NCQA accreditation. Review period started June 1st. Site visit will take place in February.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q1 2018. There was a spike in Medi-Cal appeals from December 2017 to January 2018. Q1 2018 58% overturn rate, 23% upheld, 11% partially favorable, 7% withdrawn, and 1% dismissed. For CalMediConnect (CMC), Q12018 Part C&D appeals slight increase from January 2018 to March 2018. Redeterminations Q1 2018, 70% overturned, 27% upheld, 3% partially favorable, 0% dismissed.	
	SCFHP Global DUR Dr. Liu presented and update on Global DUR. Streamlined requirements for managed Medi-Cal plans. Retrospective DUR of opioids. Concomitant use of anticholinergics and antipsychotics. Will present at Pharmacy Committee to share updates.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:30 p.m. to discuss the following items: Membership Report, Pharmacy Dashboard, Drug Use Evaluation Results, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect Formulary and Prior Authorization Criteria, Recommendations for changes to Medi-Cal and Healthy Kids Formulary and Prior Authorization Criteria, DHCS Medi-Cal CDL Updates & Comparability, Prior Authorization Criteria and New Drugs.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Robertson presented the membership report.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard.	

Santa Clara Family Health Plan

	Drug Utilization & Spend Review Dr. McCarty presented the Drug Use Evaluation Results.	
	Drug Utilization & Spend Review Dr. McCarty presented the Spend and Trend Overview.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 1Q2018 P&T minutes as well as the MedImpact 2Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 1Q2018 P&T Minutes, and MedImpact 2Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting.	Upon motion duly made and seconded, formulary modifications were approved as presented.
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented DHCS Medi-Cal CDL Updates & Comparability.	
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: 1. Diabetic Supplies 2. Androgel 3. Humira 4. Enbrel	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
	New Drugs and Class Reviews Dr. McCarty presented the following new drug reviews: 1. Aimovig 2. Erleada 3. PCSK9 Inhibitors Line Extensions: 1. Noctiva 2. Sinuva 3. Sublocade 4. Lonhala Magnair	Upon motion duly made and seconded, all recommendations were approved as presented.

	5. Firvanq 6. Bonjesta 7. Zypitamag	
	Reconvene in Open Session Committee reconvened to open session at 7:50 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 1Q2018. High impact drugs: Symdeko, Erleada, Trogarzo, Ilumya, Andexxa, Aimovig, Epidiolex, baricitinib, lorlatinib, Nuvaring, Adcirca, Remodulin, Letairis, Ampyra, Cialis, Tracleer, Kaletra and medium/low impact drugs: Delzicol, Onexton, Zortress, Acanya, Levitra, Androgel, Moviprep, Flector, Proventil HFA, Rapaflo.	
9	**Adjournment at 7:55 PM**	

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
July 18, 2018

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y
Sherry Holm	Behavioral Health Director	Y
Andrea Smith	Utilization Review and Discharge Planning Nurse	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the April 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items:	

ITEM	DISCUSSION	ACTION REQUIRED
	Health Plan will start moving to the new location in South San Jose July 27th. It will be a two phase move. July 30th will be the first day of business in the new location. CMS audit will start August 20th and will be via WebEx. Auditors will be onsite the week of September 3rd.	
V. Discussion/Follow up items	Discussion was had on time for future meetings in the new location. Committee unanimously decided to keep the meeting at the current time of 6 p.m.	
VI. Action Items	a. Care Coordinator Guidelines Ms. Castillo presented two new care coordinator guidelines. Outpatient physical therapy: Care coordinator can approve up to 12 visits. Requests exceeding 12 visits must be forwarded to the nurse for review. Wheelchair repair: Care coordinator can approve if wheelchair is 3 years old or less. After motion duly made, seconded, two new care coordinator guidelines were approved as presented. b. UM Program Evaluation 2017 Dr. Boris presented the 2017 UM Program Evaluation for Medi-Cal and Healthy Kids. Added findings in last column of evaluation.	Present UM Program Evaluation for Cal MediConnect at next UM Committee meeting.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	a. Membership Dr. Robertson presented the update on membership. As of July, membership is at 258,500. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.1% of compliance for routine requests, 97.2% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 97.4% compliant for routine, urgent 97 %, retro 100%. ii. Standard Utilization Metrics Data is for April 1, 2017 to March 31, 2018. For MediCal/non SPD, discharges per thousand is at 3.76, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 15.07. Average length of stay 4.83. For CMC population 5.70 days average length of stay. Discharges per thousand 246.9. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is 50th percentile ranking for average length of stay. Medi-Cal SPD's 180.9 discharges per thousand, CMC is at 246.9 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 5.70 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 14.6. Goal is around 11 to 12% for Non SPD population. SPD Inpatient Readmissions for Medi-Cal overall average of 21.8%. Readmissions on CMC at 15.6%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 19.93%; Ages 65+ readmission rate of 14.23%. For age 18 to 64, greater than 75th percentile ranking, age 65+, less than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures: Back Surgery comparison to benchmark, lower. Mastectomy higher in females age 15 to 44, lower age 45-64. Bariatric surgery higher in females age 20 to 44, lower in males age 20 to 44. Medi-Cal Behavioral Health Metrics based on 3 areas: ADHD Medication, Antidepressant Medication Management, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. Initiation phase and continuation maintenance phase for ADHD Medication is at less than 10th percentile rank. Antidepressant Medication Management Acute Phase Treatment and Continuation Phase Treatment is at greater than 75th percentile rank. Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia is at greater than 90th percentile.	Pull authorization data for next UM Committee meeting. Present criteria for gastric bypass: BMI, age, diagnosis

ITEM	DISCUSSION	ACTION REQUIRED

c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q2 18)
Ms. Castillo presented the Q2 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 2nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 2nd Quarter review of 2018, the findings are as follows:

A. For the dates of services and denials for January, February and March of CY 2018 were pulled in the 1st quarter sampling year.
   a. 30 unique authorizations were pulled with a random sampling.
      i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB
      ii. Of the sample 100% or 30/30 were denials
      iii. Of the sample 27% or 8/30 were expedited request; 73% or 22/30 were standard request.
         1. 100% or 8/8 of the expedited authorizations met regulatory turnaround time of 72 calendar hours
         2. 65% or 15/20 of the standard authorizations met regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB)
      iv. 63% or 19/30 are medical denials, 37% or 11/30 are administrative denials
      v. 100% or 30/30 of cases were denied by MD or pharmacist.
      vi. 100% were provided member and provider notification.
      vii. 90% or 28/30 of the member letters are of member's preferred language.
      viii. 100% of the letters were readable and rationale for denial was provided.
      ix. 100% of the letters included IMR information, interpreter rights and instructions on how to contact CMO or Medical Director.

Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows:

- Continue QA report monitoring process
- Manage reviews to meet turnaround time requirements

ITEM	DISCUSSION	ACTION REQUIRED
	d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q218. Required to have a rolling report for any authorizations that does not have a claim attached. Looking at lag time of claims. Need to follow up on why service was not rendered if no claim attached. At end of year will conduct outreach calls to members who have not had services rendered yet. In January, 64% of all authorizations had services rendered for all lines of business. Total number of authorized services not rendered is at 5,727. Percentage of authorizations with no services rendered is 45.2%. e. Procedure for documentation requirements for Prior Authorization when no clinical notes attached Ms. Castillo presented the procedure for documentation requirements when no clinical notes are attached to an authorization request. Any requests without clinical documentation, UM staff makes 3 documented attempts to acquire necessary documentation for review before considering denial for insufficient information. This avoids unnecessary denials. f. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 2,024 calls, Healthy Kids 50 calls, Cal MediConnect calls 93 during the first quarter of 2018. For Medi-Cal the highest number of dispositions rendered was see provider within 24 hours, followed by home/self-care. For Cal MediConnect, see provider within 24 hours, followed by see ED immediately. For Health Kids, no services necessary, followed by see provider within 24 hours. Highest volume for Triage Guidelines used for call types: Medi-Cal-information only, abdominal pain, chest pain, allergic reactions Healthy Kids-information only, bites and stings Cal MediConnect- information only, abdominal pain	

ITEM	DISCUSSION	ACTION REQUIRED
VIII. Behavioral Health UM Reports	Turn Around Time	

ITEM	DISCUSSION	ACTION REQUIRED
	Ms. Holm presented an update on turnaround time. Discussion on ways to improve access to Cal MediConnect members. Required to place with follow up appointment within ten days of discharge. Dr. Alkoraishi mentioned Urgent Care for behavioral health is available at Valley Medical Center. Urgent Care is underutilized. Developmental Screening Summary Ms. Holm presented developmental screening summary. Encourage all children screening with age specific screening tools or age appropriate screening tool for developmental, behavioral, social delays. To be done during regularly scheduled well child visit appointments. Santa Clara Family Health Plan will pay the 96110 code as a Fee for Service to practitioner offices when billed with a well-child diagnosis to Independently contracted providers, PAMF, PMG, and PC. Next steps involve provider education, engagement of delegated provider networks, Valley Health Plan discussion and group discussion.	
IX. Adjournment	Meeting adjourned at 7:30 PM	
NEXT MEETING	The next meeting is scheduled for Wednesday, October 17, 2018, 6:00 PM	

Prepared by:

_____ Date _____

Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

	2017	2018								
Quality & Case Management	**YTD**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**YTD**
Initial Health Assessment										
# of members eligible for an IHA	**48,934**	2,766	2,839	3,013	2,967	4,177	3,298	3,302	3,344	**25,706**
# of IHA completed within 120 days of enrollment	**18,558**	1,284	1,245	1,315	1,259	1,600	1,422	1,525	1,442	**11,092**
% of IHA completed within 120 days of enrollment	**37.9%**	46.4%	43.9%	43.6%	42.4%	38.3%	43.1%	46.2%	43.1%	**43.1%**
Facility Site Reviews										
# of Facilities Due for FSR within the month	**29**	1	3	4	3	5	2	3	0	**21**
# of FSRs completed	**29**	1	3	4	3	5	2	3	0	**21**
# of FSRs that passed	**27**	1	3	4	2	5	2	3	0	**20**
# of FSRs with corrective action	**27**	1	3	4	3	5	2	3	0	**21**
% of FSRs completed timely	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	**100%**

Santa Clara Family Health Plan

TO: Santa Clara County Board of Supervisors

FROM: Santa Clara County Health Authority Governing Board
Santa Clara Community Health Authority Governing Board

DATE: December 2018

Annual Report

Santa Clara County Health Authority and Santa Clara Community Health Authority, collectively doing business as Santa Clara Family Health Plan (SCFHP), serve more than 250,000 low-income residents of Santa Clara County through the Medi-Cal, Cal MediConnect (CMC), and Healthy Kids programs. Following several years of tremendous membership growth, Medi-Cal enrollment across the state has begun to decline. SCFHP experienced a 6% decrease in membership during the fiscal year, while maintaining a consistent 78% Medi-Cal market share. Attached is a summary of SCFHP 2017-2018 Financial Highlights.

During fiscal year 2017-2018, SCFHP focused on further compliance program enhancements to reflect the compliance expectations of state and federal regulators. SCFHP also completed implementation of its new core system (QNXT) for claims processing and authorizations. The focus over the last fiscal year was stabilizing and optimizing this system, as well as the Essette case management system. Web portal functionality for members and providers was also implemented, providing self-service inquiry capabilities to decrease call volumes and improve customer satisfaction. Additional investments were made in implementing new credentialing and customer service workflow software, along with redesign of phone system capabilities for greater operational efficiency. Reporting and analytics were also expanded, and work continued on improving the quality and coordination of care provided to our members.

As a health plan that exclusively serves the safety net population in our community, we continue to work closely with Valley Health Plan, Valley Medical Center, and Santa Clara Valley Health and Hospital System (SCVHHS). During the fiscal year and to-date, the health plan has actively partnered with the County on the Whole Person Care initiative, with a focus on the Nursing Home Diversions program.

In 2017, SCFHP purchased a building in southeast San Jose to address the space needs of a growing staff, and rising lease expenses, in a fiscally sound manner. The new office space was value engineered and built out during the fiscal year, and the health plan officially moved in July 2018.

For fiscal year 2018-2019, the health plan will continue enhancement of its compliance program with a focus on delegation oversight and CMS audit activities, plus undertake improvements in quality measures and undergo a survey by NCQA for our Cal MediConnect program. SCFHP will also develop a Health Homes program with implementation by July 2019, and continue to collaborate with SCVHHS on the Whole Person Care initiative.

Santa Clara Family Health Plan™

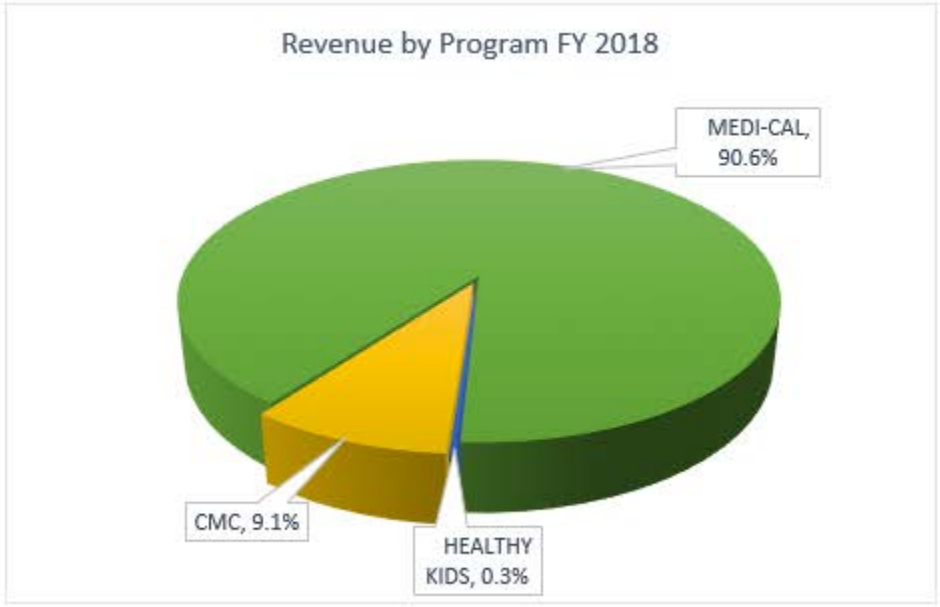
Financial Highlights Fiscal Year 2017-2018

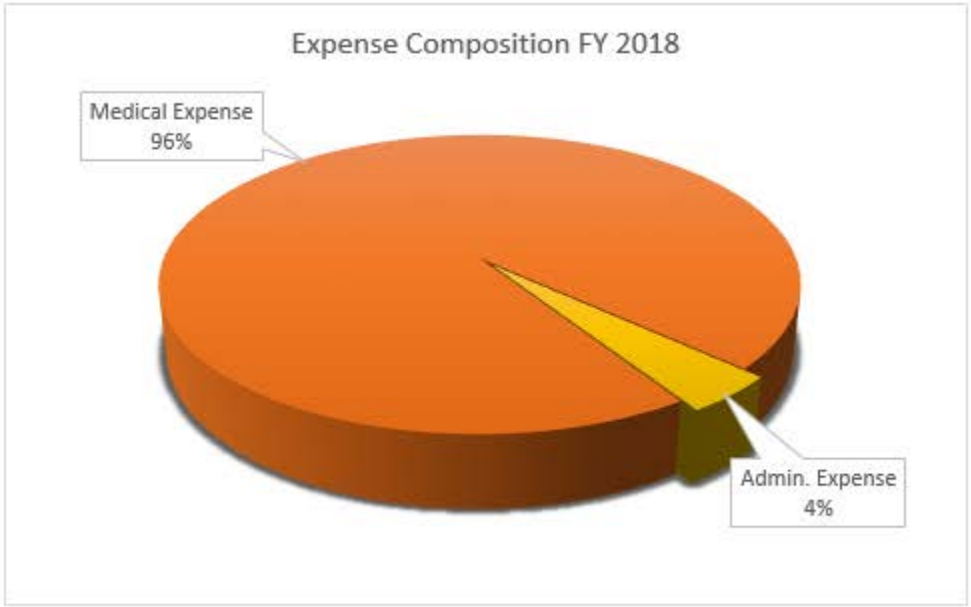
SCFHP Financial Highlights for FY17-18

- Total enrollment decreased 6.0% to 259,475 members at June 30, 2018 from 276,028 members at June 30, 2017.
- Net position increased by $19,635,304 to $178,015,865 for the fiscal year ended June 30, 2018 from $158,380,561 for the fiscal year ended June 30, 2017 due to operating income of $15,867,109 and non-operating income of $3,768,195.
- Total assets and deferred outflows of resources decreased to $763,293,226 as of June 30, 2018 from $866,340,704 as of June 30, 2017.
- Total liabilities and deferred inflows of resources decreased to $585,277,361 at June 30, 2018 from $707,960,143 at June 30, 2017.
- The current ratio (current assets divided by current liabilities) of 1.26 as of June 30, 2018 reflected an increase from 1.22 at June 30, 2017.

SCFHP Financial Highlights for FY17-18, continued

- Fiscal Year 2017-2018 Revenue and Expense Composition (excluding MCO taxes):





- For FY17-18, of every dollar of revenue, SCFHP distributes approximately 96% to providers and retains 4% for administrative expenses.

Santa Clara Family Health Plan™

QIC – MedImpact Oversight

Dang Huynh, PharmD

Annual MedImpact Oversight Audit

Results of Audit & CAP for Approval

Audit Period: 1/1/2017 – 12/31/2017

Area of Audit: **Complaint**

#	Area Of Audit
1001	Communication Services
1002	Procedure for Pharmaceutical Management
1003	Cultural Competency
1004	Formulary Versions
1005	Record Retention
1006	Eligibility Data Load
1007	P & T Committee Attendance
1008	Drug Monographs
1009	Cost and Utilization Data
1010	Pharmacy Audit
1011	Pharmacy Audit of Drug Storage
1012	Pharmacy Audit of Member Drug Signing Process
1013	Good Faith and Fair Dealing

#	Area Of Audit
1014	Rebate Payment Process
1015	Credentialing
1016	Pharmacy Medi-Cal Verification Process
1017	Fraud, Waste, and Abuse
1018	Hierarchy Rules
1019	Communication with Pharmacies
1020	Accidental Disclosures
1023	Membership File
1024	Delegated Entity Annual Audit Material Delivery
1028	Delegate Reporting
1029	Financial Solvency
1030	Credentialing and Recredentialing Standards
1031	Part D Formulary Benefit Administration (FA)

Area of Audit: **Non-Compliant**

#	Area Of Audit
1026	Fraud, Waste, and Abuse (FWA) Compliance Training
1027	Health Insurance Portability Accountability Act (HIPAA)
1032	Part D Coverage Determinations, Appeals and Grievances (CDAG)

#1026: FWA Compliance Training

Factor (As per 42 C.F.R §§ 422.503(b)(4((vi)(C), 423.504(b)(4)(vi)(C)):

Policies & procedures and supporting documentation annual FWA compliance training.

Findings:

Documentation provided by MedImpact did not demonstration confirmation.

Corrective Action Required:

MedImpact to provide correct documentation and verification to confirm training is being documented for HIPAA, FWA, and general compliance training in correct CMS formats.

#1027: HIPAA

Factor (As per 42 C.F.R §§ 422.503(b)(4((vi)(C), 423.504(b)(4)(vi)(C)):

Policies & procedures and supporting documentation annual HIPAA compliance training.

Findings:

Documentation provided by MedImpact did not confirm that new employees are trained within 90 days of hire and annually thereafter (within 12 months).

Corrective Action Required:

MedImpact to provide that HIPPA training is being documented upon hire and annually (within 12 months).

#1032: Part D CDAG

Medicare Prescription Drug Benefit Manual – Chapter 6 & Chapter 18

Appropriateness of Clinical Decision-Making & Compliance with CMS Requirements

Findings:

1. PA# 11821 – Denial language not member friendly.
2. PA# 11875, 11875, 11715, 11391, 11723 – Incorrect language preference.
3. PA# 11323, 11329, 11232, 11579 – Incorrect verbiage.
4. PA# 10914, 11199, 11661, 11537 – Incorrect denial/review.

Corrective Action Required:

MedImpact to provide Root Case Analysis and Impact Report with CAP for each prior authorization case. CAP will need to include on-going monitor and process improvement plan.

SANTA CLARA FAMILY HEALTH PLAN

Pharmacy Benefit Information 2018: Telephone Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 5, 2018

I. Overview

Pharmaceutical benefits and drugs change periodically throughout the year. In an effort to best serve members, Santa Clara Family Health Plan (SCFHP) has a responsibility to ensure that members can contact the organization over the telephone and receive accurate, quality information on drugs, coverage, and cost.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members related to pharmacy benefits. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the pharmacy benefit information provided by CSRs to members.

II. Methodology: Telephone

Annually, Santa Clara Family Health Plan audits the information provided to members over the telephone by its Customer Service Representatives (CSRs). The auditor randomly selects 10 calls during which a member has requested information on pharmacy benefits. The calls are checked for the ability for CSRs to provide accurate reflection of:

a. Financial responsibility per LIS level (copays)
b. Initiate the exceptions process
c. Order a refill for an existing mail-order prescription
d. Assistance to locate an in-network pharmacy
e. Assistance to conduct a pharmacy proximity search based on zip codes in Santa Clara County
f. Determine potential drug to drug interactions
g. Determine drug side effects and significant risks, and
h. Determine the availability of a generic substitution.

The audit will be performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefit information provided over the telephone (see Appendix A for audit sheets). The look-back period is 6 months for the initial audit and up to 24 months for the subsequent year audit.

Goal:

Accuracy: 100%

Quality: 100%

III. Data

Table 1: Accuracy and Quality of Pharmacy Benefit Information for financial responsibility, exceptions process, location of in-network pharmacy, conducting a proximity search, determining drug-drug interactions, common side effects, and the availability of generic substitutions.

Measure	Total Sample	Accuracy Goal Met			% Accuracy Goal Met	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 1 Financial responsibility									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?	10	10	0	0	100%	10	0	0	100%
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?	10	10	0	0	100%				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?						0/0	0/0	0/0	0/0
5. Call Documentation: Did the CSR select the appropriate contact code(s)?						10	0	0	100%
Measure: Factor 2 Exceptions process									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did the CSR follow exception process?	10	10	0	0	100%	10	0	0	100%
3. Did the member agree to initiate exception process?						10	0	0	100%
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone?	10	10	0	0	100%	10	0	0	100%
5. Did CSR inform member of the next step after submitting the exception request?	10	9	1	0	90%	9	0	1	100%
6. Was the exception request submitted for the correct medication in Med Access system?	10	10	0	0	100%				
7. Was the exception request submitted correctly (standard vs expedited) per member's request?	10	10	0	0	100%				

8. Call Documentation: Did the CSR select the appropriate contact code(s)?						7	3	0	70%
Measure	**Total Sample**	**Accuracy Goal Met**			**% Accuracy Goal Met**	**Quality Goal Met**			**% Quality Goal Met**
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 3 Order a Refill for an existing prescription; SCHFP does not offer mail order services therefore this Factor NA.									
Measure: Factor 4 and 5 Location of in-network pharmacy, conducting a proximity search									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc.	10	10	0	0	100%				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code?						10	0	0	100%
4. If yes (question # 3), did CSR conduct a proximity search correctly per member's request?	10	10	0	0	100%				
5. Call Documentation: Did the CSR select the appropriate contact code(s)?						10	0	0	100%
Measure: Factor 6, 7, 8 Determining drug-drug interactions, common side effects, availability of generic substitutions									
1. Was the request initiated by member or member's rep?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
2. Did the CSR transfer request to Pharmacy Helpdesk?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Call Documentation: Did the CSR select the appropriate contact code(s)?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0

*Some questions related to both quality and accuracy and some related to one area or the other. If a cell is grey it does not relate to that area of review.

IV. Accuracy and Quality Analysis

SCFHP did not test the quality and accuracy of the ability for members to order a refill on an existing, mail-order prescription (Factor 3) because SCFHP does not offer a mail order service. This factor is not applicable for SCFHP. If Members wish to order from their in-network retail pharmacy by mail this is done with the retail pharmacy, if available.

For factor 1, 2, 4, 5, 6, 7 and 8, both accuracy and quality measures were audited. The greyscale in the tables indicate some questions were not required for accuracy and quality for some factors and were colored grey which are intentionally left unanswered.

Accuracy:

The measures for Factor 1, financial responsibility for a drug; Factor 4 and 5, location of in-network pharmacy and conducting a proximity search met the accuracy goal at 100%.

The following measures for Factor 2, exceptions process, met the accuracy goal of 100% in the area of Job Knowledge questions 2, 4, 6, and 7. For Job Knowledge question 5, 90% of the calls met the target goal. This is 10% below the target goal of 100%. For the plan of correction, the current job aid will be revised to include additional talking points for CSRs to cover with the member. One of the talking points will be to alert the member to the next steps after the submission of the exception request.

During the accuracy audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes Therefore, there is no data to report on Factor 6, 7 and 8.

Quality:

The measures for Factor 1 financial responsibility for a drug, met the quality goal at 100% for Job Knowledge questions 1, 2, and 5 as well as Call Documentation. None of the calls had an interaction in which CSR needed to educate the member that using a generic medication would lower member's financial responsibility since member have limited financial responsibility.

The measures for Factor 2, exceptions process, met the quality goal of 100% for Job Knowledge questions 1-5. Call Documentation for this factor met 70% of the target goal. For the plan of correction, the current job aid will be revised to include additional guidance in order to give CSRs the capability to choose the correct contact codes.

The measures for Factors 4 and 5, location of in-network pharmacies and proximity search, met the quality goal of 100% for Job Knowledge questions 1 and 3 as well as Call Documentation.

During the quality audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes. Therefore, there is no data to report on these factors.

Deficiencies:

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
Exceptions process (Factor 2, Job Knowledge # 5)	Accuracy: The CSR informs the member of the next step after submitting the exception request	The job aid will include additional talking points for CSRs to cover with the member.	November 30, 2018		
Exceptions process (Factor 2, Call Documentation)	Quality: The CSR selects the appropriate contact code to summarize the interaction.	The job aid will include additional guidance for CSRs to choose the correct contact codes.	November 30, 2018		

APPENDIX A

Audit Sheet #1

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 1. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 1 Financial Responsibility.

Factor 1 Financial Responsibility	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?				
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #2

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 2. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 2 Exceptions Process.

Factor 2 Exceptions Process	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR follow exception process? Accuracy: The CSR accurately follows and completes all applicable steps of the exception submission process. Quality: The CSR ensures that the member understands all steps of the exception submission process.				
3. Did the member agree to initiate exception process? Quality: The CSR obtains verbal acknowledgement from the member to initiate the exception process.				
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone? Accuracy: The CSR completes the exception process during the live call. Quality: The CSR confirms with the member that the exception request has been submitted during the live call.				
5. Did CSR inform member of next steps after exception request submission? Accuracy: The CSR informs the member of the next steps after submitting the exception request. Quality: The CSR verifies that the member understands the next steps after submitting the exception request.				
6. Was the exception request submitted for the correct medication in Med Access? Accuracy: The CSR correctly submits the exception request for the desired medication, dosage, etc.				
7. Was the exception request submitted correctly (standard vs expedited) per member's request? Accuracy: The CSR submits the request based on the member's request.				
Call Documentation	Y/N	N/A	Y/N	Y/N
8. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #3

Audit Sheet #3

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 3. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search.

Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc. Accuracy: The agent provides the name, address, phone number, and hours of operation for an in-network pharmacy when requested by the member.				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code? Quality: The CSR provides the name and details of a network pharmacy based on the member's desired zip code.				
4. If yes (question #3), did CSR conduct a proximity search correctly per member's request? Accuracy: The CSR provides a proximity search based on the member's desired location details, such as city or zip code.				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #4

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 4. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.

Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR transfer request to Pharmacy Helpdesk? Accuracy: The CSR transfers a request regarding drug-drug interactions, common side effects, or the availability of generic substitutes to the Pharmacy Help Desk as appropriate.				
Call Documentation	Y/N	N/A	Y/N	Y/N
Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selects the appropriate contact code to summarize the interaction.				

Santa Clara Family Health Plan
Personalized Information on Health Plan Services:
Website and Telephone Functionality - 2018 Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 5, 2018

I. Overview

In order to best serve our members, it is important for members to have the ability to easily obtain personalized health plan information.

Santa Clara Family Health Plan (SCFHP) has the responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. This includes the ability to request or reorder an SCFHP member ID card, to change primary care practitioners (PCPs), and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services.

SCFHP ensures the availability of this information by:

1) Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, member ID card requests, and the determination of services requiring a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization; if there is a copay and the amount of the copay for pharmacy benefits and to offer assistance including the ability to initiate an Organization Determination on behalf of a member.
2) SCFHP Website – Members may submit requests for SCFHP member ID cards and to change PCPs via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs to members.

II. Methodology

A. Via Telephone

Annually, SCFHP audits Customer Service telephone calls to and from members. The auditor (Customer Service Quality Manager) randomly selects 20 member contacts based on select call categories of member requested information on determining how and when to obtain referrals and authorizations for specific services or for information on costs for pharmacy services. The auditor assesses the call to determine whether the member was able to obtain answers to their inquiries in one session, without the need to contact the Health Plan another time. To determine the quality and accuracy of member inquiries, the auditor listens to the recorded call and reviews the CSR's call documentation for completeness. The audit is performed on an annual basis by collecting and assessing data on the

completion of an evaluation form (see Appendix A for Audit Sheet). Data included in this analysis was captured from May 1, 2018 through October 31, 2018.

SCFHP members do not have any financial responsibility for covered services as long as members follow the plan's rules such as receiving services within the SCFHP network or contracted providers.

B. Via Web

Customer Service receives confirmation through Microsoft Outlook when a member completes a request to reorder an ID card or change a primary care practitioner. A dedicated staff person in the Customer Service department checks the e-mail inbox intermittently throughout each business day to assure a timely response to the member. The staff responds to the members request and documents the request in the QNXT call tracking system using appropriate contact codes.

SCFHP audits requests received via the Health Plan website for turnaround times to identify opportunities for improvement. However, there were no requests for ID cards or PCP change during the look-back period in the past 6 months. The auditor uses the test account to check the accuracy and quality of how and when to obtain referrals and authorization for specific services.

Goals:

Accuracy: 100%

Quality: 100%

Table 1: Website- Accuracy of information provided for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% Goal Accuracy Goal Met
information is accurately showing if a referral and/or authorization is required for specific service			
1.The information on how and when to obtain a referral and authorization for medical services is populated correctly	5	5	100%
2. Information accurately reflect what services SCFHP would pay for and if there is any limits on the services	5	5	100%
3. Information accurately reflect what services are excluded or not covered by SCFHP	5	5	100%

Table 2: Website- Quality of information for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met
Information is legible, complete and allows the member to understand			
1. The link for the member handbook moves to the correct page	5	5	100%
2. Detailed instructions are provided on what chapter/section of the member handbook to refer to on how and when to obtain referrals and authorizations for specific services	5	5	100%

III. Data

Table 1: Telephone interactions: Accuracy of information provided is assessed for the following.

Evaluation Criteria	Total Sample	Accuracy Goal Met			% Accuracy Goal Met
Job Knowledge		Yes	No	N/A	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	18	1	1	94.7%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		Yes	No	N/A	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the CSR summarize accurately the service request or interaction in the data base system?	20	20	0	0	100%

Table 2: Telephone interactions: Quality of information is assessed for the following during accuracy review.

Evaluation Criteria	Total Sample	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		**Yes**	**No**	**N/A**	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system?	20	20	0	0	100%

III. Accuracy and Quality Analysis

A. Accuracy: Accuracy measures met the target goal of 100% for Job Knowledge evaluation criteria 1, 2 and 4 as well as Call Documentation criteria 1 and 2. For Job Knowledge evaluation criteria 3, accuracy measure met 94.7% which is 5.3% below the 100% target goal. During the audit of the telephone calls, in one of the calls, the CSR did not offer to initiate an Organization Determination for the member. It was noted that the CSR referred the member back to their treating physicians in order to have an authorization submitted for the specific services

The plan of correction involves retraining the CSR to provide the member the option to work with their physician or to have the CSR initiate an Organization Determination.

The current job aids will be updated to reflect this action step to improve upon the deficiencies, and all CSRs will attend a refresher training session for the authorization and referral inquiry handling process. The target date of completion is November 30, 2018.

Website: All of the website measures met the accuracy goal at 100%.

B. Quality: Quality measures met the goal at 100% of the target goal of 100% for both the Telephone and Website

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	Accuracy: The agent explains that they can initiate and submit an organization determination or the member can work with their provider to submit an authorization.	Updated job aid to include this instruction and re-training for all CSRs.	November 30, 2018		

APPENDIX A

Audit Sheet

Reviewed by: **Date Reviewed:** **QNXT call number:**

Call recording number:

Accuracy and Quality of Personalized Information on Health Plan Services over the telephone

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	**Call # Date**		**Accuracy Goal Met**	**Quality Goal Met**
Job Knowledge	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Was the inquiry initiated by the member or member's representative? Accuracy: The CSR confirmed who the caller was in relationship to the member. Quality: The CSR verified personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization? Accuracy: The CSR confirms whether or not the requested service requires an authorization. Quality: The CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service.				
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination. Accuracy: The CSR accurately explains how the member can obtain an authorization or referral. Quality: The CSR explains thoroughly how the member can obtain and offer to initiate an organization determination.				
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member? Accuracy: The CSR accurately provides list of network provider to the member Quality: The CSRs provides list of network provider and offer to schedule an appointment with network providers				

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Call # Date		Accuracy Goal Met	Quality Goal Met
Call Documentation	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Did the agent document call in the data base system and select appropriate contact code(s)? Accuracy: The agent used the correct contact code for the interaction. Quality: The agent did not use incorrect contact codes that do not pertain to the interaction.				
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system? Accuracy: The agent clearly documents all aspects of the interaction with the member. Quality: The agent's documentation is easy to understand by the auditor without the need for the auditor to listen to the call.				

Clinical Practice Guidelines 2018 Evaluation

Clinical and Preventative Guideline	Measure	CMC CY 2015 Baseline Rate	CMC CY 2016	CMC CY 2017	NCQA MA Benchmark	CY 2017 vs. Baseline CMC Comparison	MC CY 2015 Baseline Rate	MC CY 2016	MC CY 2017	NCQA MCAID Benchmark	CY 2017 vs. Baseline MC Comparison
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Test	89.54%	91.24%	91.73%	10th Percentile	0.02	86.37%	88.32%	88.32%	50th Percentile	0.02
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Poor	47.20%	32.85%	27.98%	25th Percentile	(0.19)	32.36%	37.23%	34.06%	75th Percentile	0.02
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - HbA1c Control	44.04%	55.96%	60.58%	25th Percentile	0.17	60.10%	53.77%	54.50%	75th Percentile	(0.06)
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - Eye Exam	53.28%	62.53%	72.26%	50th Percentile	0.19	51.90%	62.29%	63.02%	50th Percentile	0.11
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - Med Attn Neph	96.67%	91.97%	91.73%	<10th Percentile	(0.05)	85.64%	88.81%	86.62%	<10th Percentile	0.01
Diabetes Clinical Guidelines	Comprehensive Diabetes Care - BP <140/90	31.87%	59.61%	58.39%	10th Percentile	0.27	37.96%	59.37%	62.53%	50th Percentile	0.25
Hypertension Clinical Guidelines	Controlling High Blood Pressure	29.17%	60.10%	67.40%	25th Percentile	0.38	36.01%	66.91%	65.94%	75th Percentile	0.30
Behavioral Health Guidelines	ADD Initiation Phase						35.45%		36.80%	10th Percentile	0.01
Behavioral Health Guidelines	ADD C&M Phase						32.77%		40.19%	10th Percentile	0.07
Child and Adolescent Preventative Guidelines	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life						74.45%	73.97%	72.75%	50th Percentile	(0.02)
Child and Adolescent Preventative Guidelines	Childhood Immunization Status - Combo 3						72.02%	77.37%	77.62%	75th Percentile	0.06
Child and Adolescent Preventative Guidelines	Immunizations for Adolescents - Combo 1						79.56%		83.45%	50th Percentile	0.04
Prenatal Preventative Guidelines	Prenatal Postpartum Care - Timeliness of Prenatal Care						79.56%	82.48%	83.70%	50th Percentile	0.04
Prenatal Preventative Guidelines	Prenatal Postpartum Care - Post Partum Care						64.23%	68.61%	69.10%	50th Percentile	0.05

Santa Clara Family Health Plan
Member Experience, Including Behavioral Health: 2017 Analysis

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For review by the Quality Improvement Committee, December 5, 2018

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 CY2017, 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 Grievance and Appeals 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 2017 (January 1-December 31). 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:

- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and
- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category

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

Time Frame: January 1, 2017 - December 31, 2017						
Complaint / Grievance Category	**1Q-2017 /1000**	**2Q-2017**	**3Q-2017**	**4Q-2017**	**Total Grievances**	**Grievances / per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	4 *0.53*	3 *0.40*	11 *1.47*	7 *0.93*	25	3.341
Access	4 *0.53*	3 *0.40*	5 *0.66*	5 *0.66*	17	2.272
Attitude/Service	3 *4.14*	2 *3.07*	26 *4.47*	48 *6.41*	128	17.108
Billing/Financial	24 *3.20*	5 *0.66*	88 *11.76*	74 *9.89*	191	25.528
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	**63** ***8.42***	**34** ***4.54***	**130** ***17.37***	**134** ***17.91***	**361**	**48.249**

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 represents all member complaints/grievances and is not a sample. In 2017, the complaints/grievances analysis showed a significant increase in the second half of the year in two categories that did not met goal: Attitude/Service and Billing/Financial. Attitude and Service

increased by 55% with a result of 31 in the first quarter and a result of 48 in the fourth quarter. The Billing and Financial category had the largest increase and more than tripled over the course of the year with a result of 24 in the first quarter and a result of 88 and 74 in the third and fourth quarters respectively. In addition, Attitude/Service had a result of 17 per 1000 members for the year and Billing and Financial had a result of 25.5 per 1000 members. The remaining three categories, Quality of Care, Access, and Quality of Practitioner Site met goal with significantly lower numbers and remained flat throughout the year.

Table 2. CMS Member Appeal Categories

Time Frame: January 1, 2017 - December 31, 2017						
Appeals Category	**1Q-2017**	**2Q-2017**	**3Q-2017**	**4Q-2017**	**Total Appeals**	**Appeals/per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	43 *5.74*	37 *4.94*	56 *7.48*	143 *19.11*	279	37.289
Quality of Practitioner Office Site	0	0	0	0	0	0.000

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 2 is representative of all member appeals and is not a sample. In 2017, the appeals analysis showed a significant increase in the second half of the year in the following category: Billing/Financial. The Billing and Financial category more than tripled over the course of the year with a result of 43 in the first quarter and a result of 143 in the fourth quarter. In addition, the results indicate 37 appeals per 1000 members which does not met goal. The remaining four categories, Quality of Care, Access, Attitude/Service and Quality of Practitioner Site had results of zero appeals therefore met goal.

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 & 2)

SCFHP convened a Grievance and Appeals workgroup on October 3, 2018 that included interdepartmental representatives from the following departments Behavioral Health Case Management, Grievance and Appeals Operations, Compliance, Quality Improvement, Customer Service, and the Executive Team to conduct and review a root cause analysis of the increased number of Attitude/Service and Billing/Financial complaints/grievances and the Billing/Financial appeals.

In analyzing the Attitude/Service complaints/grievances the following root causes were determined for the increase:

- There was an increase in the number of transportation grievances from Yellow Cab. These complaints were related to not being picked up on time. In addition, because the Transportation Services Program expanded in 2017, there was a significant increase in opportunities for transportation related grievances.
- There were no other identified trends in the grievances received during Q4 2017. The concerns varied from the delay in processing authorizations to the attitude of Customer Service Representatives with SCFHP.

In analyzing the Billing/Financial complaints/grievances the following root cause was determined to be responsible for the Q3 2017 increase:

- Quest Diagnostics inappropriately balance billed SCFHP members for lab services. This was due to Quest Diagnostics misunderstanding of the Cal MediConnect line of business in that both the primary and secondary payment comes from SCFHP. This was corrected by working with the Provider Network Management and Customer Service Departments to relay the appropriate billing practices to Quest Diagnostic and resulted in a reduction of those cases in Q4 2017.

In analyzing the Billing and Financial appeals the following root causes were determined to be responsible for the increase:

- The Grievance & Appeals Department received a new body of work related to post-service claims denials. Effective 9/1/2017, claims reconsiderations transitioned from the Provider Dispute Resolution team to G&A, so these denials began being included in the counts of appeals
- Additionally, Cal MediConnect members started to receive Integrated Denial Notices related to claim denials. This notice includes information regarding a member's right to file an appeal on a denied payment and resulted in an increase of appeals

Behavioral Health Member Complaints/Grievances and Appeals

Table 3. Behavioral Health CMS Member Complaint/Grievance Categories

Time Frame: January 1, 2017 - December 31, 2017						
Behavioral Health Complaint / Grievance Category	**1Q-2017**	**2Q-2017**	**3Q-2017**	**4Q-2017**	**Total Grievances**	**BH Grievances/per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	0	0	0	0	0	0.000
Access	0	1 *0.13*	0	0	1 0.13	0.134
Attitude/Service	1 *0.13*	0	2 *0.26*	4 *0.53*	7 *0.93*	0.936
Billing/Financial	2 *0.26*	0	5 *0.66*	0	7 *0.93*	0.936
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	**3** ***0.40***	**1** ***0.13***	**7** ***0.93***	**4** ***0.53***	**15** ***2.00***	**2.005**

Quantitative Analysis: Behavioral Health Member Complaints/Grievances

SCFHP tracks and trends all member behavioral health 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 member and member representative initiated complaints from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those member records were reviewed to verify whether or not a complaint was filed. The data as shown in Table 3 represents all member behavioral health grievances/complaints and is not a sample. In 2017, the complaints/grievances analysis showed a result of zero complaints/grievances in the following categories: Quality of Care, and Quality of Practitioner Site. The remaining three categories: Access, Attitude/Service and Billing/Financial had low occurrences and remained flat throughout the year. All categories met goal.

Table 4. Behavioral Health CMS Member Appeals Categories

Time Frame: January 1, 2017 - December 31, 2017						
Behavioral Health Appeals Category	**1Q-2017**	**2Q-2017**	**3Q-2017**	**4Q-2017**	**Total Appeals**	**BH Appeals per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	0	0	0	0	0	0.000
Access	0	0	0	0	0	0.000
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	0	0	0	3 *0.401*	3	0.401
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	**0**	**0**	**0**	**3**	**3**	**0.401**

Quantitative Analysis: Behavioral Health Member Appeals

SCFHP tracks and trends behavioral health 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 member and member representative initiated appeals from a subset of the Cal MediConnect membership. Specifically, all members who utilized behavioral health services were identified, and those members were reviewed to verify whether or not an appeal was filed. The data as shown in Table 4 represents all member behavioral health appeals and is not a sample. In 2017, the behavioral health appeals analysis showed a result of zero appeals for the following categories: Quality of Care, Access, Attitude/Service and Quality of Practitioner Site. The Billing and Financial category had low occurrences throughout the year. All categories met goal.

2. Behavioral Health CMS Member Satisfaction Survey

Methodology:
SCFHP conducts an annual telephone, member satisfaction survey of Cal MediConnect members who receive behavioral health services. SCFHP identified all members that received behavioral health services between 12/01/2017 and 12/31/2017. The surveyor asked the member a total of 20 questions and recorded the answers in an on-line survey tool. A total of 230 members were identified and SCFHP staff attempted to reach each member via telephone to conduct the member satisfaction survey.

Quantitative Analysis: Behavioral Health Member Satisfaction Survey Results

The first 6 questions of the survey capture demographic information such as gender, age, race/ethnicity, and level of education **(Please See Figure 1).** Highlights and summarization of the demographic questions include:

- 57, or 25% of the 230 members identified completed the survey.
- The majority of non-responders did not participate because they never answered the phone.
- 24, or 10% of the total members contacted refused to participate in the survey.
- The majority of the respondents were female, over 55, White or Hispanic with an education above the high school level.

***Figure 1*. Behavioral Health: Member Satisfaction Survey Results (Questions 1-6)**

Sample Size	230
Completed Survey	57
Did not complete survey	173
% complete	25%

Gender:	
Male	22
Female	35

Age:	
18-34	0
35-54	11
55+	46

Race/Ethnicity:	
American Indian/Native Alaskan	0
Asian	6
Black/African American	7
Hispanic/Latino	14
Native Hawaiian/Pacific Islander	1
White/Caucasian	26
I prefer not to answer	3

Level of Education:	
Less than High School	6
High School/GED	19
Post-Secondary Education	14
College Graduate	18

Reason for not completing:	
Deceased	14
Would not answer phone	93
No working phone #	19
Member/PR Refused	24
Member/PR Incapable	11
Member Termed/Disenrolled	11
Other	1
Total	**173**

Questions 7-20 of the survey are related to the quality of care and are as follows:

Q7) How often did you get an appointment as soon as you wanted?
Q8) How often did you see someone as you wanted when you needed help right away?
Q9) How often did you get the help or advice you needed over the phone?
Q10) How often did your counselor show respect for what you had to say?
Q11) How often did your counselor explain things in a way that you could understand? -
Q12) How often did your counselor listen carefully?
Q13) How often did your counselor spend any time with you? -
Q14) How often did you feel comfortable raising issues or concerns? -
Q15) Compared to 12 months ago, how would you rate your ability to deal with daily problems? -
Q16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations? -
Q17) Compared to 12 months ago, how would you rate your ability to Accomplish the things you wanted to do?
Q18) Compared to 12 months ago, how would you rate your ability to deal with social situations? -
Q19) What effect has your counseling had on your symptoms and problems?
Q20) What effect has your counseling had on the quality of your life?

Highlights and summarization of the quality of care questions include:

For Questions 7-14 included in **Table 1** below:

- Question 9, "How often did you get the help or advice you needed over the phone?", had a significant number of negative responses with 19 members (33%) stating "never" as their answer.

Table 1	**Never**	**Sometimes**	**Usually**	**Always**	**Total**
7) How often did you get an appointment as soon as you wanted?	3	6	17	31	57
8) How often did you see someone as you wanted when you needed help right away?	3	12	13	29	57

9) How often did you get the help or advice you needed over the phone?	19	12	9	17	57
10) How often did your counselor show respect for what you had to say?	2	5	7	43	57
11) How often did your counselor explain things in a way that you could understand?	3	3	11	40	57
12) How often did your counselor listen carefully?	0	6	9	42	57
13) How often did your counselor spend any time with you?	2	8	11	36	57
14) How often did you feel comfortable raising issues or concerns?	0	7	6	44	57

For Questions 15-18 included in **Table 2** below:

- Question 15, "Compared to 12 months ago, how would you rate your ability to deal with daily problems?", had the lowest result with 12 members stating their answer as "much worse" or "a little worse".

Table 2						
	Much Worse	**A Little Worse**	**About the Same**	**A Little Better**	**Much Better**	**Total**
15) Compared to 12 months ago, how would you rate your ability to deal with daily problems?	4	8	8	15	22	57
16) Compared to 12 months ago, how would you rate your ability to deal with crisis situations?	1	3	16	15	22	57
17) Compared to 12 month ago, how would you rate your ability to accomplish the things you wanted to do?	2	6	12	23	14	57
18) Compared to 12 months ago, how would you rate your ability to deal with social situations?	3	2	17	16	19	57

For Questions 19 and 20 included in **Table 3** below:

- Question 19, "What effect has your counseling had on your symptoms and problems?", and Question 20, "What effect has your counseling had on the quality of your life?", most members answered positively with either "a little" or "much better" as their response.

Table 3					
	A Little or Very Harmful	**Not Helpful or Harmful**	**A Little Helpful**	**Very Helpful**	**Total**
19) What effect has your counseling had on your symptoms and problems?	1	2	24	30	57

20) What effect has your counseling had on the quality of your life?	0	5	18	34	57

SCFHP will use 2017 data as a baseline result. 2018 data will be compared to 2017 to identify trends and areas that need improvement.

3. Reporting

Committee Approval

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee		

Santa Clara Family Health Plan™

Member Satisfaction with Complex Case Management: 2018 Analysis

Quality Improvement Committee: December 5,2018

Author: Shawna Cagle, Manager, Case Management

Introduction

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with the Complex Case Management (CCM) Program to ensure adequate satisfaction with program goals is achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and member complaint categories related to the CCM program. This analysis allows the organization to formulate an action plan addressing low member satisfaction with (CCM) functions within SCFHP.

Member Satisfaction with CCM Processes

SCFHP measures member satisfaction with the CCM program through annual monitoring of complaints from members related to CCM processes and through the performance of a member satisfaction survey. All members enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of case management (CM) services. Each survey will have specifically identified look-back periods, specific questions/data elements and noted and will adhere to specific timeframes in which the outreach for each survey will be conducted. Surveys will be conducted via telephonic outreach to members. SCFHP will conduct an annual analysis of all member survey data.

Complex Case Management (CCM):

1. All members enrolled in CCM for 60 days or more will be included in the survey sample
2. All members who participated in CCM will be provided an opportunity to complete a Satisfaction Survey
3. CCM survey data will be collected from those who choose to participate
4. CCM survey data will be compiled and analyzed at least once during the look back period to support Population Health Impact Analysis
5. CM survey data will be published annually in April

Methodology

SCFHP CMC members who were enrolled in CCM for 60 days or more were provided telephonic outreach by CM care coordination staff not directly involved in their care. Survey responses were collected on an ongoing basis since the CCM program officially launched June 1, 2018. Case Management staff conducted two telephone outreach calls for each qualified member. Feedback data was documented in, and reported from, the CM software platform Essette. Answers to questions are scored on a 0-5 scale (0 = refused to answer and 5 = strongly agree, with highest score possible is 44.) Ten members were contacted, seven members completed the survey, and three members were unable to be contacted. The overall response rate was 70%.

Overall goal is to have members respond "agree" or "strongly agree" for questions 1-8 and "satisfied" or "very satisfied" for question 9 for a total score of 35 or better or 90% overall satisfaction. Members were also encouraged to provide comments and feedback. Members had the right to refuse to participate in all or parts of the survey.

The below table shows how the survey questions meet the intent of PHM 5 Element F by showing a crosswalk between the question and the NCQA requirement:

Factor 1: Analyzing member feedback	
NCQA survey content requirements	**Question Mapping**
Information about the overall program	12) Overall, how satisfied are you with the Case Management Services you received?
The program staff	4) My case manager treated me with respect. 5) My case manager listened to what I had to say. 6) My case manager returned my phone calls in a timely manner.
Usefulness of the information disseminated	9) I better understand my disease or condition after being in the complex case management program. 8) My case manager involved me in discussing and planning my care. 7) My case manager helped me find the services that I needed.
Member's ability to adhere to recommendations	10) I am able to better manage my health and health care after being in the case management program.
Percentage for members indicating that the program helped them achieve health goals.	11) My situation is better because of my case manager's help.

Results

	Strongly Agree		Agree		Not Sure		Disagree		Strongly Disagree		Refused To Answer	Sample Size	90% Goal Met
	N	%	N	%	N	%	N	%	N	%	N		
My case manager treated me with respect.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager listened to what I had to say.	5	71%	2	29%	0	0%	0	0%	0	0%	0	7	Y
My case manager returned my phone calls in a timely manner.	6	86%	1	14%	0	0%	0	0%	0	0%	0	7	Y
My case manager helped me find services that I needed	5	71%	0	0%	2	29%	0	0%	0	0%	0	7	N
I better understand my disease or condition after being in the case management program.	4	57%	1	14%	1	14%	1	14%	0	0%	0	7	N
I am able to better manage my health and health care after being in the case management program.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
My situation is better because of my case manager's help.	3	43%	2	29%	1	14%	1	14%	0	0%	0	7	N
	Very Satisfied		Satisfied		Somewhat Satisfied		Not at all satisfied		Refused to Answer				
Overall, how satisfied are you with the Case Management Services you received?	5		1		1		0		0			7	Y

Member Complaints Related to the CCM Program

The process for measuring member CCM complaints is through the Grievance and Appeals (G&A) department. Grievances files by members regarding the CCM Program are flagged "CCM" and reported directly to Case Management Department Leadership. CM Leadership works directly with G&A to resolve the grievance. CCM grievances are measured and reported annually. To date there have been (0) grievances for CCM services. The low volume is most likely due to the recent official implementation date of the CCM program in June of 2018 and the relatively low, but growing, volume of consenting enrollees.

Analysis

SCFHP sets performance goals for each measure and through the analysis process, identifies opportunities to improve member satisfaction with the CCM process. 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 to achieving the performance goal. The process incorporates opportunities and interventions to address the root cause.

a. Quantitative analysis

In conclusion, 100% of members stated they were overall satisfied or somewhat satisfied with the CCM Program, resulting in meeting the 90% goal for this measure.

- 100% percent of members believe that their assigned case manager treated them with respect and listened to what they had to say.
- 100% of members felt their assigned case manager returned phone calls in a timely manner.
- 71% of member believe that their case manager helped them find the services they needed. 29% stated they were unsure.
- 71-72% of members responded that they better understand their disease or condition, are better able to manage their health and their situation is better because of their case mangers help. 14% were not sure, and another 14% disagreed.

b. Qualitative analysis

- SCFHP did not meet the 90% performance goal in four areas:
    1. Help in finding services needed (71%)
    2. Increased understanding of the members' condition (71%)
    3. Improved ability to manage own health (72%)
    4. Improved overall health situation (72%)
- However, in areas 2-4, only one person answered that they "Disagreed". In area 1, two people answered "Not Sure" which equated to 28% of
- Although a small number of people surveyed expressed satisfaction, the performance rates indicate possible areas of improvement within the CCM program
- The survey data was presented and discussed at the Quality Improvement Committee (QIC) on October 10, 2018. The QIC was attended by multiple internal staff (representing Case Management, Quality Improvement, Provider Network Management and Compliance) as well as external physicians. The group discussed the four categories where the performance goal was not met. One issue was noted with the survey format, in which not all members can be reached telephonically and the survey content was not specific enough to evaluate areas of the program that need improvement. The 2019 survey will be updated to include more specificity and detailed questions. The CM team will also implement a paper/mailed survey. The group also noted that one member disagreed that they were better able to understand their disease and/or condition at the end of the program. It was noted that the Case Management team should evaluate the way in which they provide members information about their condition, including health education and other resource materials. This opportunity was selected for 2019 and the case management team will work to ensure trainings are scheduled for case management staff to review available materials and reinforce processes for educating members.

Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
Members do not understand their condition well enough and are not satisfied with the services provided because of inadequate provision of tools and materials assisting the member in self-management	Case Managers will have access to Health Education materials and resources that can be made available to Member and/ or Caregiver	Provide ongoing training to CCM Case Management Staff on health education materials, resources, and free/low-cost community programs available to members.	Y	January 2019
Not all members eligible to complete the Survey were reached by phone.	To format the survey into a paper questionnaire that can be mailed to the member.	Create a CCM Experience Survey document that can be mailed to the member directly through the Case Management Platform (Essette) Correspondence module.	Y	January 2019
Current survey questions lack enough detail to evaluate specific program areas that need improvement	Revise survey questions to identify specific areas of case management support member feel they need.	Configure additional questions within the current CCM Survey Assessment in Essette.	Y	January 2019

Member Satisfaction with the CCM Process Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	December 5, 2018	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Health Homes Program**	**Policy No.:**	QI.28
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	× Medi-Cal	□ Healthy Kids	□ CMC

I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

II. Policy

SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports
- Housing Navigation

I. SCFHP Responsibilities:

a. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified
b. Ensure that the CB-CME has the capacity to provide assigned HHP members with a multi-disciplinary care team

i. SCFHP will encourage participation of member care team members who are not on the multi-disciplinary care team (such as a member's PCP or Specialist)

c. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
   i. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
   ii. SCFHP will share each member's health history with assigned CB-CMEs
   iii. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process

d. Identify, review and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
   i. Identify members through the DHCS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
   ii. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed

e. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g., Whole Person Care)

f. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP

g. Develop and administer payment structure for CB-CMEs
   i. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding

h. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

II. **CB-CME Responsibilities**

a. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
   i. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide

b. Complete a readiness assessment as developed by SCFHP
   i. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps prior to enrolling members

c. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements

d. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate

e. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
   i. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination
   ii. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools

f. Maintain a multi-disciplinary care team to provide outreach and enrollment
   i. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
   ii. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP

g. Utilize existing health information technology (HIT) to collect and share data to SCFHP
   i. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes

h. CB-CME will attend required trainings for the HHP
i. CB-CME may utilize community health workers to conduct outreach and other services as appropriate

I. References

- Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide.* Sacramento, CA
- Department of Health Care Services. (2018). *All Plan Letter 18-012.* Sacramento, CA: Managed Care Quality and Monitoring Division.
- Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions.* Sacramento, CA: Marjorie Swartz.

II. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
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	Quality Improvement Committee		

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: October 3, 2018

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	17	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	16	
Number practitioners recredentialed within 36-month timeline	16	
% 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 09/30/2018	247	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
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	1381	1041	714	758	398	117

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.

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

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.

Santa Clara Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, June 21, 2018
6:00 PM - 8:00 PM
210 E. Hacienda Avenue Campbell, CA 95008

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	Y
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	N
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	Y
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Lily Boris, MD	SCFHP Medical Director	N
Caroline Alexander	SCFHP Administrative Assistant, Medical Management	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:07 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	
	The SCFHP 1Q2018 P&T Minutes from March 15, 2018 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 1Q2018 P&T Minutes from March 15, 2018 were approved as

		submitted and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	Health Plan Updates Dr. Robertson presented the Health Plan Updates. Santa Clara Family Health Plan is moving to the new building on 50 Great Oaks in July. Discussion was had and a vote taken regarding Pharmacy Committee meeting time on a move forward basis in the new building. Proposed start meeting at 6:30 p.m. or continue to meet at 6 pm. Committee voted and it was unanimous to continue meeting at 6 p.m. Health Plan is busy working towards NCQA accreditation. Review period started June 1st. Site visit will take place in February.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q1 2018. There was a spike in Medi-Cal appeals from December 2017 to January 2018. Q1 2018 58% overturn rate, 23% upheld, 11% partially favorable, 7% withdrawn, and 1% dismissed. For CalMediConnect (CMC), Q12018 Part C&D appeals slight increase from January 2018 to March 2018. Redeterminations Q1 2018, 70% overturned, 27% upheld, 3% partially favorable, 0% dismissed.	
	SCFHP Global DUR Dr. Liu presented and update on Global DUR. Streamlined requirements for managed Medi-Cal plans. Retrospective DUR of opioids. Concomitant use of anticholinergics and antipsychotics. Will present at Pharmacy Committee to share updates.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:30 p.m. to discuss the following items: Membership Report, Pharmacy Dashboard, Drug Use Evaluation Results, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect Formulary and Prior Authorization Criteria, Recommendations for changes to Medi-Cal and Healthy Kids Formulary and Prior Authorization Criteria, DHCS Medi-Cal CDL Updates & Comparability, Prior Authorization Criteria and New Drugs.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Robertson presented the membership report.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard.	

Santa Clara Family Health Plan

	Drug Utilization & Spend Review Dr. McCarty presented the Drug Use Evaluation Results.	
	Drug Utilization & Spend Review Dr. McCarty presented the Spend and Trend Overview.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 1Q2018 P&T minutes as well as the MedImpact 2Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 1Q2018 P&T Minutes, and MedImpact 2Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting.	Upon motion duly made and seconded, formulary modifications were approved as presented.
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented DHCS Medi-Cal CDL Updates & Comparability.	
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: 1. Diabetic Supplies 2. Androgel 3. Humira 4. Enbrel	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
	New Drugs and Class Reviews Dr. McCarty presented the following new drug reviews: 1. Aimovig 2. Erleada 3. PCSK9 Inhibitors Line Extensions: 1. Noctiva 2. Sinuva 3. Sublocade 4. Lonhala Magnair	Upon motion duly made and seconded, all recommendations were approved as presented.

	5. Firvanq 6. Bonjesta 7. Zypitamag	
	Reconvene in Open Session Committee reconvened to open session at 7:50 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 1Q2018. High impact drugs: Symdeko, Erleada, Trogarzo, Ilumya, Andexxa, Aimovig, Epidiolex, baricitinib, lorlatinib, Nuvaring, Adcirca, Remodulin, Letairis, Ampyra, Cialis, Tracleer, Kaletra and medium/low impact drugs: Delzicol, Onexton, Zortress, Acanya, Levitra, Androgel, Moviprep, Flector, Proventil HFA, Rapaflo.	
9	**Adjournment at 7:55 PM**	

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 17, 2018

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	N
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	N
Sherry Holm	Behavioral Health Director	N

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the July 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. CEO Update	Dr. Robertson presented the CEO update. The health plan moved to new location on July 30th. Participated in CMS audit, now working on corrective actions. New Chief Medical Officer Laurie Nakahira starts on October 31st.	
V. Old Business/Follow up items	Ms. Castillo presented some follow up items from the July 18th UM committee meeting. Presented authorization data for gastric bypass as well as criteria for gastric bypass. Six authorizations were pulled for date range of June 1st to August 31st of 2018. Age range of members ranged from 26 to 59 years of age, BMI ranged from 39 to 63. Reviewed guidelines for Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy as well as with Gastric Bypass.	No action required.
VI. Action Items	a. Prior Authorization Grid approval Ms. Castillo presented the 2019 Prior Authorization Grid. New grid combines all lines of business. Created a separate grid for medications (2019 Medical Benefit Drug Prior Authorization Grid). b. UM Program Evaluation 2017 Cal MediConnect Ms. Castillo presented the 2017 UM Program Evaluation for Cal MediConnect. Santa Clara Family Health Plan evaluates its Utilization Management (UM) Program annually to determine their overall effectiveness, identify needed improvements, and assess progress toward improvement of annual goals. The annual evaluation is also used to identify goals, trends, work plan activities, and opportunities for improvement in the coming year. SCFHP has a UM Program that objectively monitors and evaluates appropriate UM services delivered to members which operates with the principles outlined in the program. The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage.	Approved as presented. Approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	The 2017 UM program evaluation resulted in program changes. The UM program and UM policies were described to have it available for members and providers, the UM staff description was updated as staffing changes and expansion were implemented in mid-2017, Practitioner and member satisfaction monitoring were included, and Behavioral Health staff involvement was defined. These changes are outlined in the 2018 Program description. They are made to meet regulatory requirement and to ensure effectiveness of the program structure. UM continues to strive to meet regulatory requirements that are written in the 2018 UM Program description and to meet goals described in the 2018 UM work plan a. Membership Dr. Robertson presented the update on membership. As of October, membership is at 255,311. Membership remains flat. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.5% of compliance for routine requests, 98.7% compliant for expedited/urgent requests, 96.8% compliant for retro requests. For Medi-Cal line of business, 98.7% compliant for routine, urgent 99.4 %, retro 99.3%. Have implemented outbound calls to members and providers. Call member and inform them authorization is approved, fax provider immediately with letter and follow up with a call. ii. Standard Utilization Metrics Data is for July 1, 2017 to June 30, 2018. For MediCal/non SPD, discharges per thousand is at 3.68, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 11.82. Average length of stay 4.83. For CMC population 6.11 days average length of stay. Discharges per thousand 267.7. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is less than 50% percentile ranking for average length of stay. Medi-Cal SPD's 141.9 discharges per thousand, CMC is at 262.7 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 6.11 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 15.57%. SPD Inpatient Readmissions for Medi-Cal overall average of 21.71%. Readmissions on CMC at 16.5%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 24.01%; Ages 65+	

ITEM	DISCUSSION	ACTION REQUIRED
	readmission rate of 13.52%. For age 18 to 64, greater than 90th percentile ranking, age 65+, greater than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures have ranged where they have been. c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q3 18) Ms. Castillo presented the Q3 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 3nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 3nd Quarter review of 2018, the findings are as follows: A. For the dates of services and denials for July, August and September of CY 2018 were pulled in the 3rd quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB ii. Of the sample 100% or 30/30 were denials iii. Of the sample 40% or 12/30 were expedited request; 60% or 18/30 were standard request. 1. 100% or 12/12 of the expedited authorizations met regulatory turnaround time of 72 calendar hours 2. 89% or 16/18 of the standard authorizations met regulatory turnaround time, 11% or 2/18 are non-compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB) iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials v. 93% or 28/30 of cases were denied by MD, 7% or 2/30 cases were denied by a pharmacist vi. 100% or 30/30 were provided member and provider notification. vii. 58% or 7/12 expedited authorizations were provided oral notifications to member. viii. 83% or 25/30 of the member letters are of member's preferred language. ix. 100% or 30/30 of the letters were readable and rationale for denial was provided. x. 97% or 29/30 of the letters included the criteria or EOC that the decision was based upon.	

ITEM	DISCUSSION	ACTION REQUIRED
	xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Monitor other causes of untimeliness such as FDRs and escalate it to compliance. • Provide staff training in checking member's preferred language when sending member's UM letters. • Continue QA monitoring and reporting. d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q318. Not much claims authorization activity in August. Do a 3 month look back. 56.8% of authorizations have matched a claim for Cal Medi-Connect line of business. 55% of authorizations have matched a claim for Medi-Cal line of business. Do outbound calls to members to find out why the appointment was never attended or scheduled. Present to UM committee the findings. Dr. Tobaggi asked if there are members complaining they are not getting appointments and why we are doing these statistics. Dr. Boris explained DMHC requested data. e. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 942 calls, Healthy Kids 15 calls, Cal MediConnect calls 45 during the third quarter of 2018 (September 2018 data not yet received). For Medi-Cal 31 triage dispositions rendered to call 911/EMS immediately. For Cal MediConnect, 4 triage dispositions were rendered to call 911/EMS immediately. For Health Kids, no triage dispositions rendered to call 911/EMS immediately. Highest volume for Triage Guidelines used for call types: Medi-Cal-CareNet Health Information only, Abdominal/Pelvic Pain, Abnormal vaginal bleeding, urinary symptoms (female), allergic reactions	

ITEM	DISCUSSION	ACTION REQUIRED
	Healthy Kids-CareNet Health Information only, Bites, Stings, Rash/Hives, Nasal allergies, Eye pus or discharge Cal MediConnect- CareNet Health Information only, BP Control problems, Insect bites/stings f. Interrater Reliability (Medical & Behavioral Health Q3) Twice a year staff is tested. Results are presented to UM Committee. For UM staff only 3 of 21 staff did not pass with score of 80% or higher. Most common reason was improper identification of required turnaround time for specific lines of business. Also lack of understanding for specific Care Coordinator guidelines and improper selection and application of clinical guidelines for medical review. The corrective action's plan after identifying the common findings are: • Mandatory remedial training and with retest for staff that were found non proficient within 1 month of the IRR test. Completed on 10/5/2018. • Continued training to all UM and MLTSS staff for all UM process and workflows to comply with regulatory standards. • UM management weekly monitoring as outlined in UM procedure and quarterly report to UM committee. Summary of the IRR remedial training: Attendees: All staff that were found non proficient in the IRR testing (1 coordinator and 2 licensed staff). Discussion topics: • Identification of lines of business • Regulatory turnaround time based on line of business • Care Coordinator Guidelines • UM Policy and procedure for Hierarchy of clinical criteria • Selection and application of clinical criteria, specifically MCG Retesting: 3 recreated hypothetical cases Scoring and passing score follows the same procedure as the IRR testing. All 3 staff that attended the remediation were re-tested and were found proficient. For behavioral health staff, 1 out of 3 staff did not pass with score of 80% or higher. Personal Care coordinator (PCC) was provided additional training on 9/27/18 and passed the re-test with a score of 90%. Retest was provided on 9/28/18. Findings were staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go for	

ITEM	DISCUSSION	ACTION REQUIRED
	clarification. While ongoing support throughout the department is provided, additional training is required for new PCC to review process of authorizations. This training was provided on 9/27/2018 and retesting completed on 9/28/2018. The corrective action's plan after identifying the common findings are: • Mandatory remedial training with post testing for all non-proficient staff • Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled for all staff who complete Behavioral Health Authorizations.	
VIII. Behavioral Health UM Reports	Dr. Boris presented the Dashboard Metrics reports for Behavioral Health. Divided by lines of business. For CMC line of business, at 100% of compliance for routine requests, 100% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 95.3% compliant for routine, urgent 85.7 %, retro 98.8%. Have implemented outbound calls to members and providers.	Pull 6 months of data for LTSS and present at next UM committee meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Adjournment	Meeting adjourned at 7:30 PM	

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, January 16, 2019, 6:30 PM	

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

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 Health 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-filing 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 13, 2018 by the following vote:

AYES:

NOES:

ABSENT:

Signed: _____
Chair

Attest: _____
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	2
Chief Operating Officer	2
Chief Medical Officer	2
Chief Information Officer	2
Chief Compliance and Regulatory Affairs Officer	2
Director of Provider Network Management	6
Director of Infrastructure and System Support	4
Director of Quality and Pharmacy	6
Medical Director	6
Consultant	7
Newly Created Position	*

*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.

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Four Months Ended October 31, 2018

Agenda

Santa Clara Family Health Plan

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Financial Highlights

	MTD		YTD	
Revenue	$86 M		$336 M	
Medical Expense (MLR)	$82 M	94.3%	$317 M	94.5%
Administrative Expense (% Rev)	$4.9 M	5.6%	$18.8 M	5.6%
Other Income/(Expense)	$243,171		$629,378	
Net Surplus (Loss)	**$250,495**		**$248,141**	
Cash on Hand			$210 M	
Net Cash Available to SCFHP			$202 M	
Receivables			$507 M	
Total Current Assets			$726 M	
Current Liabilities			$578 M	
Current Ratio			1.26	
Tangible Net Equity			$178 M	
% of DMHC Requirements			**506.2%**	

Financial Highlights

Net Surplus (Loss)	▶ Month: Surplus of $250K is $174K or 41.0% unfavorable to budget of $424K. ▶ YTD: Surplus of $248K is $433K or 63.6% unfavorable to budget of $681K.
Enrollment	▶ Month: Membership was 255,311 (318 favorable to budget of 254,993). ▶ YTD: Member months were 1,027,195 (454 favorable to budget of 1,026,741).
Revenue	▶ Month: $86.5M ($5.6M or 6.9% favorable to budget of $80.8M) ▶ YTD: $335.7M ($11.5M or 3.5% favorable to budget of $324.3M)
Medical Expenses	▶ Month: $81.6M ($5.9M or 7.8% unfavorable to budget of $75.7M). ▶ YTD: $317.3M ($13.4M or 4.4% unfavorable to budget of $303.9M).
Administrative Expenses	▶ Month: $4.9M ($0.2M or 4.3% unfavorable to budget of $4.7M). ▶ YTD: $18.8M ($0.6M or 3.0% favorable to budget of $19.4M).
Tangible Net Equity	▶ TNE was $178.3M (506.2% of minimum DMHC requirements of $35.2M)
Capital Expenditures	▶ YTD Capital Investment of $4.4M was primarily due to building renovation work.
Ratios	▶ MTD MLR at 94.3% compared to budget of 93.6%. ▶ MTD ALR at 5.6% compared to budget of 5.8%.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Since June 2018, total enrollment has decreased by 4,164 members.
- As detailed on page 14, much of the Medi-Cal Non-Dual enrollment decline has been in the Child, Medicaid Expansion (MCE), and Adult categories of aid. Medi-Cal Dual enrollment has stabilized while CMC enrollment has grown due to outreach efforts. Since March 2018, non-dual LTC enrollment has increased by 33% to 471 members.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the end of FY18 by 1.7%.
  - CMC membership has increased since the end of FY18 by 1.3%.
  - Healthy Kids membership has increased since the end of FY18 by 0.7%.

	For the Month of October 2018			For Four Months Ending October 31 2018				
	Actual	Budget	Variance	Actual	Budget	Variance	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	244,493	244,504	-(0.0%)	984,086	984,965	-(0.1%)	1,046,481	-(6.0%)
Healthy Kids	3,217	2,894	11.2%	12,845	11,636	10.4%	9,782	31.3%
CMC	7,601	7,595	0.1%	30,264	30,140	0.4%	29,639	2.1%
Total	**255,311**	**254,993**	**0.1%**	**1,027,195**	**1,026,741**	**0.0%**	**1,085,902**	**-(5.4%)**

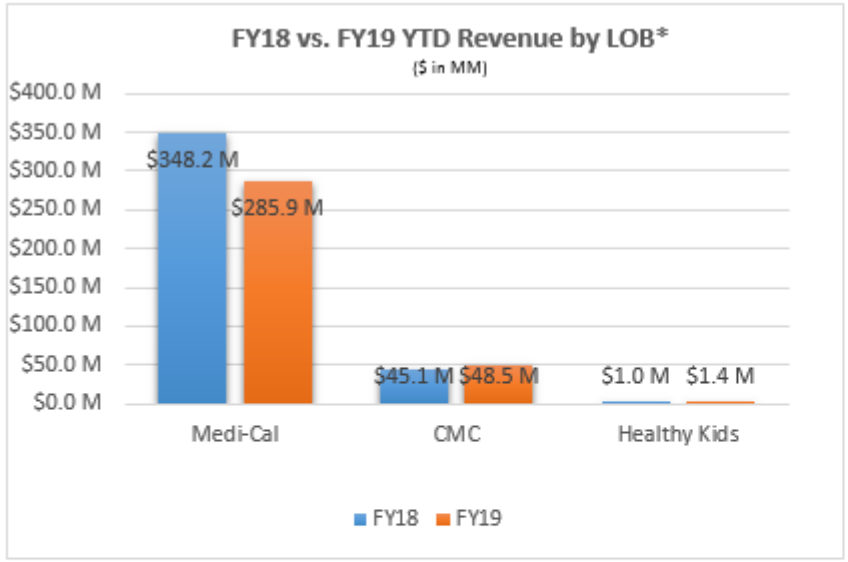
Santa Clara Family Health Plan Enrollment By Network
October 2018

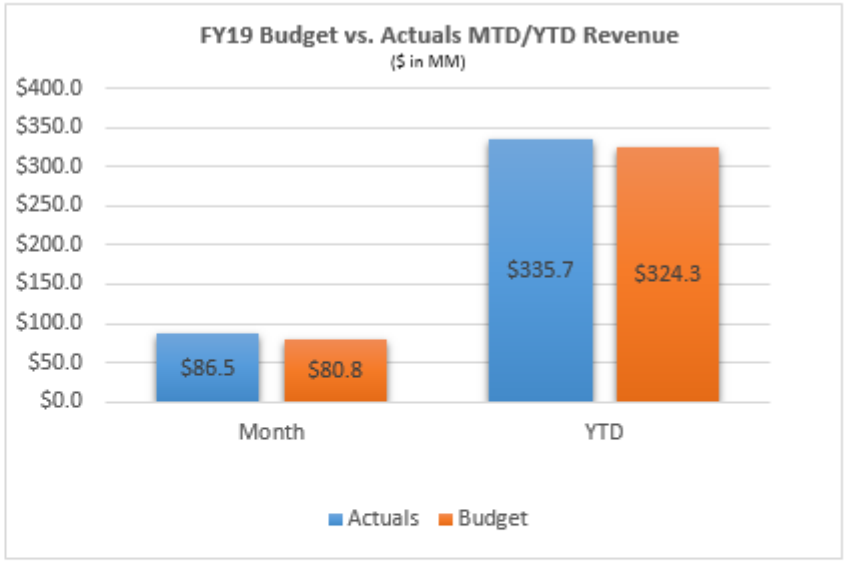
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	29,707	12%	338	11%	7,601	100%	37,646	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	122,123	50%	1,404	44%	-	0%	123,527	48%
Palo Alto Medical Foundation	7,133	3%	97	3%	-	0%	7,230	3%
Physicians Medical Group	44,553	18%	1,144	36%	-	0%	45,697	18%
Premier Care	15,176	6%	234	7%	-	0%	15,410	6%
Kaiser	25,801	11%	-	0%	-	0%	25,801	10%
Total	**244,493**	**100%**	**3,217**	**100%**	**7,601**	**100%**	**255,311**	**100%**
Enrollment at June 30, 2018	248,776		3,196		7,503		259,475	
Net Δ from June 30, 2018	-1.7%		0.7%		1.3%		-1.6%	

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

Revenue

- Current month revenue of $86.5M is $5.6M or 6.9% favorable to budget of $80.8M. YTD revenue of $335.7M is $11.5M or 3.5% favorable to budget of $324.3M. The current month variances were due to a variety of factors, including:
  - Revised estimate of CMC and MLTSS calendar year revenue of $3.8M.
  - Unbudgeted pass-through revenue of $1.6M.
  - Mix of members between programs and within the Medi-Cal categories of aid.





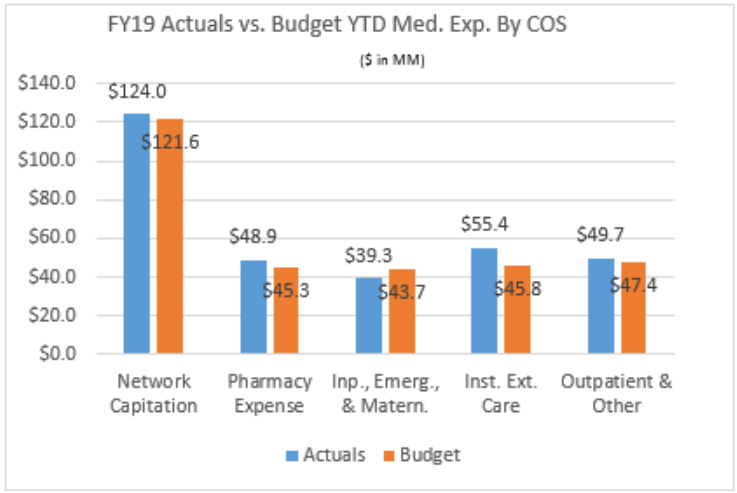
	FY18 vs. FY19 YTD Revenue by LOB*			
	FY18	FY19	Variance	
Medi-Cal	$348.2 M	$285.9 M	($62.3 M)	-17.9%
CMC	$45.1 M	$48.5 M	$3.4 M	7.6%
Healthy Kids	$1.0 M	$1.4 M	$0.4 M	37.9%
Total Revenue	**$394.3 M**	**$335.7 M**	**($58.5 M)**	**-14.8%**

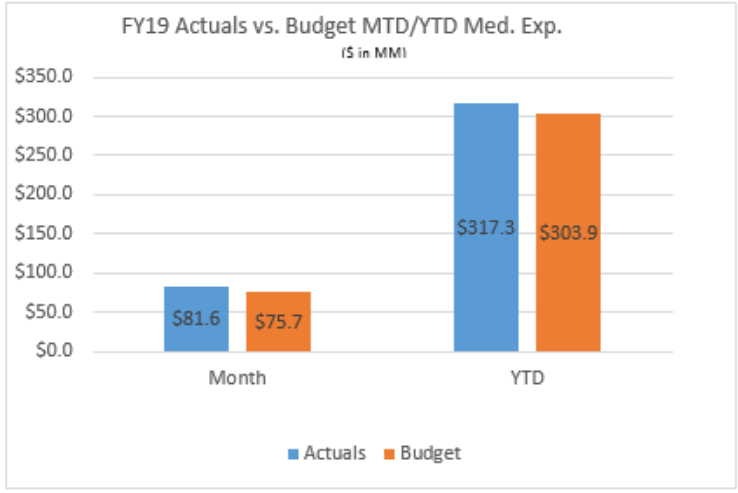
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$86.5	$80.8	$5.6	6.9%
YTD	$335.7	$324.3	$11.5	3.5%

*IHSS was included in FY18 revenue through 12/31/17

Medical Expense

- Current month medical expense of $81.6M is $5.9M or 7.8% unfavorable to budget of $75.7M. YTD medical expense of $317.3M is $13.4M or 4.4% unfavorable to budget of $303.9M. The current month variances were due to a variety of factors, including:
  - Increased Inpatient, Specialist Services, and LTC expenses contributed to the unfavorable variance versus budget.
  - Pharmacy costs exceed budget by $3.6M due to an increased utilization of insulin products, oral cancer agents, and biologics, an increase in scripts/1,000, and a decrease in generics use.
  - Increased estimates for prior period medical expenses and higher emerging trends.





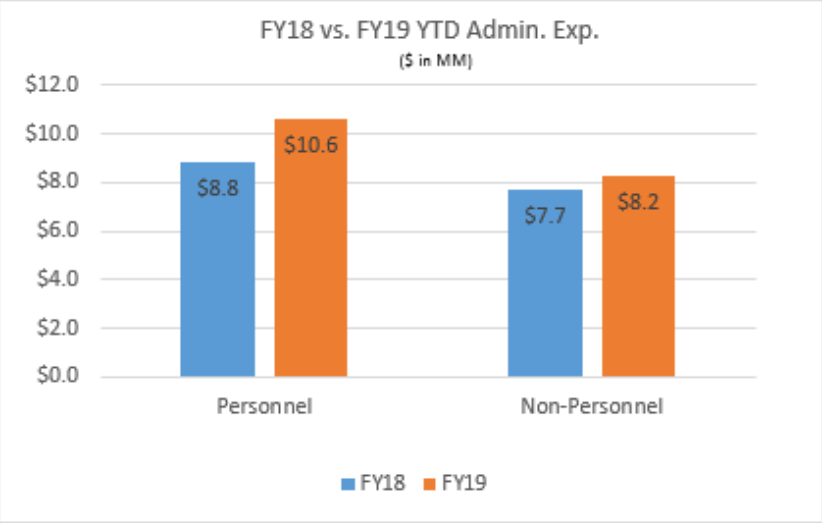
	FY19 Actuals vs. Budget YTD Med. Exp. By COS			
	Actuals	Budget	Variance	
Network Capitation	$124.0	$121.6	-$2.4	-2.0%
Pharmacy Expense	$48.9	$45.3	-$3.6	-7.9%
Inp., Emerg., & Matern.	$39.3	$43.7	$4.4	10.1%
Inst. Ext. Care	$55.4	$45.8	-$9.6	-20.9%
Outpatient & Other	$49.7	$47.4	-$2.3	-4.8%
Total Medical Expense	**$317.3**	**$303.9**	**-$13.4**	**-4.4%**

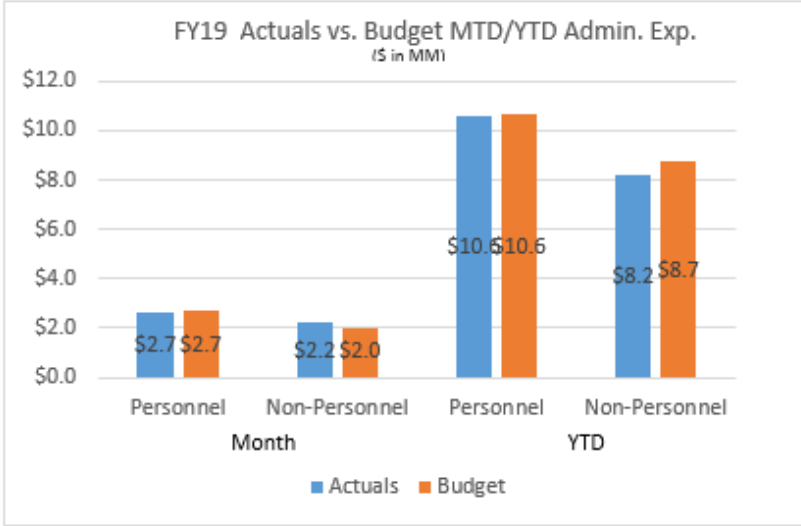
	FY19 Actuals vs. Budget MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$81.6	$75.7	-$5.9	-7.8%
YTD	$317.3	$303.9	-$13.4	-4.4%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $4.9M is $203K or 4.3% unfavorable to budget of $4.7M. YTD admin expense of $18.8M is $0.6M or 3.0% favorable to budget of $19.4M.
  - MTD and YTD Personnel Expenses are at budget.
  - Consulting and temp staff expenses have seen an increase due to CMC program and data validation audits.
  - YTD Postage and printing expenses are unfavorable due to timing of expenses.





	FY18 vs. FY19 YTD Admin. Exp.			
	FY18	FY19	Variance	
Personnel	$8.8	$10.6	$1.8	20.2%
Non-Personnel	$7.7	$8.2	$0.5	6.9%
Total Administrative Expense	**$16.5**	**$18.8**	**$2.3**	**14.0%**

		FY19 Actuals vs. Budget MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.7	$2.7	$0.0	1.3%
	Non-Personnel	$2.2	$2.0	-$0.2	-12.0%
	MTD Total	**$4.9**	**$4.7**	**-$0.2**	**-4.3%**
YTD	Personnel	$10.6	$10.6	$0.1	0.6%
	Non-Personnel	$8.2	$8.7	$0.5	5.8%
	YTD Total	**$18.8**	**$19.4**	**$0.6**	**3.0%**

Balance Sheet

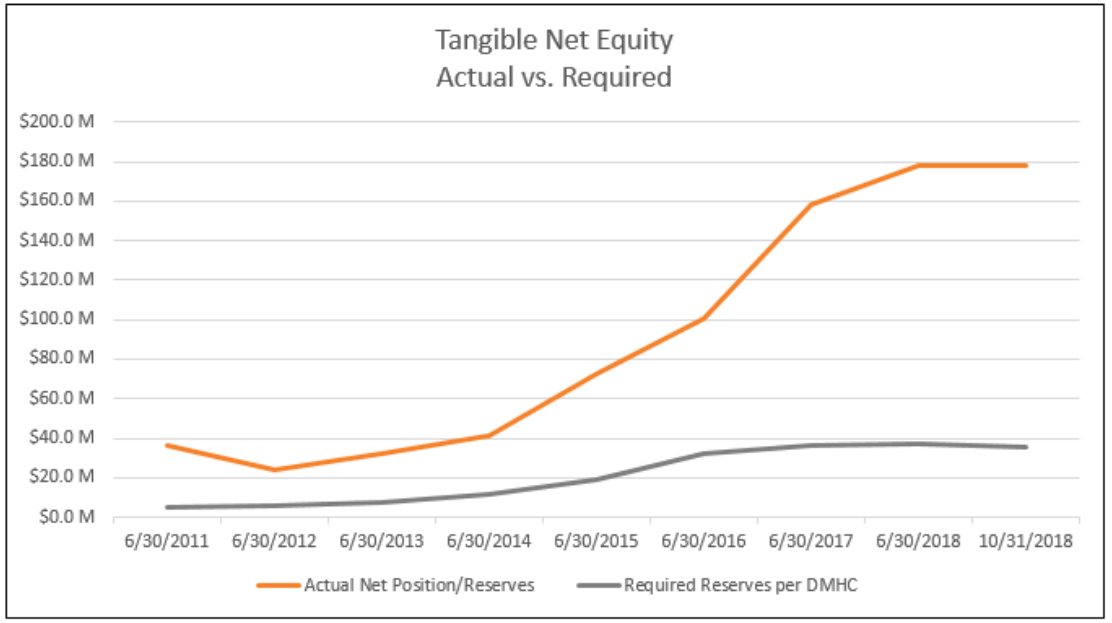
- Current assets totaled $726.3M compared to current liabilities of $577.9M, yielding a current ratio (Current Assets/Current Liabilities) of 1.26:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash as of October 31, 2018 decreased by $13.9M compared to the cash balance as of year-end June 30, 2018. The overall cash position decreased largely due to timing of receipt of revenues, largely paid in arrears and payment of quarterly MCO taxes.
- Current Cash & Equivalents components and yields were as follows:

Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$77,744,296	1.29%	$100,000	$400,000
Cash & Equivalents				
Bank of the West Money Market	$366,581	0.90%	$14,945	$37,986
Wells Fargo Bank Accounts	$131,824,379	1.76%	$240,750	$778,040
	$132,190,960		$255,695	$816,026
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.08%	$13	$51
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$210,241,106**		**$355,707**	**$1,216,077**

Tangible Net Equity

- TNE was $178.3M or 506.2% of the most recent quarterly DMHC minimum requirement of $35.2M. TNE trends for SCFHP are shown below.

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	6/30/2018	10/31/2018
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$178.3 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$35.2 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$70.4 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	506.2%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS October 2018

Financial Reserve Target #1: Tangible Net Equity

Actual TNE	$178,264,003
Current Required TNE	$35,214,408
Excess TNE	**$143,049,595**
Actual as % Required	506.2%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	$123,250,430
500% of Required TNE (High)	$176,072,042
TNE Above/(Below) SCFHP Low Target	**$55,013,574**
TNE Above/(Below) High Target	**$2,191,961**

Financial Reserve Target #2: Liquidity

Cash & Cash Equivalents	$210,241,106
Less Pass-Through Liabilities	
Net Payable to State of CA [1]	-
Other Pass-Through Liabilities	($7,896,914)
Total Pass-Through Liabilities	**($7,896,914)**
Net Cash Available to SCFHP	$202,344,193
SCFHP Target Liability	
45 Days of Total Operating Expense	($120,210,934)
60 Days of Total Operating Expense	($160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$82,133,259**
Liquidity Above/(Below) High Target	**$42,062,948**

[1] Pass-Through from State of CA	
Receivables Due to SCFHP	500,700,382
Payable Due From SCFHP	(450,560,154)
Net Receivables/(Payables)	**$50,140,229**

Capital Expenditures

- Capital investments of $4.4M were made in the 4 months ending October 2018, largely due to the renovation of the new building.
- YTD capital expenditure includes the following:

Expenditure	YTD Actual	Annual Budget	
New Building	$4,056,386	$ 7,874,631	Note 1
Systems	-	1,125,000	
Hardware	59,760	1,550,000	
Software	252,000	702,000	
Furniture and Fixtures	-	-	
Automobile	-	-	
Leasehold Improvements	-	-	
TOTAL	**$4,368,146**	**$11,251,631**	

Note 1: Includes FY18 budget rollover of $6,628,131

Santa Clara Family Health Plan™

Financial Statements

Enrollment By Aid Category

		2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10
NON DUAL	Adult (over 19)	27,604	27,657	27,465	27,359	27,351	27,184	27,000	26,651	26,567	26,353
	Adult (under 19)	101,226	101,653	101,197	100,606	100,449	100,201	99,296	98,245	98,183	97,410
	Aged - Medi-Cal Only	10,892	10,906	10,906	10,924	10,891	10,979	10,916	10,834	10,905	10,878
	Disabled - Medi-Cal Only	10,807	10,825	10,786	10,801	10,750	10,765	10,748	10,697	10,653	10,618
	Adult Expansion	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959	73,601
	BCCTP	15	15	15	15	15	13	13	14	13	12
	Long Term Care	385	370	353	358	370	390	442	419	423	471
	Total Non-Duals	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**	**219,343**
DUAL	Adult (21 Over)	421	419	416	401	397	393	387	385	382	385
	Aged (21 Over)										
	Disabled (21 Over)	23,300	23,405	23,312	22,969	23,064	22,941	23,024	23,066	23,083	23,045
	Adult Expansion	474	433	470	451	421	451	455	485	521	533
	BCCTP	1	1	2	2	2	2	2	2	2	1
	Long Term Care	1,209	1,155	1,118	1,117	1,159	1,165	1,211	1,185	1,193	1,186
	Total Duals	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**	**25,150**
	Total Medi-Cal	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**
	Healthy Kids	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**
CMC	CMC Non-Long Term Care	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386	7,383
	CMC - Long Term Care	257	255	256	241	237	228	221	222	214	218
	Total CMC	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**
	Total Enrollment	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**

Income Statement

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 73,796,616	85.3%	$ 68,720,218	85.0%	$ 5,076,398	7.4%	$ 285,890,368	85.2%	$ 276,151,896	85.2%	$ 9,738,472	3.5%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,728,482	3.2%	2,504,017	3.1%	224,465	9.0%	9,458,523	2.8%	9,936,941	3.1%	(478,417)	-4.8%
CMC MEDICARE	9,597,189	11.1%	9,323,124	11.5%	274,065	2.9%	39,008,604	11.6%	36,997,887	11.4%	2,010,717	5.4%
TOTAL CMC	12,325,671	14.3%	11,827,141	14.6%	498,530	4.2%	48,467,127	14.4%	46,934,828	14.5%	1,532,299	3.3%
HEALTHY KIDS	342,079	0.4%	300,687	0.4%	41,393	13.8%	1,389,549	0.4%	1,208,980	0.4%	180,569	14.9%
TOTAL REVENUE	**$ 86,464,367**	**100.0%**	**$ 80,848,046**	**100.0%**	**$ 5,616,321**	**6.9%**	**$ 335,747,045**	**100.0%**	**$ 324,295,705**	**100.0%**	**$ 11,451,340**	**3.5%**
MEDICAL EXPENSE												
MEDI-CAL	$ 67,852,826	78.5%	$ 64,215,918	79.4%	$ (3,636,908)	-5.7%	$ 267,474,783	79.7%	$ 258,459,859	79.7%	$ (9,014,924)	-3.5%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,665,657	3.1%	2,196,190	2.7%	(469,467)	-21.4%	10,039,520	3.0%	8,715,360	2.7%	(1,324,159)	-15.2%
CMC MEDICARE	10,528,692	12.2%	8,975,347	11.1%	(1,553,344)	-17.3%	38,463,474	11.5%	35,612,505	11.0%	(2,850,969)	-8.0%
TOTAL CMC	13,194,348	15.3%	11,171,537	13.8%	(2,022,811)	-18.1%	48,502,993	14.4%	44,327,865	13.7%	(4,175,129)	-9.4%
HEALTHY KIDS	528,619	0.6%	270,818	0.3%	(257,801)	-95.2%	1,334,386	0.4%	1,088,888	0.3%	(245,498)	-22.5%
TOTAL MEDICAL EXPENSES	**$ 81,575,793**	**94.3%**	**$ 75,658,273**	**93.6%**	**$ (5,917,520)**	**-7.8%**	**$ 317,312,162**	**94.5%**	**$ 303,876,611**	**93.7%**	**$ (13,435,550)**	**-4.4%**
MEDICAL OPERATING MARGIN	**$ 4,888,573**	**5.7%**	**$ 5,189,772**	**6.4%**	**$ (301,199)**	**-5.4%**	**$ 18,434,883**	**5.5%**	**$ 20,419,093**	**6.3%**	**$ (1,984,210)**	**-17.3%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,661,322	3.1%	$ 2,696,896	3.3%	$ 35,573	1.3%	$ 10,576,557	3.2%	$ 10,639,974	3.3%	$ 63,417	0.6%
RENTS AND UTILITIES	18,044	0.0%	23,611	0.0%	5,567	23.6%	259,972	0.1%	312,004	0.1%	52,033	16.7%
PRINTING AND ADVERTISING	169,047	0.2%	44,150	0.1%	(124,897)	-282.9%	469,146	0.1%	323,600	0.1%	(145,546)	-45.0%
INFORMATION SYSTEMS	133,858	0.2%	226,473	0.3%	92,615	40.9%	748,170	0.2%	905,892	0.3%	157,723	17.4%
PROF FEES/CONSULTING/TEMP STAFFING	1,188,300	1.4%	940,292	1.2%	(248,008)	-26.4%	4,471,041	1.3%	3,873,935	1.2%	(597,106)	-15.4%
DEPRECIATION/INSURANCE/EQUIPMENT	388,329	0.4%	469,566	0.6%	81,238	17.3%	1,434,276	0.4%	1,858,765	0.6%	424,489	22.8%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	206,610	0.2%	145,917	0.2%	(60,693)	-41.6%	439,255	0.1%	880,988	0.3%	441,733	50.1%
MEETINGS/TRAVEL/DUES	91,114	0.1%	113,526	0.1%	22,412	19.7%	340,478	0.1%	453,611	0.1%	113,133	24.9%
OTHER	24,625	0.0%	17,804	0.0%	(6,821)	-38.3%	77,226	0.0%	140,799	0.0%	63,573	45.2%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,881,249**	**5.6%**	**$ 4,678,236**	**5.8%**	**$ (203,013)**	**-4.3%**	**$ 18,816,121**	**5.6%**	**$ 19,389,569**	**6.0%**	**$ 573,448**	**3.0%**
OPERATING SURPLUS (LOSS)	$ 7,324	0.0%	$ 511,536	0.6%	$ (504,212)	-98.6%	$ (381,238)	-0.1%	$ 1,029,524	0.3%	$ (1,410,762)	-137.0%
OTHER INCOME/EXPENSE												
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(239,119)	-0.1%	(239,120)	-0.1%	1	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(300,000)	-0.1%	(300,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	377,950	0.4%	47,605	0.1%	330,345	693.9%	1,168,497	0.3%	190,420	0.1%	978,077	513.6%
OTHER INCOME/EXPENSE	**243,171**	**0.3%**	**(87,175)**	**-0.1%**	**330,346**	**-378.9%**	**629,378**	**0.2%**	**(348,700)**	**-0.1%**	**978,079**	**-280.5%**
NET SURPLUS (LOSS)	**$ 250,495**	**0.3%**	**$ 424,361**	**0.5%**	**$ (173,867)**	**-41.0%**	**$ 248,141**	**0.1%**	**$ 680,824**	**0.2%**	**$ (432,683)**	**-63.6%**

Balance Sheet

	October 2018	September 2018	August 2018	June 2018
Assets				
Current Assets				
Cash and Marketable Securities	$210,241,106	$233,279,977	$235,488,840	$224,156,209
Receivables	507,221,511	501,964,866	497,747,680	493,307,425
Prepaid Expenses and Other Current Assets	8,811,521	7,176,276	7,792,800	7,024,982
Total Current Assets	**726,274,138**	**742,421,119**	**741,029,320**	**724,488,615**
Long Term Assets				
Property and Equipment	42,947,276	42,357,057	42,306,060	38,579,130
Accumulated Depreciation	(15,535,421)	(15,212,360)	(14,888,918)	(14,309,761)
Total Long Term Assets	27,411,855	27,144,697	27,417,142	24,269,369
Total Assets	**753,685,993**	**769,565,816**	**768,446,462**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,535,240**
Total Deferred Outflows and Assets	**768,221,233**	**784,101,056**	**782,981,702**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	5,327,669	5,194,835	5,065,866	8,351,090
Deferred Rent	(0)	(0)	(0)	17,011
Employee Benefits	1,599,737	1,584,704	1,527,690	1,473,524
Retirement Obligation per GASB 45	5,121,914	5,062,134	5,002,354	4,882,795
Advance Premium - Healthy Kids	80,686	87,424	80,809	66,195
Deferred Revenue - Medicare	-	-	8,858,943	9,928,268
Whole Person Care/Prop 56	7,896,914	7,324,264	6,746,392	9,263,004
Payable to Hospitals	-	-	0	0
Due to Santa Clara County Valley Health Plan and Kaiser	9,213,279	11,186,460	12,243,869	6,691,979
MCO Tax Payable - State Board of Equalization	8,784,631	27,231,162	18,113,329	(0)
Due to DHCS	28,225,971	30,997,453	28,918,776	24,429,978
Liability for In Home Support Services (IHSS)	413,549,552	413,549,552	413,549,551	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	95,703,417	89,491,100	90,857,988	92,470,504
Total Current Liabilities	**577,878,294**	**594,083,611**	**593,340,091**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,124,796	2,049,796	1,974,796	1,824,796
Total Non-Current Liabilities	**8,044,296**	**7,969,296**	**7,894,296**	**7,744,296**
Total Liabilities	**585,922,590**	**602,052,907**	**601,234,387**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	17,229,058	17,350,172	17,633,610	18,067,094
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	160,481,454	160,360,340	160,076,903	140,008,115
Current YTD Income (Loss)	248,141	(2,354)	(264,500)	19,635,303
Total Net Assets / Reserves	178,264,003	178,013,509	177,712,675	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**768,221,233**	**784,101,056**	**782,981,702**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	$334,413,583
Medical Expenses Paid	(311,557,949)
Adminstrative Expenses Paid	(33,571,087)
Net Cash from Operating Activities	**($10,715,453)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(4,368,146)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	1,168,497
Net Increase/(Decrease) in Cash & Cash Equivalents - YTD	**(13,915,102)**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Oct 18)	**$210,241,106**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**$248,141**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	1,225,660
Changes in Operating Assets/Liabilities	
Premiums Receivable	(13,914,086)
Other Receivable	(1,168,497)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(1,786,539)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(13,954,969)
State Payable	12,580,624
Santa Clara Valley Health Plan & Kaiser Payable	2,521,300
Net Pension Liability	300,000
Medical Cost Reserves & PDR	3,232,913
Deferred Inflow of Resources	-
Total Adjustments	**($12,189,254)**
Net Cash from Operating Activities	**($10,715,453)**

Statement of Operations - 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 2018

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 285,890,368	$ 9,458,523	$ 39,008,604	$ 48,467,127	$ 1,389,549	**$ 335,747,045**
MEDICAL EXPENSE	$ 267,474,783	$ 10,039,520	$ 38,463,474	$ 48,502,993	$ 1,334,386	**$ 317,312,162**
(MLR)	93.6%	106.1%	98.6%	100.1%	96.0%	**94.5%**
GROSS MARGIN	$ 18,415,586	$ (580,996)	$ 545,130	$ (35,866)	$ 55,164	**$ 18,434,883**
ADMINISTRATIVE EXPENSE	$ 16,022,026	$ 530,080	$ 2,186,142	$ 2,716,221	$ 77,874	**$ 18,816,121**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 2,393,560	$ (1,111,076)	$ (1,641,012)	$ (2,752,088)	$ (22,710)	**$ (381,238)**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 535,919	$ 17,731	$ 73,124	$ 90,855	$ 2,605	**$ 629,378**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 2,929,479	$ (1,093,345)	$ (1,567,888)	$ (2,661,233)	$ (20,105)	**$ 248,141**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 290.51	$ 312.53	$ 1,288.94	$ 1,601.48	$ 108.18	**$ 326.86**
MEDICAL EXPENSES	$ 271.80	$ 331.73	$ 1,270.93	$ 1,602.66	$ 103.88	**$ 308.91**
GROSS MARGIN	$ 18.71	$ (19.20)	$ 18.01	$ (1.19)	$ 4.29	**$ 17.95**
ADMINISTRATIVE EXPENSES	$ 16.28	$ 17.52	$ 72.24	$ 89.75	$ 6.06	**$ 18.32**
OPERATING INCOME/(LOSS)	$ 2.43	$ (36.71)	$ (54.22)	$ (90.94)	$ (1.77)	**$ (0.37)**
OTHER INCOME/(EXPENSE)	$ 0.54	$ 0.59	$ 2.42	$ 3.00	$ 0.20	**$ 0.61**
NET INCOME/(LOSS)	$ 2.98	$ (36.13)	$ (51.81)	$ (87.93)	$ (1.57)	**$ 0.24**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	984,086	30,264	30,264	30,264	12,845	1,027,195
REVENUE BY LOB	85.2%	2.8%	11.6%	14.4%	0.4%	100.0%

RESOLUTION TO FUND CALPERS
OTHER POST-EMPLOYMENT BENEFITS LIABILITY

WHEREAS, the Santa Clara County Health Authority dba Santa Clara Family Health Plan (the Plan) participates in the California Public Employees' Retirement System's (CalPERS) California Employers' Retiree Benefit Trust (CERBT) program. The Plan makes regular contributions to the CalPERS CERBT program, which will provide other post-employment benefits (OPEB) as medical benefits to retired employees.

WHEREAS, on an annual basis, the Plan's actuaries calculate the actuarial unfunded OPEB liability. The Plan seeks to make annual contributions of the unfunded OPEB liability to reduce its overall OPEB expense and to work toward full funding of its OPEB liability.

NOW, THEREFORE, BE IT RESOLVED:

I. On an annual basis the Plan's executive management will obtain the actuarial unfunded employer OPEB liability per the annual OPEB valuation reports and will present their recommendation of funding such annual amounts to the Plan's Governing Board.

II. Based on the most recent OPEB valuation, dated June 30, 2017, the Plan will make an employer contribution of $1,332,000 including interest, payable by December 31, 2018. This is the second of three annual contributions with the final annual payment anticipated to be made by December 31, 2019.

III. Once the annual employer contribution is approved by the Governing Board, the Plan's CFO will remit funds to the CalPERS CERBT program in a timely manner.

PASSED AND ADOPTED by the Governing Board of the Santa Clara County Health Authority.

_____
this 13th day of December, 2018.

BY:

_____
Robert Brownstein, Board Chair,
Santa Clara County Health Authority

Santa Clara Family Health Plan.

POLICY

Policy Title:	**Cash Disbursements**	**Policy No.:**	**FIN.03**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Annually**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

1. Purpose

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls, policies and procedures governing all disbursement of funds, and ensure that the Plan's assets are protected, properly recorded, and routinely reconciled.

2. Policy

The Chief Executive Officer (CEO) and Executive Management team are charged with the authority and responsibility for maximizing the purchasing value of the Plan's funds as follows:

a. Acquiring services, supplies and equipment for all departments in an economical, consistent, expeditious, and reasonable manner.
b. Analyzing bids, awarding contracts, and assuring vendor performance through effective contract administration.
c. Identifying qualified vendors and maintaining good vendor relationships.
d. Educating and training employees and vendors on this policy and associated procedures.

Unless specifically exempted, no expenditure of funds should occur without a contract, statement of work (SOW), or check request approved by the CEO (or, for urgent purchases and/or in the CEO's absence, an Executive Management designee). Exceptions include:

a. Contracts with healthcare providers involved in the delivery of healthcare services (which are governed by specific procedures of the Provider Network Management department).
b. Personnel (which are governed by specific procedures of the Human Resources department).
c. Items under $1,000, which are subject to approval after purchase.
d. Urgent purchases, as designated by CEO or CFO. Emergency purchases require CEO or CFO advance approval. Should an emergency occur in the absence of the CEO and CFO, another Executive may approve the purchase and subsequently the purchase will be approved by the CFO.
e. Telephone and utilities expenses, which are recurring in nature and require initial approval by Facilities department and CFO.

f. Brokered insurance and reinsurance, following a competitive bidding process, which require CFO review and approval.
g. Postage, delivery, and shipping charges, which require approval after purchase.
h. Janitorial or facilities services, which require approval after purchase.
i. Purchases made via credit card or purchasing card, which require subsequent approval.

All contracts in excess of $250,000 require the review and approval of the Governing Board or the Executive/Finance Committee.

This policy is supported by specific detailed procedures on such topics as:

a. Procurement
b. Authorization/approval of administrative and capital expenditures
c. Company credit and purchasing cards
d. Accounts payable vendor maintenance
e. Prepaid expenses
f. Stale checks & escheatment
g. Provider refunds
h. Any future disbursement procedures, as needed

3. Responsibilities

The Plan's Chief Financial Officer (CFO) has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Plan's adherence to this policy and related procedures. All departments are responsible for complying with this policy.

4. References

See list of Finance definitions and abbreviations per Finance procedure FIN.01.01.

5. Approvals:

First Level Approval	Second Level Approval
Signature Neal Jarecki	Signature Dave Cameron
Name Controller	Name CFO
Title 12/13/2018	Title 12/13/2018
Date	Date

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

Santa Clara
Family Health Plan

POLICY

Policy Title:	**Special Project Board Discretionary Fund**	**Policy No.:**	GO.02
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Governance & Org Structure	**Policy Review Frequency:**	
Lines of Business (check all that apply):	☐ Medi-Cal	☐ Healthy Kids	☐ CMC

I. Purpose

To define and outline the requirements and criteria by which SCFHP may provide funding for special projects through a Board Discretionary Fund.

II. Policy

SCFHP has established a Board Discretionary Fund to allow the Plan to provide funding for special projects and initiatives focused on serving the health needs of the safety net population in Santa Clara County. The amount of reserves available for the Discretionary Fund will be based on the amount available, if any, over the Board designated maximum Tangible Net Equity (TNE), determined annually after release of the audited financial statements. Availability of reserves will also be subject to the Plan exceeding the Board-established liquidity target range.

It is SCFHP's policy to make strategic investments, subject to the availability of funds, in special projects that support the mission of the Plan, are consistent with annual and strategic objectives, strengthen community partnerships, and explore new and emerging models of care or facilitate expansion of best practice quality care.

The Executive/Finance Committee may approve special project investments up to $100,000. Project funding over $100,000 must be approved by the Governing Board.

Special project investments must meet all of the following criteria:

1. The funding fulfills an overriding public purpose to carry out SCFHP's mission to provide high quality, comprehensive health care coverage to those in Santa Clara County who do not have access to, or are not able to purchase, good health care at an affordable price.
2. The funding will be used to address assessed needs of the Plan and its members.
3. The special project will be consistent with the strategic and/or annual objectives of the Plan.
4. The special project will have measurable outcomes.
5. There is a lack of other resources in the community to fund the special project.
6. Continued special project funding from SCFHP would not be required for sustainability of the special project.
7. The funding will not be used for general operating costs, but may support project overhead.

8. The funding will not adversely impact the ability of SCFHP to operate and to deliver services and programs.
9. The funding will not financially benefit any Santa Clara County Health Authority official or employee.
10. The funding will not be used for political purposes (e.g., donations to political campaigns or ballot measures).

Special Projects to be funded must also meet two or more of the following considerations:

1. The special project will strengthen both the Plan and the member safety net.
2. The special project investment can be included in the Plan's claimable cost structure.
3. The special project will address regulatory or accreditation needs.
4. The funding will be used to pilot a promising approach for addressing emerging health care issues.
5. The funding will facilitate expansion of best practices/evidence-based care.
6. The special project will address social determinants of health.
7. The funding will promote quality care and cost efficiency.
8. The special project will leverage, or build on, existing partnerships or investments.

III. References

1. Tangible Net Equity Policy
2. Liquidity Policy

IV. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v.1	**Original**			**June 28, 2018**

Network Detection and Prevention Report

December 2018

SCCHA Governing Board Meeting

12/7/2018

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, such as 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 down 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 if from the Palo Alto Firewall recently implemented and these events of low to no threat and more of an FYI for reporting.

Santa Clara Family Health Plan

Attack Statistics Combined

August/September/October/November

	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
Severity Level	Aug	Sep	Oct	Nov	Aug	Sep	Oct	Nov	Aug	Sep	Oct	Nov
Critical	1	4	2	1	1	8	2	4	.006	.01	.001	.001
High	10	2	2	3	3213	4	43	40	0.173	.01	.003	.02
Medium	17	22	19	8	3214	404	226	85	0.261	.18	.014	.04
Low	40	31	28	33	655301	209616	162111	198902	35.346	99.53	99.47	99.86
Informational	18	4	2	4	1190637	564	599	158	64.220	.27	.037	.08

Email Background

For email protection SCFHP utilizes software that intercepts every incoming email and scans them for suspicious content, attachments or URLs (Uniform Resource Locator or address to the World Wide Web). The software has anti-malware and phishing-detection technology that is constantly being updated to detect the latest threats. It is configured to detect phishing attempts as well SPF (Sender Policy Framework) anti-spoofing. SPF is a simple technology that detects spoofing by providing a mechanism to validate the incoming mail against the sender's domain name. The software can check those records to make sure mail is coming from legitimate email addresses.

Santa Clara Family Health Plan

Email Security – Monthly Statistics

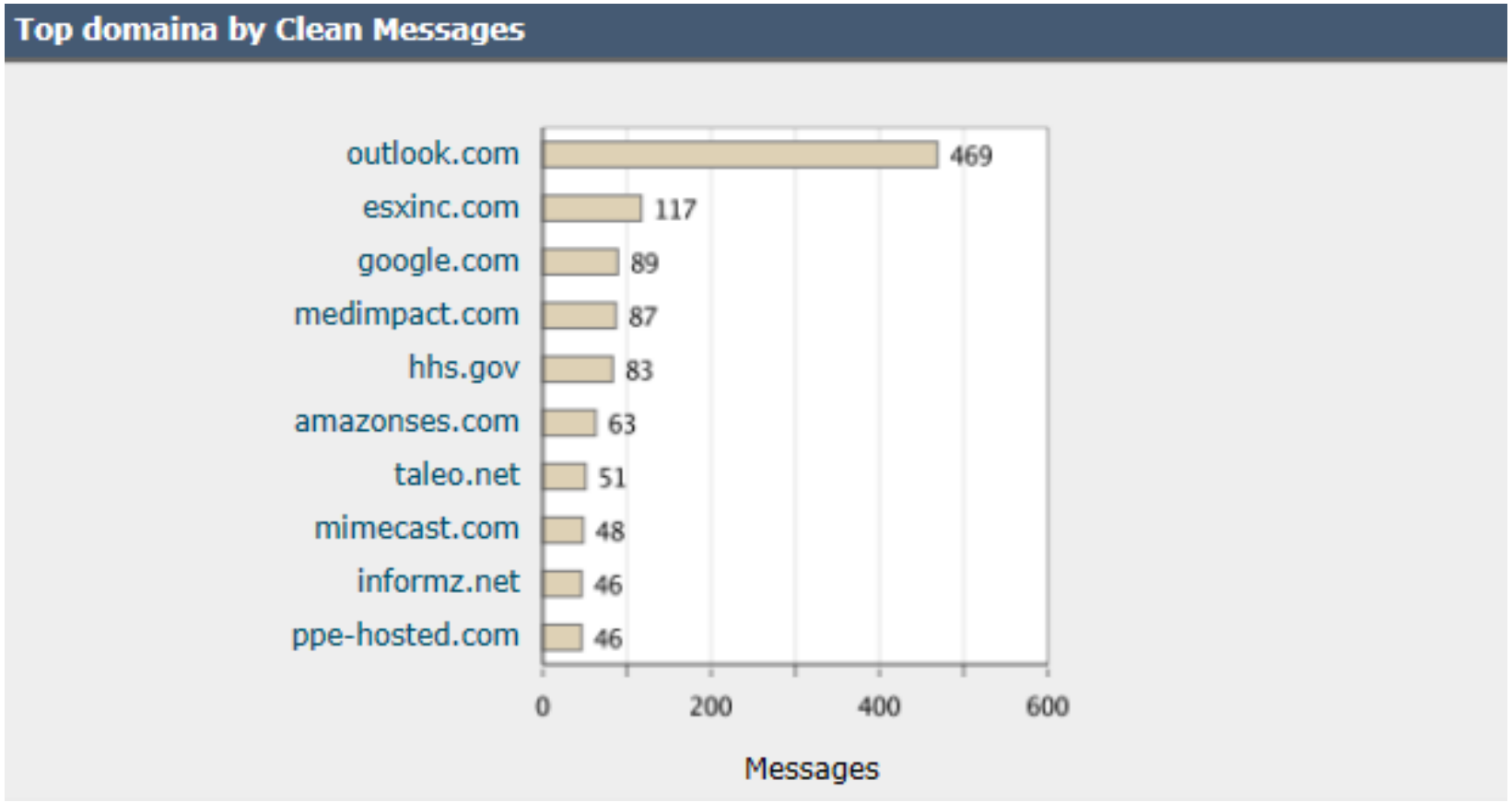
Incoming Mail Summary

Message Category	%	Messages
Stopped by Reputation Filtering	61.6%	119.8k
Stopped as Invalid Recipients	0.0%	55
Spam Detected	4.1%	8,030
Virus Detected	0.0%	2
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.3%	539
Stopped by Content Filter	0.1%	265
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**65.9%**	**128.2k**
Marketing Messages	9.9%	19.2k
Social Networking Messages	0.5%	896
Bulk Messages	5.5%	10.7k
Total Graymails:	**15.8%**	**30.8k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	18.2%	35.5k
Total Attempted Messages:		**194.5k**

Month of November

12/7/2018

Email Security – Daily Statistics



Snap Shot of one day

12/7/2018

SCFHP Phishing Attacks

		INCIDENT 48 – 8/07/2018	INCIDENT 49 – 8/07/2018	INCIDENT 50 – 9/24/2018
TYPE OF ATTACK		Phishing	Phishing	Phishing
SUMMARY	No incidents for month of July	1 employee	1 employee	1 employee
RESPONSE		**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
		Step 2. Block on cisco ironport from Source email rockysmith7998@gmail.com Email did not contain a unique word to block without potentially blocking legitimate emails. No IP available from email to block.	**Step 2.** Block on cisco ironport from Source email aduncan@libertymgt.com Email did not contain a unique word to block without potentially blocking legitimate emails. No IP available from email to block.	**Step 2.** Block on cisco ironport from Source email accounts@willerbymanor.co.uk and Filter expression “Remittance Advice”. Blocked IP Address - 80.255.3.95
		Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
		Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

SCFHP Phishing Attacks

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	INCIDENT 51– 10/5/2018	INCIDENT 52 – 10/8/2018	INCIDENT 53 – 10/29/2018	INCIDENT 54 – 10/29/2018
TYPE OF ATTACK	Phishing	Phishing	Phishing	Phishing
SUMMARY	1 employee	1 employee	1 employee	1 employee
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
	Step 2. Block Source email on Cisco Ironport - ceo_dropbox@rieveergroup.com and filtered Expression "Are you on Seat?" No IP available from email to block.	**Step 2.** Block Source email on Cisco Ironport – noreply@microsoft-activation.jfkbjkl.website and filtered expression "Office365 Postmaster". No IP available from email to block.	**Step 2.** Block Source email on Cisco Ironport – jimmyfall316@gmail.com and Filter expression "Quote of the day". Blocked IP address 209.185.167.195	**Step 2.** Block Source email on Cisco Ironport - Jimmyteh@Conduent.com and filtered Expression "Shipping Status changed" Blocked IP address 185.94.191.124
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

SCFHP Phishing Attacks

	INCIDENT 55 – 11/28/2018			
TYPE OF ATTACK	Phishing			
SUMMARY	1 employee			
RESPONSE	**Step 1.** Analyze email and take appropriate action.			
	Step 2. Block Source email domain on Cisco Ironport – @alertsp.chase.com and filtered Expression “Account Notification #17769” Blocked IP address 173.203.187.96			
	Step 3. Remove threat by permanently deleting email.			
	Step 4. Monitor email and user.			

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Santa Clara Family Health Plan

Questions

12/7/2018

Santa Clara County Health Authority
Updates to Pay Schedule
December 13, 2018

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Behavioral Health Treatment Program Manager	Annually	67,942	84,928	101,913
Customer Service Representative I	Annually	43,303	53,046	62,789
Customer Service Representative II	Annually	47,633	58,351	69,068
Director, Application and Product Development	Annually	168,189	218,645	269,102
Director, IT Business Integration	Annually	168,189	218,645	269,102
Supervisor, Utilization Management	Annually	67,942	84,928	101,913

Adjust Salary Schedule in its entirety as recommended by C-Biz Talent & Compensation Solutions **by adjustment factor of 1.95%** to ensure salary range minimums and maximums remain competitive to the market.

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
December 13, 2018

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Customer Service Representative I (Y Rate)	Annually	38,613	47,301	59,155
Customer Service Representative II (Y Rate)	Annually	42,475	52,032	67,225
Vice President, Health Services	Annually	197,966	257,356	316,746