Santa Clara Family Health Plan
The Spirit of Care

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Regular Meeting of the
Santa Clara County Health Authority
Governing Board

Thursday, March 22, 2018
2:30 PM – 5:00 PM
210 E. Hacienda Avenue
Campbell, CA 95008
Board Room

Agenda

1.	**Roll Call** Welcome new Board Member, Dr. Ria Paul.	Ms. Lew	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. **<u>Announcement Prior to Recessing into Closed Session</u>** Announcement that the Governing Board will recess into closed session to discuss Item No. 3(a) & (b) below.	Ms. Lew	2:35	5 min
3.	**Adjourn to Closed Session**		2:40	
	a. **<u>Anticipated Litigation</u>** (Government Code Section 54956.9(d)(2)): It is the intention of the Governing Board to meet in Closed Session to confer with Legal Counsel regarding significant exposure to litigation: 5 potential cases.			
	b. **<u>Conference with Labor Negotiators</u>** (Government Code Section 54957.6): It is the intention of the Governing Board to meet in Closed Session to confer with its Designated Representative(s). • Santa Clara County Health Authority Designated Representatives: Dolores Alvarado, Liz Kniss, Michele Lew, and Linda Williams • Unrepresented Employee: Chief Executive Officer			
4.	**Report from Closed Session**	Ms. Lew	3:10	5 min

5. **Annual CEO Compensation Review** — Ms. Lew — 3:15 — 5 min
   Approve annual salary adjustment and incentive bonus for the Chief Executive Officer.
   Possible Action: Approve an annual salary increase and incentive bonus for the CEO

6. **Approve Consent Calendar and Changes to the Agenda** — Ms. Lew — 3:20 — 5 min
   Items removed from the Consent Calendar will be considered as regular agenda items.
   Possible Action: Approve Consent Calendar

   a. Approve minutes of the December 14, 2017 **Regular Board** Meeting
   b. November 16, 2017 **Executive/Finance Committee** Meeting
   - Ratify approval of the Enterprise Data Warehouse (EDW) Development

   c. Accept minutes of the January 25, 2018 **Executive/Finance Committee** Meeting
   - Ratify approval of the Tentative Agreement with SEIU Local 521
   - Ratify approval of the November 2017 Financial Statements
   - Ratify approval to authorize the CEO to negotiate and execute contract with General Contractor consistent with material terms as described to the Committee

   d. Accept minutes of the February 22, 2018 **Executive/Finance Committee** Meeting
   - Ratify approval of the December 2017 Financial Statements

   e. Accept minutes of the February 22, 2018 **Compliance Committee** Meeting
   - Ratify acceptance of the Compliance Report & CMC and Medi-Cal Compliance Monitoring
   - Ratify acceptance of the Regulatory Audits and Corrective Action Plans (CAP)
   - Ratify acceptance of the Fraud, Waste, and Abuse Report

   f. Accept minutes of the February 21, 2018 **Quality Improvement Committee** Meeting
   - Ratify approval of the Clinical, Behavioral, and Medical Prevention Practice Guidelines
   - Ratify approval of the QI Program Description
   - Ratify approval of the Case Management Strategy Description
   - Ratify approval of the Health Education Program Description
   - Ratify approval of the Cultural and Linguistics Program Description and Evaluation
   - Ratify approval of the Behavioral Health Policies
     - QI.23 Alcohol Misuses Screening and Behavioral Counseling Intervention in Primary Care
     - QI.24 Outpatient Mental Health Services

- Ratify approval of the Palliative Care Policy
  - QI.25 Intensive Outpatient Palliative Care
- Ratify approval of the LTSS Policy
  - QI.16 MLTSS Care Coordination
- Ratify acceptance of Committee Reports:
  - Credentialing Committee – October 4 & December 6, 2017
  - Pharmacy & Therapeutics Committee – September 21, 2017
  - Utilization Management Committee – October 18, 2017

g. Accept minutes of the February 1, 2018 **Provider Advisory Council** Meeting

h. Accept minutes of the March 1, 2018 **Consumer Advisory Committee** Meeting

7.	**CEO Update** Discuss status of current topics and initiatives. **Possible Action:** Accept CEO Update	Ms. Tomcala	3:25	5 min
8.	**Funding for Enrollment Assistance** Consider proposal to collaborate with The Health Trust to provide enrollment assistance to the community. **Possible Action:** Approve funding to support The Health Trust in providing enrollment assistance through June 2019	Ms. Tomcala	3:30	10 min
9.	**Compliance Report** Review and discuss quarterly compliance activities and notifications. **Possible Action:** Accept Compliance Report	Ms. Larmer	3:40	10 min
10.	**January 2018 Financial Statements** Review recent organizational financial performance. **Possible Action:** Approve January 2018 Financial Statements	Mr. Cameron	3:50	10 min
11.	**Grievance & Appeals System Solution** Consider contracting with a selected vendor for a system to support Grievance and Appeals processes and regulatory reporting. **Possible Action:** Authorize CEO to negotiate, execute, amend, and terminate a contract with selected vendor to provide a Grievance and Appeals system solution	Chris Turner	4:00	10 min
12.	**New Building Update** Provide status of progress and cost estimate on build-out. **Possible Action:** Approve budget as attached and authorize the CEO to execute contracts to build out the new office building at 50 Great Oaks Blvd.	Mr. Cameron/ Ms. Tomcala	4:10	15 min

13. Retiree Health Benefits Resolutions Approve resolutions to change the retiree health benefit plan contribution for new hires after May 1, 2018. **Possible Action:** Approve the Resolutions - • Fixing the Employer Contribution at an Equal Amount and • Adopting Cafeteria Plan and Health Reimbursement Account Benefits to Supplement the Amount Contributed by the Employer for Employees and Annuitants Under the Public Employees' Medical and Hospital Care Act	Ms. Valdez	4:35	5 min
14. Retirement Benefit Program Review proposal to modify the deferred compensation plans offered to employees. **Possible Action:** Approve revisions to the retirement benefit programs and authorize CEO to execute all applicable documents to activate the changes.	Ms. Tomcala/ Mr. Cameron	4:25	10 min
15. Publicly Available Salary Schedule Ranges Consider changes to the Publicly Available Salary Schedule. **Possible Action:** Approve Publicly Available Salary Schedule	Ms. Valdez	4:40	5 min
16. Adjournment	Ms. Lew	4:45	

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 210 E. Hacienda Avenue, Campbell.

This agenda and meeting documents are available at

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Regular Meeting of the
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Thursday, March 22, 2018
4:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Agenda

1.	**Roll Call**	Ms. Lew	4:45	5min
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.	Ms. Lew	4:50	3min
3.	**Meeting minutes** Review meeting minutes of the December 14, 2017 Regular Board Meeting. **Possible Action:** Approve December 14, 2017 Regular Board Meeting minutes	Ms. Lew	4:53	2min
4.	**Continuation of Santa Clara Community Health Authority** Discuss potential dissolution of the Santa Clara Community Health Authority. **Possible Action:** Authorize Management to move forward with dissolution of the Santa Clara Community Health Authority	Mr. Cameron/ Ms. Tomcala	4:55	5min
5.	**Adjournment**		5:00	

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Regular Meeting of the
Santa Clara County Health Authority
Governing Board

Thursday, December 14, 2017
Board Room
210 E. Hacienda Avenue
Campbell, CA 95008

Board Members Present
Bob Brownstein, Chair
Michele Lew, Vice Chair
Brian Darrow
Darrell Evora
Kathleen King
Liz Kniss
Paul Murphy
Jolene Smith
Brenda Taussig
Waldermar Wenner, M.D.
Linda Williams

Board Members Absent
Dolores Alvarado
Chris Dawes

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Chris Turner, Chief Operating Officer
Jonathan Tamayo, Chief Information Officer
Neal Jarecki, Controller
Beth Paige, Compliance Officer
Rita Zambrano, Executive Assistant

Others Present
Richard Noack, Hopkins & Carley LLP
Jim Frieman, SEIU Representative

Minutes - DRAFT

1. **Roll Call**

   Bob Brownstein, Chair, called the meeting to order at 2:55 pm. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Adjourn to Closed Session**
   a. **Conference with Labor Negotiators**
   The SCCHA Governing Board met in Closed Session to confer its Designated Representatives regarding negotiations with SEIU Local 521.

4. **Report from Closed Session**

   Mr. Brownstein reported the Board met in Closed Session to confer with its Designated Representatives to discuss labor negotiations.

5. 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 September 28, 2017 **Regular Board** Meeting

b. Accept minutes of the December 8, 2017 **Bylaws Committee** Meeting

c. Accept minutes of the October 27, 2017 **Executive/Finance Committee** Meeting and:
- Ratify the F 2016-17 External Audit Report
- Ratify approval of the August 2017 Financial Statements

d. Accept minutes of the November 16, 2017 **Executive/Finance Committee** Meeting and:
- Ratify approval of the September 2017 Financial Statements
- Ratify the Fund Pension Liability
- Ratify the Fund Retiree Healthcare Liability
- Ratify Enterprise Data Warehouse (EDW)

e. Accept minutes of the November 16, 2017 **Compliance Committee** Meeting and:
- Ratify approval of the Compliance Committee Charter
- Ratify approval of the Quarterly and Operational Compliance Reports

f. Accept minutes of the November 8, 2017 **Quality Improvement Committee** Meeting and:
- Ratify acceptance of Committee Reports:
  - Credentialing Committee – August 2, 2017
  - Pharmacy & Therapeutics Committee – June 15, 2017
  - Utilization Management Committee – July 19, 2017

g. Accept minutes of the December 12, 2017 **Consumer Advisory Committee** Meeting

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

6. Resignation of Board Member

Mr. Brownstein noted a letter from Dr. Wally Wenner had been received, resigning from the Santa Clara County Health Authority Governing Board.

It was moved, seconded, and unanimously approved to accept, with gratitude for his many years of service, the resignation of Waldemar Wenner, M.D., from the Santa Clara County Health Authority Governing Board effective December 31, 2017.

7. Executive/Finance Committee Appointment

Mr. Brownstein noted that Dr. Wenner served as a member of the Executive/Finance Committee. He further noted that Dr. Wenner also served as the Chair of the Consumer Advisory Committee (CAC).

It was moved, seconded, and unanimously approved to appoint Dolores Alvarado to the Executive/Finance Committee, and to appoint, in a split role, Brenda Taussig and Paul Murphy as Chair of the Consumer Advisory Committee.

8. CEO Update

Christine Tomcala, Chief Executive Officer, noted that the Plan received HEDIS results and in 2018 will receive 66% of Medi-Cal enrollees auto-assigned by the State, with Anthem receiving 34%.

Ms. Tomcala also noted SCFHP received the 2017 award for Greatest Improvement in Quality Strategy Focus Areas from the California Department of Health Care Services (DHCS)

Ms. Tomcala reminded the Board the Plan sponsored an outdoor classroom space for Veggielution in honor of the Plan's 20th Anniversary and noted that approval and permits have been issued and a work plan is being developed. In lieu of the ribbon cutting ceremony, the Plan will host an open house in our new building and will highlight the classroom space through photos.

Ms. Tomcala shared the new version of the logo with the Board.

Ms. Tomcala advised that continuation of the CHIP program has bipartisan support in Congress, but there is a high likelihood action will not be taken before states are at risk for running out of CHIP funds by the end of December.

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

9. Annual Report to the County of Supervisors

Ms. Tomcala presented the combined Annual Report of the Santa Clara County Health Authority and Santa Clara Community Health Authority. She summarized financial highlights for fiscal 2016-17, the improvements in quality results, collaborative strategic planning efforts with Valley Health Plan, and attainment of interim NCQA accreditation.

It was moved, seconded, and the Annual Report to the County Board of Supervisors was **unanimously approved.**

10. Joint Strategic Planning Committee Update

Mr. Brownstein advised that although the joint strategic planning sessions with Santa Clara County went well, the absence of bipartisan problem-solving support in Washington, D.C., provides challenges for a successful strategic plan. Ms. Tomcala noted that the Plan and its partners will continue to work together on operational issues.

11. Amendments to the Bylaws

Robin Larmer, Chief Compliance & Regulatory Affairs Officer, presented redlined and clean versions of the Bylaws.

Ms. Larmer noted that the proposed revised Bylaws modified Section 5.2.2 authorizing the Executive/Finance Committee to act with the authority of the Board in the event of an urgent or emergent matter that the Executive/Finance Committee or Chief Executive Officer determines reasonably requires handling before a special meeting of the Board can be convened. The current Bylaws allow the Executive/Finance Committee to take such action in the event of an emergency. The Executive/Finance Committee agreed to notify the Board of such action, as soon as practicable.

Ms. Larmer further noted that under the terms of the current Bylaws, the Bylaws Committee is responsible for nominating officers. The Committee agreed the Bylaws should provide for a nominating committee to fulfil the nominating function. There was discussion, and it was agreed the Board would convene a Nominating Committee on an ad hoc basis as needed.

A motion was made recommending the Board approve the Bylaws with the proposed revisions to (1) remove from the Bylaws Committee the responsibility of nominating Officers; and (2) authorize the Executive/Finance Committee to act on urgent and emergent circumstances when determined reasonably necessary by the Executive/Finance Committee or the Chief Executive officer.

It was moved, seconded and the Amendments to the Bylaws were **unanimously approved.**

12. Compliance Report

Ms. Larmer presented the November/December Compliance Report noting both routine business and structural changes.

Ms. Larmer provided an update on progress toward completion of the Core 2.1 Performance Improvement Plan (PIP). The team has made steady progress and has continued to provide frequent updates to CMT. CMT has expressed satisfaction with the team's progress and revised HRA completion processes. Core 2.1 monthly reporting to CMT continues and initial HRA completion rates for the past three months remain at or near 100%.

SCFHP's interdisciplinary reporting initiative continues to meet routinely to evaluate and implement process improvements in regulatory report development, production and submission. To ensure consistency, uniformity, and replicability of reports

for audit and validation purposes, the team developed a uniform report template that will define regulatory and business requirements and technical specifications for all regulatory and most operational reports.

SCFHP received a passing score on the 2017 Performance Measure Validation Activity (PMV) for Core Measure 2.1, CA1.2 and CA1.4.

The Plan received the final 2017 DHCS Audit Report. DHCS overturned two findings, a Corrective Action Plan (CAP) was submitted and DHCS is in following up with requests for clarification..

DMHC accepted the Plan's CAP addressing 2 minor MY 2015 Timely Access violations. SCFHP also paid the $10,000 fine assessed by DMHC.

Other CMS Compliance Notices;
(1) CMS Notice of Non-Compliance (NONC) was received on October 13, 2017 for Part D Call Center Monitoring Accuracy and Accessibility Study – Interpreter Availability Measure. The Plan is working with a translation/interpreter vendor to ensure availability of a French interpreter.
(2) CMS Warning Letter was received on December 6, 2017 because two reports were submitted 7 days late. Compliance has corrected this and staff is being trained on the report submission calendar.
(3) CMS requested that the Plan submit a CAP to address deficiencies in the 2017 Data Validation audit (to validate data submitted in 2016). Although performance has improved over its 2016 performance, the Plan fell short of the 95% passing rate. SCFHP is developing a work plan to develop and implement the CAP using a process similar to that used to develop the Core 2.1 PIP.

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

13. Conflict of Interest Code

Ms. Larmer proposed revisions to the Conflict of Interest Code for the Board's consideration.

It was moved, seconded, and the Resolution adopting the revised Conflict of interest Code was **unanimously approved.**

14. October 2017 Financial Statements

Mr. Cameron presented the October 2017 financial statements which reflected a net surplus of $2.9 million for the month and a net surplus of $10.8 million for the first four months of the fiscal year. This represented a favorable year-to-date budget variance of $9.1 million.

Enrollment decreased by approximately 1,000 members between September and October 2017, continuing a downward trend which commenced in November 2016. The causes remain under review and may include members going "off the grid" due to recent changes in the political climate and/or member relocations due to the high cost of living locally. CMC enrollment has stabilized.

Revenue and medical expense both were lower than budget due to reduced funding for AB85 and IHSS. Both revenue and capitation expenses were also lower than budget due to aforementioned lower member months. Administrative expenses were slightly under budget, with many open staff positions (some of which are filled by temporary staff or consultants). The Plan has reduced its claims inventory to 38,000 and expects to be current by year-end.

The Plan continues to have large receivables from, and payables to, DHCS. The Plan is actively seeking reconciliation and finalization of prior year Coordinated Care Initiative (CCI) amounts. DHCS continues to recoup prior MCE rate overpayments of approximately $18 million per month, which commenced in June 2017. The Plan anticipates that DHCS will recoup all fiscal year 15/16 and 16/17 MCE rate overpayments by roughly April 2018.

Tangible Net Equity was approximately $169 million as of October 31, 2017, or 472% of the DMHC requirement. Mr. Cameron noted that the DHCS requirement will decrease once the IHSS component of CCI is removed January 1, 2018. As the DMHC minimum decreases, the Plan's percentage of that minimum requirement will likely increase. Mr. Cameron

presented a chart detailing the TNE ratios of all local health plans. Capital assets of $10.3 million have been acquired during July 2017, largely representing the purchase of the 50 Great Oaks building. The FY18 Capital Budget includes total annual expenditures of $17.3 million.

A motion was made to accept the October 2017 financial statements, was seconded, and was unanimously approved.

It was moved, seconded, and the October 2017 Financial Statements were **unanimously approved.**

15. Fund Pension Liability

Mr. Cameron noted that SCFHP participates in CalPERS to provide pension benefits to retirees. Many public agencies face large unfunded pension liabilities which are often paid over thirty years into the future. In contrast, SCFHP's Board approved a pre-funding contribution of the June 2015 liability in March 2017. To help ensure the long-term fiscal health of the Plan, Mr. Cameron presented a Resolution that would fund the June 2016 CalPERS liability, calculated at $3,228,650, including accrued interest through December 31, 2017 at the CalPERS rate of 7.0%.

It was moved, seconded and the Resolution to Fund CalPERS Pension Liability was **unanimously approved** as presented.

16. Fund Retiree Healthcare Liability

Mr. Cameron noted that SCFHP participates in the CalPERS California Employers Retiree Benefit Trust (CERBT) program for post-retirement medical benefits. The Plan's actuaries computed the unfunded liability, which was recorded in the Plan's June 2017 financial statements. To help ensure the long-term fiscal health of the Plan, Mr. Cameron presented a Resolution that would fund the Other Post-Employment Benefits Liability, including accrued interest at the CERBT rate. The Resolution provides for three annual contributions of $1,888,847 in December 2017, December 2018 and December 2019, respectively.

It was moved, seconded, and the Resolution to Fund CalPERS Other Post-Employment Benefits Liability was **unanimously approved** as presented.

17. Board Discretionary Fund

Ms. Tomcala discussed potential establishment of a discretionary Board fund for improving the community safety net.

It was moved, secdonded, and unanimously approved to appoint Linda Williams, Kathleen King, Jolene Smith, and Brenda Taussig to a temporary ad hoc committee to consider development of guidelines for establishment of a Board discretionary fund for improving the community safety net.

17. New Building Update

Ms. Tomcala noted the architects are engaged, the interior office space has been laid out, and four construction companies have been selected to submit bids.

18. Network Detection and Prevention Report

Jonathan Tamayo, Chief Information Officer, reported on firewall intrusion, detection, and prevention efforts. The network intrusion reports show unsuccessful attempts to access SCFHP's network.

19. Publicly Available Salary Schedule Ranges

Ms. Tomcala provided updates to the Publicly Available Salary Schedule. She noted that in an effort to ensure all employees are paid a living wage, the minimum pay rate for the two positions in the lowest tier of the salary structure were being increased.

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

20. Adjourn to Closed Session

a. **Public Employee Performance Evaluation**
The Governing Board met in Closed Session to consider the performance evaluation of the Chief Executive Officer.

21. Report from Closed Session

Mr. Brownstein reported the Board met in Closed Session to discuss the performance evaluation of the Chief Executive Officer.

22. Annual CEO Evaluation Process

Michele Lew, Chair of the evaluation sub-committee, reported that the FY 2016-17 performance review was discussed and a compensation recommendation was made based on the positive evaluation of the CEO. It was recommended that the CEO receive a 4% annual salary increase and a 2% bonus.

It was moved and seconded, to approve the recommended annual salary increase and incentive bonus for the CEO**.**

A substitute motion was moved and seconded to direct the Chair of the Board to meet with the Chief Executive Officer to discuss a compensation proposal not less than the recommendation of the sub-committee, with the final decision on compensation to be delegated to the Executive/Finance Committee. **The substitute motion was approved. Ms. Kniss and Mr. Murphy opposed**

23. Adjournment

The meeting was adjourned at 5:20 pm.

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Robert Brownstein, Chairman

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Board Members Present
Bob Brownstein, Chair
Michele Lew, Vice Chair
Brian Darrow
Darrell Evora
Kathleen King
Liz Kniss
Paul Murphy
Jolene Smith
Brenda Taussig
Waldemar Wenner, M.D.
Linda Williams

Board Members Absent
Dolores Alvarado
Chris Dawes

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Chris Turner, Chief Operations Officer
Jonathan Tamayo, Chief Information Officer
Neal Jarecki, Controller
Beth Paige, Compliance Officer
Rita Zambrano, Executive Assistant

Others Present
Richard Noack, Hopkins & Carley LLC
Jim Frieman, SEIU Representative

Minutes – Draft

1. **Roll Call**

Bob Brownstein, Chair, called the meeting to order at 2:30 pm. Roll call was taken and a quorum was established.

2. **Public Comment**

There were no public comments.

3. **Meeting Minutes**

The minutes of the December 15, 2016 Regular Board Meeting were reviewed.

It was moved, seconded, and the December 15, 2016 Regular Board meeting minutes were **unanimously approved.**

4. Conflict of Interest Code

Robin Larmer, Chief Compliance & Regulatory Officer, presented proposed revisions to the Conflict of Interest Code for the Board's consideration.

It was moved, seconded, and the Resolution adopting the revised Conflict of Interest Code was **unanimously approved**.

5. Annual Report to the County Board of Supervisors

Christine Tomcala, Chief Executive Officer, presented the draft report regarding the activities of the Joint Powers Authority as incorporated in the Annual Report of the Santa Clara County Health Authority.

It was moved, seconded, and the Annual Report to the County Board of Supervisors was **unanimously approved.**

Brenda Taussig, Kathleen King, Jolene Smith, and Liz Kniss joined the meeting.

6. Continuation of Santa Clara Community Health Authority

Ms. Tomcala noted that the Community Health Authority was originally created in 2006 as a means to limit taxation of non-Medi-Cal revenue. The relevant tax has since been eliminated, and management proposes to conduct due diligence to explore potential dissolution of the Community Health Authority.

It was moved, seconded, and unanimously approved to authorize Management to conduct due diligence regarding potential dissolution of the Santa Clara Community Health Authority and report its findings to the Board.

7. Adjournment

The meeting was adjourned at 2:55 pm.

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Bob Brownstein, Chair

Santa Clara
Family Health Plan
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Regular Meeting of the
Santa Clara County Health Authority
Executive/Finance Committee

Thursday, November 16, 2017
11:30 AM - 1:00 PM
210 E. Hacienda Avenue
Campbell CA 95008

Members Present
Michele Lew, Chair
Bob Brownstein
Linda Williams
Wally Wenner, M.D.

Member Absent
Liz Kniss

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance Officer & Regulatory Affairs Officer
Jonathan Tamayo, Chief Information Officer
Rita Zambrano, Executive Assistant

Minutes - Draft

1. **Roll Call**

   Michele Lew, Chair, called the meeting to order at 11:40 am. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The minutes of the October 27, 2017 Executive/Finance Committee Meeting were reviewed.

   It was moved, seconded, and the October 27, 2017 Executive/Finance Committee meeting minutes were **unanimously approved** as presented.

3. **Public Comment**

   There were no public comments.

4. **Adjourn to Closed Session**

   a. **Conference with Labor Negotiators**
   The Executive/Finance Committee met in Closed Session to confer with Designated Representatives regarding negotiations with SEIU Local 521.

b. Significant Exposure to Litigation

The Executive/Finance Committee met in Closed Session to confer with Legal Counsel relating to one item of significant exposure to litigation.

5. Report from Closed Session

Ms. Lew reported that the Committee conferred on Items 4. (a) and (b).

6. September 2017 Financial Statements

Mr. Cameron presented the financial statements for the month and year-to-date ended September 30, 2017. The Plan recorded a net surplus of $2.5 million for the month and a net surplus of $7.9 million for the three months ended September 30, 2017 ($6.5 million favorable to the year-to-date budget). Year-to-date member months of 816,000 are 1.1% unfavorable to budget and 2.5% lower than September 2016, as enrollment continues its decline noted since October 2016. Much of the decline in enrollment is in the Medi-Cal MCE category while enrollment in Medi-Cal Dual category is growing. Lower member months yielded largely offsetting variances in both revenue (unfavorable) and capitation expense (favorable). Prior period revenue is slightly higher than budget. Medical expense is under budget by 1.9% for the year-to-date. Administrative expenses are lower than budget by 3.4% for the year-to-date. The balance sheet continues to reflect significant receivables from, and payables to, DHCS. The Plan's Current Ratio (the ratio of current assets to current liabilities) is 1.2, above the DMHC-required minimum of 1.0. Capital investments consisted largely of the new building purchase. Tangible Net Equity of $166 million is 467% of the DMHC-required minimum of $35.6 million.

It was moved, seconded, and the September 2017 Financial Statements were unanimously approved as presented.

7. Fund Pension Liability

Mr. Cameron noted that SCFHP participates in CalPERS to provide pension benefits to its retired, vested employees. The latest CalPERS pension valuation report, dated June 30, 2016, indicated an unfunded pension liability of $2.5 million (93% funded). Mr. Cameron noted that many CalPERS plans defer these contributions over a 30 year period, incurring significant interest costs. Instead, he recommended that SCFHP continue pre-funding an annual pension contribution, as the Board initially approved in March 2017 (for the fiscal year ended June 30, 2015). Based on amounts obtained from both SCFHP's actuaries for the fiscal year ended June 2016, including a known reduction to the CalPERS discount rate to 7.0%, Mr. Cameron recommended pre-funding a pension contribution of $3.1 million (including accrued interest) as of November 30, 2017. By making this pre-payment immediately, rather than over 30 years, estimated future interest of $4 million is avoided.

It was moved, seconded, and unanimously approved to endorse pre-funding the pension contribution and to request approval by the Board at its December 2017 meeting. The Committee requested a revision to the resolution to accrue interest through December 2017.

8. Fund Retiree Healthcare Liability

Mr. Cameron noted that SCFHP participates in CalPERS' CERBT program to provide medical coverage to retired and vested employees. The latest CalPERS OPEB valuation report, dated June 30, 2016, indicated an unfunded liability of $2.5 million (93% funded). Mr. Cameron noted that many CalPERS plans defer these contributions

over a 30 year period, incurring significant interest costs. Instead, he recommended that SCFHP begin pre-funding OPEB contributions. Based on amounts obtained from both CalPERS and SCFHP's actuaries for the fiscal year ended June 2016, Mr. Cameron recommended making pre-funding an OPEB contribution of approximately $5.3 million as of November 30, 2017. For cash flow purposes, Mr. Cameron recommended making the contributions in three annual installments of approximately $1.9 million, payable in November 2017, November 2018 and November 2019. By making this pre-payment immediately, rather than over 30 years, estimated future interest of $6 million is avoided.

> **It was moved, seconded, and unanimously approved** to endorse pre-funding the OPEB contribution and to request approval by the Board at its December 2017 meeting. The Committee requested a revision to the resolution to accrue interest through December 2017.

9. Enterprise Data Warehouse (EDW)

Jonathan Tamayo, Chief Information Officer, presented a proposal to develop an Enterprise Data Warehouse (EDW) in conjuction with Kern Family Health Care. Mr. Tamayo updated the Committee on the existing infrastructure and technology that was developed internally by staff nine years ago and has limited capabilities. Quotes were obtained and the Plan recommends building a new system. The Committee requested additional information on the vendor at its next meeting.

> **It was moved, seconded, and unanimously approved** to authorize the CEO to negotiate, execute, amend, and terminate a contract with FluidEdge and participate in Phase I development of an Enterprise Data Warehouse with Kern Family Health Care in an amount not to exceed $300,000.

10. CEO Update

Christine Tomcala gave a brief update on the status of the Joint Strategic Planning efforts, noting the next meeting is scheduled for November 28, 2017. She also reminded the Committee that this is a temporary ad hoc committee that needs to complete its work by mid-December.

Ms. Tomcala invited Mr. Cameron to provide an update on misdirected claims. In its routine financial audit report of November 2016, the DMHC found that the Plan had not rerouted at least 95% of misdirected claims within ten working day. The Plan self-proposed a Corrective Action Plan (CAP) to address this issue and achieved 98% compliance through June 2017. During the quarter ended September 2017, the Plan's focus shifted away from misdirected claims to issues surrounding the QNXT claims system implementation. As a result, misdirected claims compliance fell to 61% during the quarter. In early October, the Plan launched a series of measures aimed at restoring misdirected claims compliance as quickly as possible and the Plan expect to regain compliance by the end of December 2017. The Plan has voluntarily extended its CAP timetable from December 2017 to March 2018.

Mr. Cameron further reported on Provider Dispute Resolutions (PDRs), noting that there are more PDRs as a result of some of the decisions made regarding misdirected claims. Compliance may slip this quarter, but there is progress and staff will continue to update the Committee.

Ms. Tomcala noted that the QNXT implementation claims back-log has been cut in half and we are seeing progress.

Ms. Tomcala updated the Committee on the new building, noting that the focus is on the design phase and selection of a general contractor.

Ms. Tomcala shared a new version of the logo with the Committee.

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

11. Adjournment

The meeting was adjourned at 12:55 pm.

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Michele Lew, Chair

Santa Clara
Family Health Plan

Enterprise Data Warehouse Executive/Finance Committee

November 16, 2017

Data Warehouse

- Current State:
  - Data Warehouse developed 9 years ago which is limited to claims, provider, member and financial data (membership capitation data). Infrastructure built on old technology
  - Other sources of data would need to be extracted and coupled with current DW with complex queries for other types of reporting.
  - Usually takes longer to develop reports.
  - 2017-2018 Budget $920,000

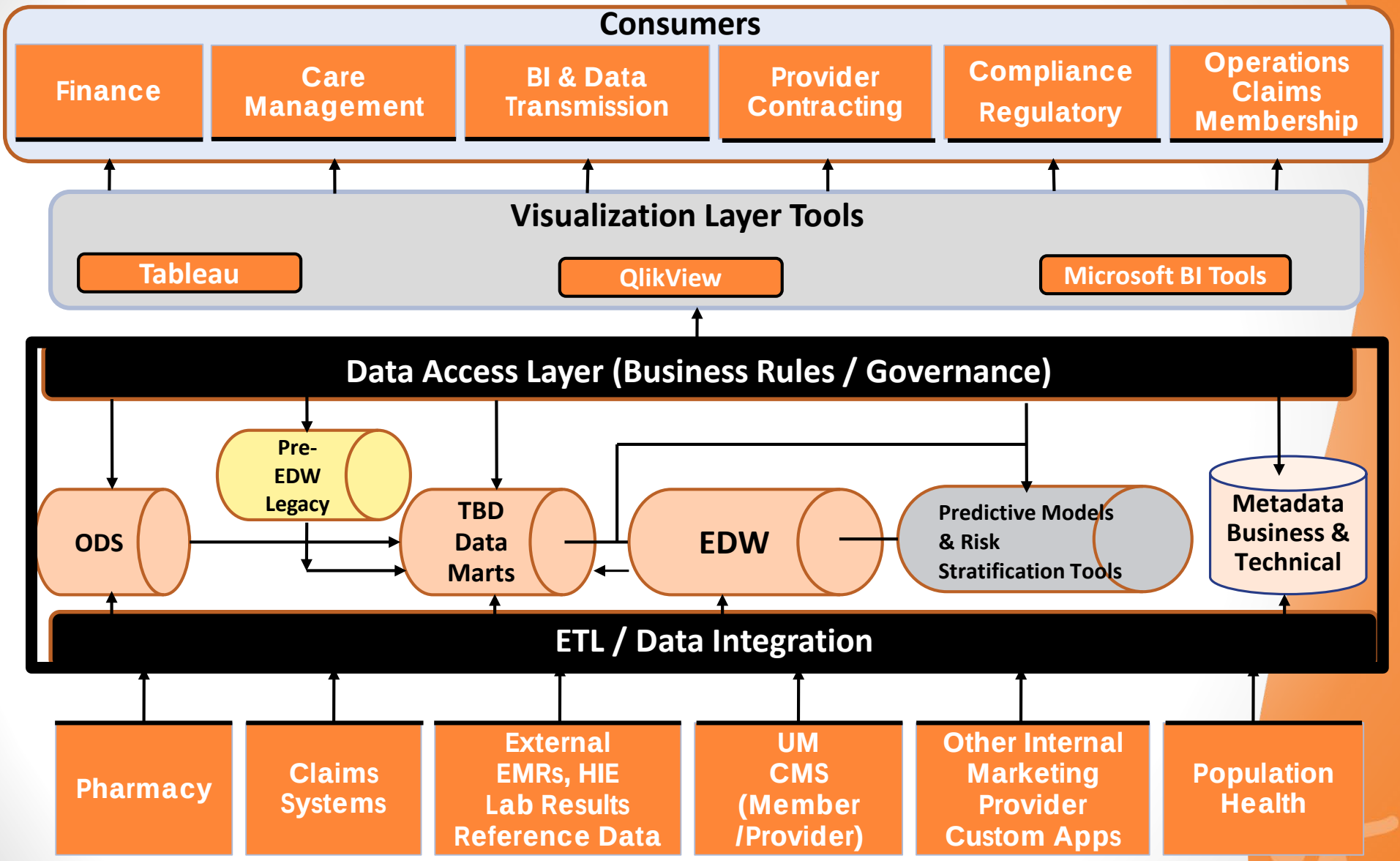
Definition

- In computing, an enterprise data warehouse (EDW), is a system used for reporting and data analysis, and is considered a core component of business intelligence. EDWs are central repositories of integrated data from one or more disparate sources. They store current and historical data in one single place that are used for creating analytical reports for knowledge workers throughout the enterprise.

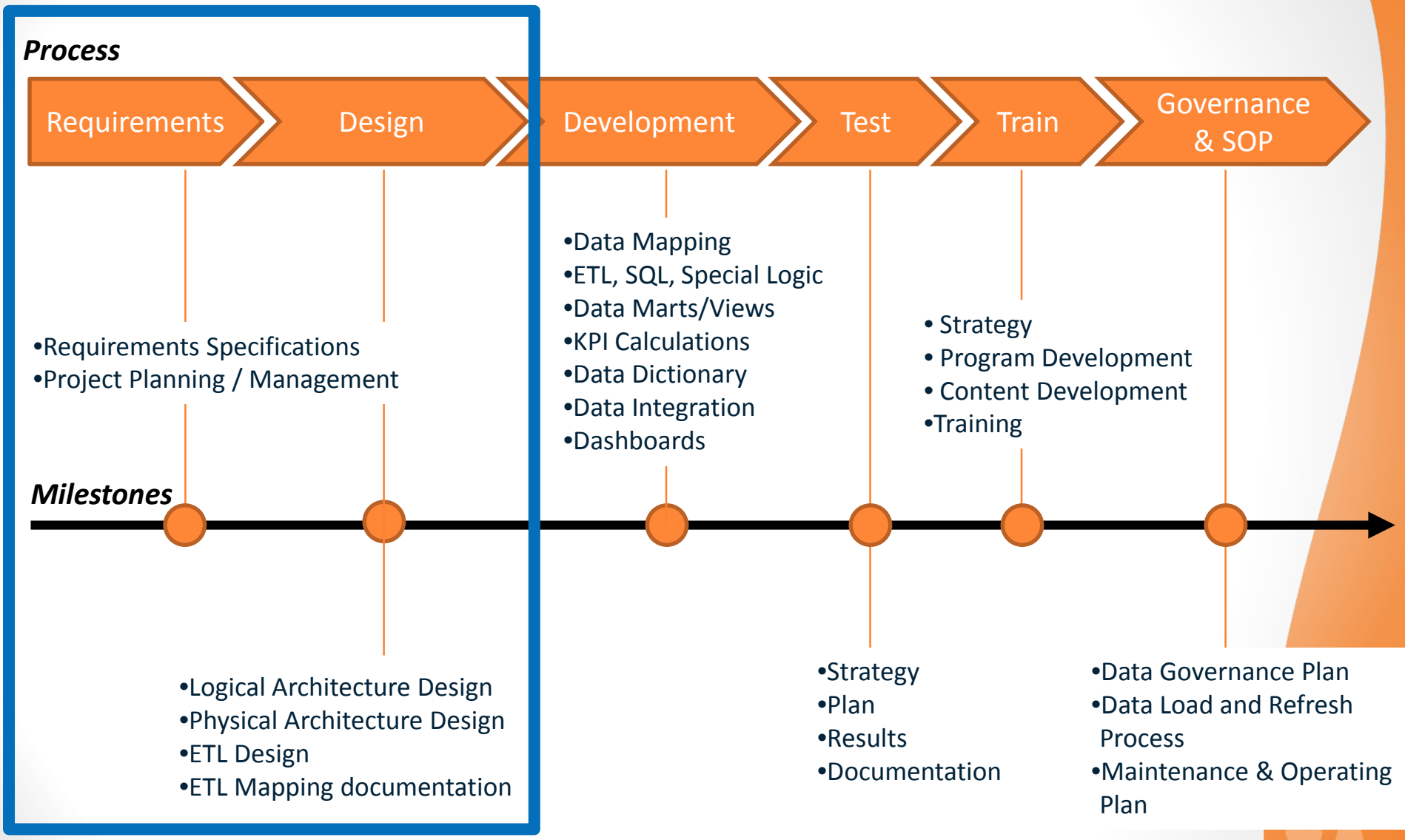
- The data stored in the warehouse is uploaded from the operational systems (such as claims or care management). The data may pass through an operational data store and may require data cleansing for additional operations to ensure data quality before it is used in the EDW for reporting.

- From Wikipedia, with slight modifications

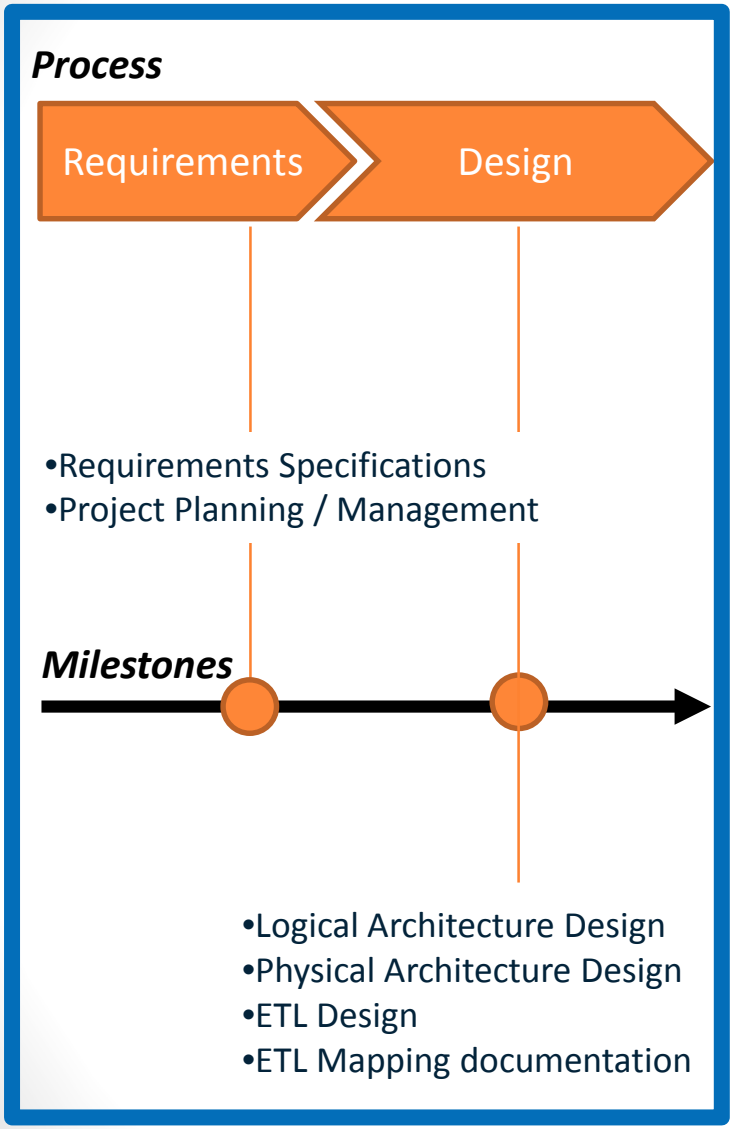
DATA ANALYTICS: HIGH LEVEL VISION



DATA ANALYTICS: PHASE 1 SCOPE



DATA ANALYTICS: PHASE 1 TIMELINE AND COSTS



Domains

- Membership
- Provider
- Claims
- Basic Auth Data
- Codes/Dates/Metadata

Phase 1 Timeline

- Project kick-off – November
- Requirements complete – December
- Design complete – March 30, 2018
- Phase 1 duration – 20 weeks

Resources

- Program Manager
- Project manager
- Business analysts (2)
- Technical manager
- Data architect
- Technical writer

Professional Services

- Fixed pro fees Phase 1 - $475,000
  - Santa Clara - $285,000
  - Kern - $190,000
- FEC contribution - $110,000
- Estimated project total - $1M to $1.2M

Overall Project Goals and Guiding Principles

- The objective of this project is to develop and populate an integrated, scalable, and maintainable Enterprise Data Warehouse across programs and systems. Once completed, the warehouse will support interactive dashboards in various visualization applications to support Executives, Operation Directors, Regulatory Reporting and External Data requests.
- The solution will be developed jointly for and with Santa Clara and Kern
- The solution will be rolled out in phases by domain
- Each party will contribute existing technology that will be incorporated into the solution
  - Santa Clara contributing initial data schema
  - Kern contributing existing dashboards
- FluidEdge will contribute Program Management and a technical writer to the project
- FluidEdge will retain the right to market the solution once completed

Finance Committee

Proposed Action:

Authorize CEO to negotiate, execute, amend, and terminate a contract with Fluid Edge and participate in Phase I development of the EDW with Kern Family Health Care in an amount not to exceed $300,00.

Santa Clara
Family Health Plan

Questions?

Santa Clara
Family Health Plan
The Spirit of Care

Regular Meeting of the
Santa Clara County Health Authority
Executive/Finance Committee

Thursday, January 25, 2018
11:30 AM - 1:00 PM
210 E. Hacienda Avenue
Campbell CA 95008

Minutes – Draft

Members Present
Michele Lew, Chair
Linda Williams
Liz Kniss
Dolores Alvarado *(via telephone)*

Members Absent
Bob Brownstein

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance Officer & Regulatory Affairs Officer
Jonathan Tamayo, Chief Information Officer
Sharon Valdez, VP Human Resources
Rita Zambrano. Executive Assistant

Others Present
Richard Noack, Hopkins and Carley LLP

1. **Roll Call**

   Michele Lew, Chair, called the meeting to order at 11:40am. Roll call was taken and a quorum was not established.

2. **Enterprise Data Warehouse Vendor**

   Jonathan Tamayo, Chief Information Officer, presented the Committee with background information on FluidEdge, the vendor selected to assist in developing the Enterprise Data Warehouse. FluidEdge has knowledge of claims processing systems and Enterprise Data Warehouse solutions and focuses its work in the health care industry.

3. **CEO Update**

   Christine Tomcala, Chief Executive Officer, presented an update on the QNXT claims system implementation. Ms. Tomcala noted it is an organizational objective to achieve a 70% auto-adjudicaton rate this year for Medi-Cal claims on QNXT. Current auto-adjudication rates are averaging 68-70%.

   Dave Cameron, Chief Financial Officer, provided an update on misdirected claims and provider dispute

resolutions, indicating they are current and monitored weekly.

Ms. Tomcala reported that, due to recent federal legislative activity, the CHIP program has been funded for an additional six years.

Dolores Alvarado joined the meeting at 12:00 pm and a quorum was established.

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

4. Meeting Minutes

The minutes of the November 16, 2017 Executive/Finance Committee were reviewed.

It was moved, seconded and the November 16, 2017 Executive/Finance Committee meeting minutes were **unanimously approved** as presented.

5. Public Comment

There were no public comments.

6. Adjourn to Closed Session

a. Conference with Labor Negotiators
The Executive/Finance Committee met in Closed Session to confer with Designated Representatives regarding negotiations with SEIU Local 521.

7. Report from Closed Session

Ms. Lew reported that the Committee conferred with its labor negotiators to consider a proposed agreement.

8. Tentative Agreement with SEIU Local 521

The Tentative Agreement with SEIU Local 521 was discussed and Ms. Lew recommended approval.

It was moved, seconded, and unanimously approved to (1) approve, and recommend that the Board approve, the Tentative Agreement with SEIU; and (2) authorize executive staff to implement the salary adjustments in advance of Board approval.

9. November 2017 Financial Statements

Mr. Cameron presented the financial statements for the month of November 2017, which reflected a net surplus of $2.1 million for the month and $12.9 million for the first five months of the fiscal year. These represent favorable budget variances of $1.5 million and $10.6 million, respectively.

November enrollment of approximately 268,000 members reflected an unfavorable budget variance of 5,152 members and a decline of approximately 1,800 members from the prior month. This continues a downward enrollment trend that began after October 2016 for which specific cause(s) are unknown. While Medi-Cal enrollment continued to decline, enrollment in Healthy Kids held steady, while enrollment in Cal Medi-Connect increased slightly.

Liz Kniss joined the meeting at 12:20 pm.

November revenue reflected a favorable budget variance of $2.9 million (2.9%) for the month and a favorable budget variance of $755 thousand (0.1%) year-to-date. The November variance was caused by higher LTC and BHT enrollment and rates versus budget.

Medical expense reflected an unfavorable budget variance of $1.7 million (1.8%) for the month and a favorable budget variance of $8.7 million (1.8%) year-to-date due to higher LTC utilizers and an unfavorable inpatient expense vs. budget**.** The overall medical loss ratio (MLR) was 94.18% for the month and 93.3% year-to-date, both favorable to budgeted MLR of 95.1% and 95.2%, respectively.

Administrative expense reflected a favorable budget variance of $78 thousand (4%) for the month and a favorable variance of $740 thousand year-to-date. Much of the variance was attributable to delayed hiring of staff, offset by increased usage of consultants.

The balance sheet continues to reflect significant Coordinated Care Initiative (CCI) receivables and payables. The Plan is actively seeking reconciliation and finalization of prior year CCI amounts with DHCS. DHCS continues to recoup prior year overpayments by approximately $18 million per month and the Plan anticipates completion of the MCE rate recoupments by approximately April 2018. The current ratio of 1.2 exceeds the DMHC minimum of 1.0.

Tangible Net Equity (TNE) of $171.3 million was 475% of the Department of Managed Health Care (DMCH) minimum requirement of $36 million.

Capital assets of $10.3 million have been acquired during the fiscal year-to-date, largely the 50 Great Oaks building. The Capital Budget includes total annual expenditures of $17.3 million.

> **It was moved, seconded and** the November 2017 Financial Statements were **unanimously approved** as presented.

10. Selection of General Contractor for Build-out of 50 Great Oaks Blvd.

Ms. Tomcala reminded the Committee that the Board delegated authorization of budgets and contracts related to the build-out to the Executive/Finance Committee. Ms. Tomcala further noted the Plan had engaged a construction and project manager, Jason Schlutt of Compass Solutions, and an architect design firm, Studio G.

Mr. Cameron noted that four general contractor bids were vetted and Build SJC was chosen. The project is a design-build arrangement and will be a union job. The contract with Build SJC will establish a fee that is a percentage of the cost of all work. Mr. Cameron noted that due to the market, material and other factors, the overall cost of the work will exceed the initial $5 million.

> **It was moved, seconded and unanimously approved** to authorize the CEO to negotiate and execute a contract with Build SJC consistent with material terms as described to the Committee.

11. Adjournment

The meeting was adjourned at 12:40 pm.

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Michele Lew, Chair

Santa Clara
Family Health Plan

The Spirit of Care

Unaudited
Financial Statements
For Five Months Ended November 2017

Table of Contents

Financial Highlights

- **Net Surplus –** November $2.1 million surplus ($1.5 million favorable to budget) and year-to-date (YTD) $12.9 million surplus ($10.6 million favorable to budget). YTD surplus is mostly driven by lower medical expenses than budget.
- **Enrollment –** November membership 268,303 (1.9% unfavorable to budget) and YTD: 1,354,206 member months (1.3% unfavorable to budget and 3.3% lower than YTD last year). While Medi-Cal enrollment has continually declined since October 2016, Cal MediConnect (CMC) membership grew for the first time since March, 2017.
- **Revenue –** Favorable to budget by $2.9 million for the month (3%) and favorable to budget by $0.8 million (0.2%) YTD
- **Medical Expenses –** Unfavorable to budget by $1.8 million for the month (1.9%) and favorable to budget by $8.7 million (1.9%)
- **Administrative Expenses –** Favorable to budget by $78 thousand (1.9%) and favorable YTD budget by $0.7 million (+3.5%)
- **Tangible Net Equity –** $171.3 million or 475% of minimum required Tangible Net Equity (TNE) of $36.0 million per Department of Managed Health Care (DMHC)
- **Capital Expenditure –** YTD capital investments of $10.3 million versus $17.3 million per annual budget, largely building purchase

	Month	YTD
Revenue	$102 million	$496 million
Medical Costs	$96 million	$463 million
Medical Loss Ratio	94.1%	93.3%
Administrative Costs	$4.1 million (4%)	$20.6 million (4.1%)
Other Income/ Expense	$196,861	$40,344
Net Surplus (Loss)	$2,106,252	$12,908,895

Cash on Hand	$285 million
Net Cash Available to SCFHP	$282 million
Receivables	$523 million
Current Liabilities	$659 million
Tangible Net Equity	$171 million
Percent Of DMHC Requirement	**475%**

Risks and Opportunities

- **Risks**
  - Fiscal Year 2017-18 YTD enrollment is below budget. Medi-Cal enrollment has been declining since October 2016.
  - Claim inventory build-up due to conversion of claims payments system is causing some volatility in claims payment and in estimation of total monthly medical expenses. The claims inventory returned to a normal level by December 2017.
  - Delay in revenue receipts due to rate differential vs. budget requires some estimation and accruals.
  - Rate reconciliation timing by Department of Healthcare Services (DHCS) for Coordinated Care Initiative (CCI) program.

- **Opportunities**
  - Continued growth in CCI membership.
  - Continue to fill open positions to replace temporary staff and consultant usage.
  - With convergence of claims processing to QNXT, all claims are processed on one system, which should allow for increased auto-adjudication rates and better efficiency.

Member Months

For the month of November 2017, total membership was lower than budget by 5,152 (-1.9%). For YTD, total member months were lower than budget by 18,241 (-1.3%). Medi-Cal membership has declined since October 2016 while CMC membership grew marginally for the first time since March, 2017.

In the five months since the end of the prior fiscal year (FY), 6/30/2017, membership in Medi-Cal decreased by 2.7%, membership in Healthy Kids program decreased by 15.0%, and membership in CMC program decreased by 2.6%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Nov 2017			For Five Months Ending Nov 30, 2017				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**Change FY18 vs. FY17**
Medi-Cal	258,633	263,155	(1.7%)	1,305,115	1,320,947	(1.2%)	1,344,671	(2.9%)
Healthy Kids	2,321	2,800	(17.1%)	12,103	14,000	(13.6%)	16,686	(27.5%)
Medicare	7,349	7,500	(2.0%)	36,988	37,500	(1.4%)	39,426	(6.2%)
Total	268,303	273,455	(1.9%)	1,354,206	1,372,447	(1.3%)	1,400,783	(3.3%)

Santa Clara Family Health Plan Enrollment by Network
November 2017

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	28,640	11%	260	11%	7,349	100%	36,249	14%
SCVHHS, Safety Net Clinics, FQHC Clinics	132,321	51%	1,029	44%	-	0%	133,350	50%
Palo Alto Medical Foundation	7,399	3%	76	3%	-	0%	7,475	3%
Physicians Medical Group	47,619	18%	773	33%	-	0%	48,392	18%
Premier Care	16,115	6%	183	8%	-	0%	16,298	6%
Kaiser	26,539	10%	-	0%	-	0%	26,539	10%
Total	**258,633**	**100%**	**2,321**	**100%**	**7,349**	**100%**	**268,303**	**100%**
Enrollment at June 30, 2017	265,753		2,732		7,543		276,028	
Net Change from Beginning of FY18	-2.7%		-15.0%		-2.6%		-2.8%	

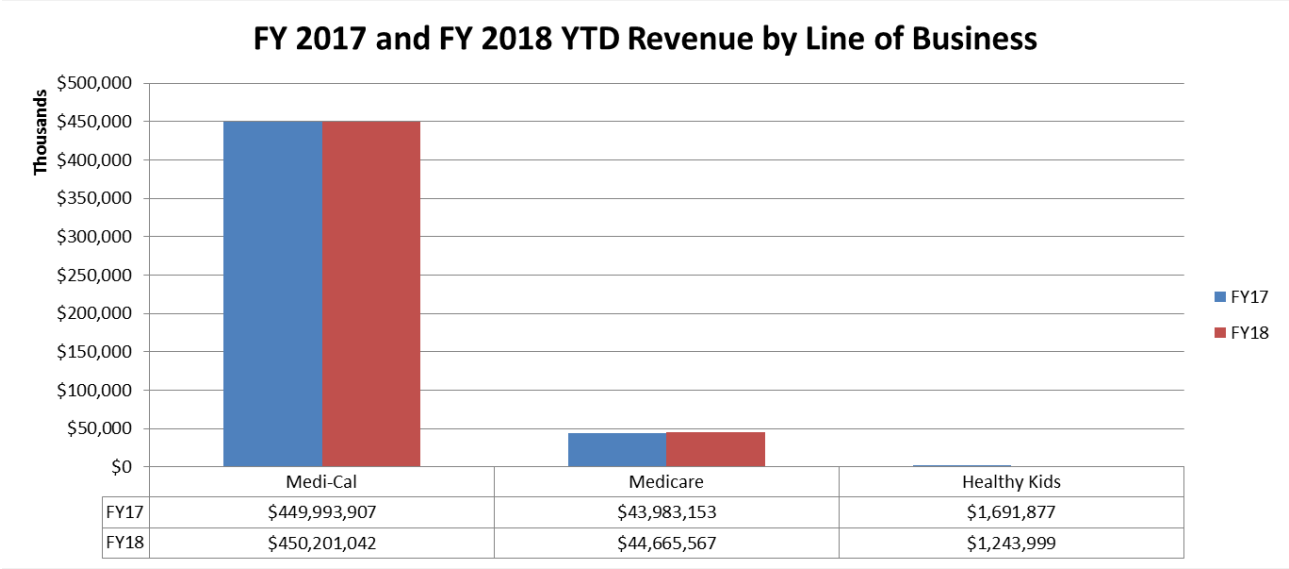
SCVHHS = Santa Clara Valley Health & Hospital System
FQHC = Federally Qualified Health Center

Revenue

Santa Clara Family Health Plan (SCFHP or The Plan) recorded net revenue of $101.8 million for the month of November 2017, compared to budgeted revenue of $98.9 million, resulting in a favorable variance from budget of $2.9 million, or +2.9%. For YTD November 2017, the Plan recorded net revenue of $496.1 million, compared to budgeted revenue of $495.4 million, resulting in a favorable variance from budget of $0.8 million, or +0.2%.

Major revenue variances for November 2017, which net to $2.9 million were:

1. Long Term Care (LTC) revenue favorable by $1.5 million due to both higher member months and rate differential.
2. In-Home Support Services (IHSS) revenue net of higher expense favorable by $0.6 million due to prior period adjustment.
3. BHT revenue favorable by $0.6 million due to both higher member months and rate differential.
4. Prior period revenue unfavorable by $1.3 million largely due to true-up of Home and Community-Based Services (HCBS) member months YTD that were estimated until October 2017; offset by a reduction in rate difference payable to DHCS for Medicaid Coverage Expansion (MCE) members and rate adjustment for Medi-Cal CMC members.
5. Assembly Bill (AB 85) revenue unfavorable by $1.2 million (no impact on net income).



	Medi-Cal	Medicare	Healthy Kids
FY17	$449,993,907	$43,983,153	$1,691,877
FY18	$450,201,042	$44,665,567	$1,243,999

Medical Expenses

For the month of November 2017, medical expense was $95.9 million compared to budget of $94.1 million, resulting in an unfavorable budget variance of $1.8 million, or -1.9%. For year to date November 2017, medical expense was $462.7 million compared to budget of $471.4 million, resulting in a favorable budget variance of $8.7 million, or +1.9%.

Major medical expense variances for November 2017 were:

1. LTC expense unfavorable due by $2.2 million due to higher number of utilizers vs. budget
2. Hospital costs unfavorable by $0.6 million due to prior period adjustment of $1.0 million offset by a $0.4 million favorable adjustment due to lower utilization vs. budget
3. Specialists' expense unfavorable by $0.5 million due to higher utilization vs. budget
4. Capitation expense favorable by $1.2 million due to lower member months vs. budget
5. AB 85 medical expense favorable by $1.2 million (no impact on net income)

YTD medical expense favorability of $8.7 million is largely driven by:

1. The Plan had recorded a net IHSS loss for FY 17. Based on this experience, a $1.0 million monthly net IHSS expense ($5.0 million YTD) was budgeted for FY18 for the potential risk the Plan still carries. This expense is under evaluation for FY18.
2. Capitation expense favorable by $3.4 million due to lower member months vs. budget.

YTD medical expense summary:

Medical Expense	Amount	% of Total
Network Capitation	$165,923,139	36%
IHSS	$74,248,143	16%
Pharmacy	$62,273,662	13%
Inpatient, Emergency, and Maternity	$56,485,703	12%
Institutional Extended Care	$54,639,445	12%
Outpatient and Other	$49,112,235	11%
Total Medical Expense	**$462,682,329**	

Administrative Expenses

Administrative costs were favorable to budget by $0.1 million (+1.9%) for the month of November 2017 and favorable to budget by $0.7 million (+3.5%) for YTD November 2017.

Major administrative expense variances for November 2017 and YTD were:

1. Payroll expense is favorable payroll due to vacant positions; Offset by higher consulting and temporary help expense.
2. Printing, Postage, and Information Services expenses are favorable due to timing but expected to match budget for the year.

Overall administrative expenses were 4.1% of revenue for YTD November 2017 (0.2% favorable to budget).

Actual vs. Budget
For the Current Month & Fiscal Year to Date - Nov 2017
Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$ 2,095,588	$ 2,388,807	$ 293,219	12.3%	Personnel	$ 10,891,827	$ 11,301,287	$ 409,460	3.6%
1,960,264	1,745,338	(214,926)	-12.3%	Non-Personnel	9,667,900	9,998,986	$ 331,086	3.3%
4,055,852	4,134,145	78,293	1.9%	Total Administrative Expense	20,559,727	21,300,274	740,546	3.5%

Balance Sheet

- Current assets totaled $815.5 million compared to current liabilities of $659.2 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0. Working capital (current assets minus current liabilities) increased by $4.5 million for the five months of the fiscal year.

- Cash as of November 30, 2017 decreased by $79.4 million compared to the cash balance as of year-end June 30, 2017. The overall cash position decreased largely due to:
    1. recoupment of FY2015-16 MCE overpayments (~$18 million per month) by DHCS.
    2. increase in net receivables by $48.6 million due to a delay in receipt of payments for Duals Recast differential revenue, Managed Care Organization (MCO) tax revenue, and Supplemental revenue.
    3. payment of MCO tax for FY17 and prior years.
    4. purchase of a new building.

- SCFHP moved $140.0 million of its cash to the county investment pool in order to achieve higher interest income while still maintaining the liquidity of its funds. With the commencement of monthly recoupment of MCE overpayments by the State beginning in June's capitation, the Plan may need to withdraw some of these funds as early as in January 2018.

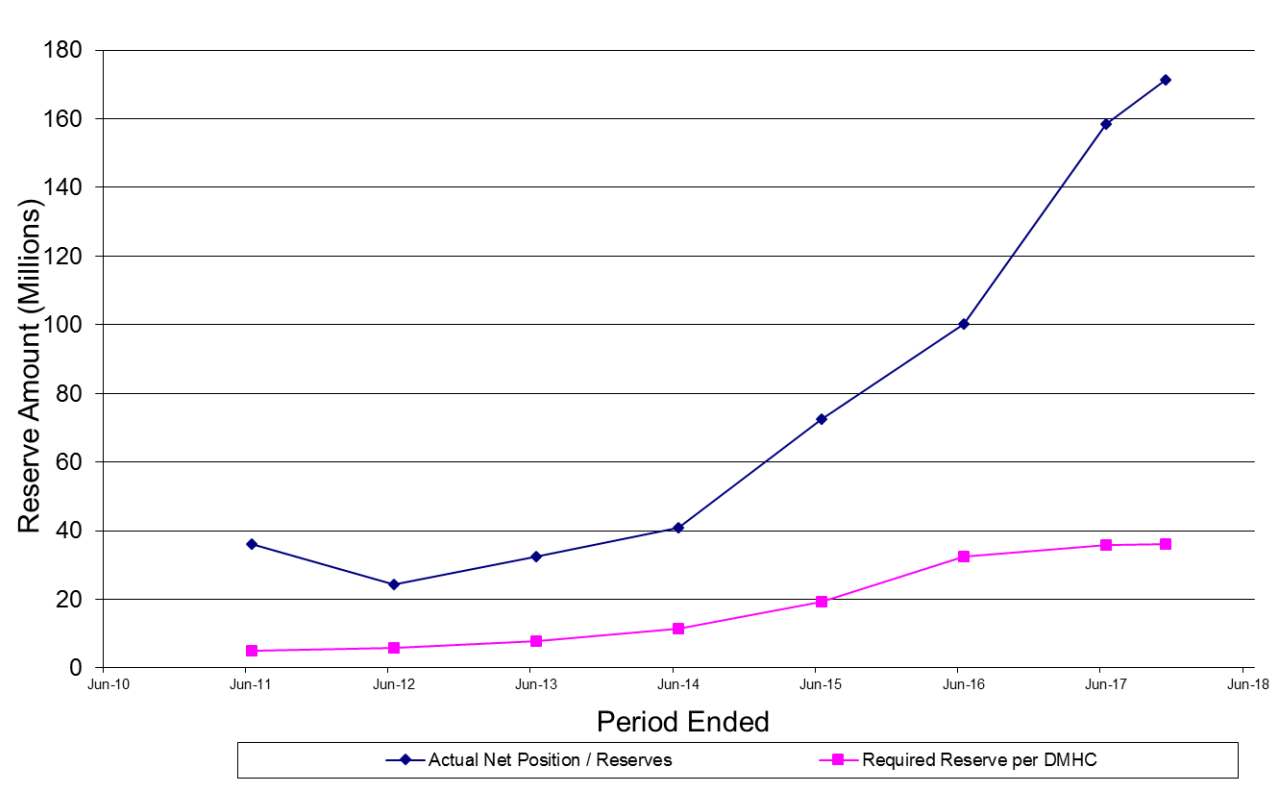
- Liabilities decreased by $35.2 million during the five months ended November 30, 2017. Liabilities decreased primarily due to the disbursement of pass-through funds to hospitals, payment of MCO tax for FY17 and prior years, and recoupment of FY2015-16 MCE overpayments by DHCS.

Tangible Net Equity (TNE)

TNE was $171.3 million at November 30, 2017 or 475% of the most recent quarterly DMHC minimum requirement of $36.0 million. TNE trends for SCFHP are shown below.

As of Period Ended:

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	11/30/2017
Actual Net Position / Reserves	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	158,380,560	171,289,455
Required Reserve per DMHC	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	35,898,000	36,049,554
200% of Required Reserve	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	71,796,000	72,099,109
Actual as % Required	722%	410%	419%	357%	377%	310%	441%	475%



Reserves Analysis

- At the September 2016 Governing Board meeting, a policy was adopted for targeting the organization's capital reserves to include a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

- As of November 30, 2017, the Plan's TNE was $45.1 million above the low-end Equity Target and $161.7 million above the low-end Liquidity Target. The Plan's TNE was $9.0 million below the high-end Equity Target and $121.6 million above the high-end Liquidity Target (see calculations below).

SCFHP RESERVES ANALYSIS NOVEMBER 2017

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$171,289,455
Current Required TNE	$36,049,554
Excess TNE	$135,239,900
Required TNE Percentage	475%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$126,173,440
500% of Required TNE (high end)	$180,247,771
TNE Above/(Below) SCFHP Low End Target	**$45,116,015**
TNE Above/(Below) SCFHP High End Target	**($8,958,317)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$285,180,287
Less Pass-through Liabilities:	
Net Receivable/(Payable) from/to State of CA*	19,033,530
Other Pass-through Liabilities	(22,232,231)
Total Pass-through Liabilities	(3,198,700)
Net Cash Available to SCFHP	$281,981,586
SCFHP Target Liquidity:	
45 days of Total Operating Expenses	($120,292,327)
60 days of Total Operating Expenses	($160,389,770)
Liquidity Above/(Below) SCFHP Low End Target	**$161,689,259**
Liquidity Above/(Below) SCFHP High End Target	**$121,591,816**
*Pass-Throughs from State of CA (excludes IHSS)	
Receivables Due to SCFHP	165,828,357
Payables Due from SCFHP	(146,794,827)
Net Receivable/(Payable)	$19,033,530

Capital Expenditure

Capital investments of $10.3 million were made during the five months ended November 30, 2017, largely due to the purchase of a new building (in order to lower the long term occupancy costs in an ever increasing rental rate situation in the current location). The YTD capital expenditure includes:

Expenditure	YTD Actual	Annual Budget
New Building*	$9,753,134	$14,300,000
Systems	32,894	1,595,000
Hardware	385,435	611,500
Software	20,647	587,000
Furniture and Fixtures	135,935	173,515
Automobile	0	33,000
Leasehold Improvements	0	10,000
TOTAL	**$10,328,044**	**$17,310,015**

**Budget includes $4.5 million of renovation expend associated with 50 Great Oaks building*

The Plan expects to incur the bulk of the remaining expenditures later in the FY 2018.

Santa Clara Family Health Plan
Enrollment by Aid-Category

		2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11
NON DUAL	Adult (over 19)	31,072	30,836	30,479	30,204	29,921	29,651	28,985	29,305	29,056	28,727	28,260
	Adult (under 19)	106,719	106,926	106,305	106,181	105,945	106,082	104,658	105,130	104,329	103,794	103,225
	Aged - Medi-Cal Only	10,371	10,400	10,400	10,520	10,538	10,674	10,776	10,772	10,802	10,876	10,861
	Disabled - Medi-Cal Only	11,014	11,043	11,058	11,073	11,062	10,899	10,886	10,656	10,642	10,646	10,654
	Child (HF conversion)	973	921	879	845	280	192	74	59	52	57	53
	Adult Expansion	83,031	82,715	82,618	82,751	82,418	82,349	80,300	80,836	80,571	80,110	79,348
	Other	34	38	38	39	35	38	33	35	45	61	82
	Long Term Care	329	324	327	325	339	356	371	382	383	380	371
	Total Non-Duals	243,543	243,203	242,104	241,938	240,538	240,241	236,083	237,175	235,880	234,651	232,854
DUAL	Aged	15,325	15,916	16,069	16,200	16,193	16,375	16,302	16,585	16,695	16,725	16,733
	Disabled	6,353	6,478	6,506	6,507	6,458	6,518	6,474	6,591	6,617	6,649	6,660
	Other	1,727	1,686	1,621	1,427	1,389	1,370	1,271	1,244	1,250	1,244	1,154
	Long Term Care	1,166	1,182	1,240	1,232	1,238	1,249	1,261	1,276	1,260	1,249	1,232
	Total Duals	24,571	25,262	25,436	25,366	25,278	25,512	25,308	25,696	25,822	25,867	25,779
	Total Medi-Cal	268,114	268,465	267,540	267,304	265,816	265,753	261,391	262,871	261,702	260,518	258,633
	Healthy Kids	2,585	2,780	2,752	2,794	2,757	2,732	2,633	2,618	2,243	2,288	2,321
CMC	CMC Non-Long Term Care	7,223	7,298	7,329	7,273	7,251	7,257	7,249	7,135	7,121	7,072	7,103
	CMC - Long Term Care	304	300	293	294	294	286	276	270	262	254	246
	Total CMC	7,527	7,598	7,622	7,567	7,545	7,543	7,525	7,405	7,383	7,326	7,349
	Total Enrollment	**278,226**	**278,843**	**277,914**	**277,665**	**276,118**	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**

Santa Clara County Health Authority
Income Statement for Five Months Ending November 30, 2017

	For the Month of Nov 2017					For Five Months Ending Nov 30, 2017				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 93,208,108	91.5%	$ 90,041,120	91.0%	$ 3,166,988	$ 450,201,042	90.7%	$ 450,905,877	91.0%	$ (704,835)
HEALTHY KIDS	$ 236,328	0.2%	$ 252,000	0.3%	$ (15,672)	$ 1,243,999	0.3%	$ 1,260,000	0.3%	$ (16,001)
MEDICARE	$ 8,383,436	8.2%	$ 8,637,957	8.7%	$ (254,522)	$ 44,665,567	9.0%	$ 43,189,787	8.7%	$ 1,475,780
TOTAL REVENUE	$ 101,827,872	100.0%	$ 98,931,078	100.0%	$ 2,896,794	$ 496,110,608	100.0%	$ 495,355,664	100.0%	$ 754,943
MEDICAL EXPENSES										
MEDI-CAL	$ 86,963,744	85.4%	$ 85,604,980	86.5%	$ (1,358,764)	$ 421,916,298	85.0%	$ 428,876,588	86.6%	$ 6,960,291
HEALTHY KIDS	$ 204,584	0.2%	$ 240,242	0.2%	$ 35,658	$ 1,113,801	0.2%	$ 1,201,209	0.2%	$ 87,408
MEDICARE	$ 8,694,301	8.5%	$ 8,267,243	8.4%	$ (427,058)	$ 39,652,230	8.0%	$ 41,336,216	8.3%	$ 1,683,986
TOTAL MEDICAL EXPENSES	$ 95,862,629	94.1%	$ 94,112,465	95.1%	$ (1,750,164)	$ 462,682,329	93.3%	$ 471,414,013	95.2%	$ 8,731,685
MEDICAL OPERATING MARGIN	$ 5,965,243	5.9%	$ 4,818,613	4.9%	$ 1,146,630	$ 33,428,279	6.7%	$ 23,941,651	4.8%	$ 9,486,628
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 2,095,588	2.1%	$ 2,388,807	2.4%	$ 293,219	$ 10,891,827	2.2%	$ 11,301,287	2.3%	$ 409,460
RENTS AND UTILITIES	$ 114,011	0.1%	$ 115,399	0.1%	$ 1,387	$ 686,691	0.1%	$ 600,584	0.1%	$ (86,107)
PRINTING AND ADVERTISING	$ 35,671	0.0%	$ 63,050	0.1%	$ 27,379	$ 165,439	0.0%	$ 565,350	0.1%	$ 399,911
INFORMATION SYSTEMS	$ 138,444	0.1%	$ 217,714	0.2%	$ 79,270	$ 864,489	0.2%	$ 1,088,570	0.2%	$ 224,081
PROF FEES / CONSULTING / TEMP STAFFING	$ 1,189,312	1.2%	$ 785,819	0.8%	$ (403,493)	$ 5,567,457	1.1%	$ 4,638,549	0.9%	$ (928,908)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 328,845	0.3%	$ 349,145	0.4%	$ 20,300	$ 1,704,361	0.3%	$ 1,733,770	0.4%	$ 29,409
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 68,659	0.1%	$ 110,411	0.1%	$ 41,752	$ 246,462	0.0%	$ 809,657	0.2%	$ 563,195
MEETINGS / TRAVEL / DUES	$ 79,177	0.1%	$ 89,081	0.1%	$ 9,903	$ 390,791	0.1%	$ 479,259	0.1%	$ 88,468
OTHER	$ 6,145	0.0%	$ 14,720	0.0%	$ 8,575	$ 42,211	0.0%	$ 83,248	0.0%	$ 41,037
TOTAL ADMINISTRATIVE EXPENSES	$ 4,055,852	4.0%	$ 4,134,145	4.2%	$ 78,293	$ 20,559,727	4.1%	$ 21,300,274	4.3%	$ 740,546
OPERATING SURPLUS (LOSS)	$ 1,909,391	1.9%	$ 684,468	0.7%	$ 1,224,923	$ 12,868,551	2.6%	$ 2,641,377	0.5%	$ 10,227,174
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (59,780)	-0.1%	$ -	$ (298,898)	-0.1%	$ (298,898)	-0.1%	$ -
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (375,000)	-0.1%	$ (375,000)	-0.1%	$ -
INTEREST & OTHER INCOME	$ 331,640	0.3%	$ 65,153	0.1%	$ 266,488	$ 714,242	0.1%	$ 325,763	0.1%	$ 388,479
NET SURPLUS (LOSS) FINAL	$ 2,106,252	2.1%	$ 614,841	0.6%	$ 1,491,411	$ 12,908,895	2.6%	$ 2,293,242	0.5%	$ 10,615,653

Santa Clara County Health Authority
Balance Sheet

	NOV 17	OCT 17	SEP 17	JUN 17
Assets				
Current Assets				
Cash and Marketable Securities	$ 285,180,287	$ 357,109,019	$ 448,058,194	$ 364,609,248
Premiums Receivable				
In Home Support Services (IHSS)	357,111,472	339,579,401	325,224,695	282,168,565
All Other	166,363,472	87,217,376	184,070,749	192,697,632
Prepaid Expenses and Other Current Assets	6,802,123	7,531,826	7,270,204	7,070,619
Total Current Assets	815,457,354	791,437,623	964,623,842	846,546,064
Long Term Assets				
Equipment	31,596,931	31,587,323	31,528,704	21,268,887
Less: Accumulated Depreciation	(12,257,068)	(11,965,083)	(11,656,940)	(10,761,759)
Total Long Term Assets	19,339,863	19,622,240	19,871,764	10,507,128
Total Assets	$ 834,797,217	$ 811,059,863	$ 984,495,606	$ 857,053,192
Deferred Outflow of Resources	$ 9,287,513	$ 9,287,513	9,287,513	9,287,513
Total Deferred Outflows and Assets	844,084,730	820,347,376	993,783,119	866,340,705
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 5,833,810	$ 5,890,149	$ 5,818,458	$ 6,157,039
Deferred Rent	61,103	67,402	73,701	92,597
Employee Benefits	1,344,252	1,276,273	1,272,378	1,262,108
Retirement Obligation per GASB 45	5,117,257	5,057,478	4,997,698	4,818,359
Advance Premium - Healthy Kids	42,696	55,358	70,072	53,439
Deferred Revenue - Medicare			10,785,993	8,372,938
Whole Person Care	2,065,180	2,065,180	2,065,180	2,065,180
Payable to Hospitals (SB90)				0
Payable to Hospitals (SB208)			29,409,629	0
Payable to Hospitals (AB 85)	11,049,602	11,067,353	31,377,923	27,378,335
Due to Santa Clara County Valley Health Plan and Kaiser	9,117,449	7,379,033	26,149,229	9,456,454
MCO Tax Payable - State Board of Equalization	25,445,080	25,566,157	42,161,354	33,865,555
Due to DHCS	121,349,747	120,989,438	156,445,574	207,658,770
Liability for In Home Support Services (IHSS)	375,163,173	357,631,102	343,276,396	300,220,266
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	100,194,202	98,182,526	93,532,008	90,922,381
Total Current Liabilities	659,158,076	637,601,974	814,007,293	694,697,947
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	7,232,370	7,157,370	7,082,370	6,857,370
Total Liabilities	672,309,946	650,678,844	827,009,163	707,474,817
Deferred Inflow of Resources	485,329	485,329	485,329	485,329
Net Position / Reserves				
Invested in Capital Assets	10,171,607	10,349,463	10,480,456	10,507,128
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	147,903,603	147,725,747	147,594,754	89,480,978
Current YTD Income (Loss)	12,908,895	10,802,643	7,908,068	58,087,104
Net Position / Reserves	171,289,455	169,183,203	166,288,628	158,380,560
Total Liabilities, Deferred Inflows, and Net Assets	$ 844,084,730	$ 820,347,376	$ 993,783,119	$ 866,340,705

Santa Clara Family Health Plan
Statement of Cash Flows
For Five Months Ending Nov 30, 2017

Cash flows from operating activities		
Premiums received	$	352,772,362
Medical expenses paid	$	(378,806,606)
Administrative expenses paid	$	(43,780,915)
Net cash from operating activities	$	(69,815,160)
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(10,328,044)
Cash flows from investing activities		
Interest income and other income, net	$	714,242
Net (Decrease) increase in cash and cash equivalents	$	(79,428,961)
Cash and cash equivalents, beginning of year	$	364,609,248
Cash and cash equivalents at Nov 30, 2017	$	285,180,287
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	12,194,653
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	1,495,309
Changes in operating assets and liabilities		
Premiums receivable	$	(48,608,747)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	268,496
Deferred outflow of resources	$	-
Accounts payable and accrued liabilities	$	(24,686,095)
State payable	$	(94,729,498)
Santa Clara Valley Health Plan and Kaiser payable	$	(339,005)
Net Pension Liability	$	375,000
Medical cost reserves and PDR	$	9,271,821
Deferred inflow of resources	$	-
Total adjustments	$	(82,009,812)
Net cash from operating activities	$	(69,815,160)

Santa Clara County Health Authority
STATEMENT OF OPERATIONS
BY LINE OF BUSINESS (INCLUDING ALLOCATED EXPENSES)

For Five Months Ending Nov 30, 2017

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$438,882,835	$55,983,773	$1,243,999	**$496,110,608**
MEDICAL EXPENSES	410,105,843	51,462,685	1,113,801	**462,682,329**
(MLR)	93.4%	91.9%	89.5%	**93.3%**
GROSS MARGIN	28,776,993	4,521,088	130,197	**33,428,279**
ADMINISTRATIVE EXPENSES	18,188,104	2,320,070	51,554	**20,559,727**
(% of Revenue Allocation)				
OPERATING INCOME/(LOSS)	10,588,889	2,201,019	78,644	**12,868,551**
OTHER INCOME/(EXPENSE)	35,690	4,553	101	**40,344**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$10,624,578	$2,205,572	$78,745	**$12,908,895**
PMPM (ALLOCATED BASIS)				
REVENUE	$336.28	$1,513.57	$102.78	**$366.35**
MEDICAL EXPENSES	314.23	1,391.33	92.03	**341.66**
GROSS MARGIN	22.05	122.23	10.76	**24.68**
ADMINISTRATIVE EXPENSES	13.94	62.72	4.26	**15.18**
OPERATING INCOME/(LOSS)	8.11	59.51	6.50	**9.50**
OTHER INCOME / (EXPENSE)	0.03	0.12	0.01	**0.03**
NET INCOME / (LOSS)	$8.14	$59.63	$6.51	**$9.53**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*1,305,115*	*36,988*	*12,103*	***1,354,206***
Revenue by LOB	*88.5%*	*11.3%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the Coordinated Care Initiative (CCI) data

Santa Clara
Family Health Plan
The Spirit of Care

Regular Meeting of the
Santa Clara County Health Authority
Executive/Finance Committee

Thursday, February 22, 2018
11:30 AM - 1:00 PM
210 E. Hacienda Avenue
Campbell CA 95008
Cambrian

Via Teleconference
Residence
1985 Cowper Street
Palo Alto, CA 94301

Minutes – DRAFT

Members Present
Michele Lew, Chair
Dolores Alvarado
Bob Brownstein
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
Jonathan Tamayo, Chief Information Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

Others Present
Janet Cory Sommers, Burke, Williams & Sorensen, LLP
Jeff Chang, Best Best & Krieger LLP *(via telephone)*

1. **Roll Call**

Bob Brownstein called the meeting to order at 11:37 am. Roll Call was taken and a quorum was established.

2. **Meeting Minutes**

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

> **It was moved, seconded, and** the January 25, 2018 Executive/Finance Committee Minutes were **unanimously approved** as presented.

3. **Public Comment**

There were no public comments.

4. **Adjourn to Closed Session**

a. **Anticipated Litigation**
The Committee met in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation in connection with a CalPERS issue.

Michele Lew joined the meeting at 11:43 am.

b. **Significant Exposure to Litigation**
The Committee met in Closed Session to confer with Legal Counsel relating to one item of significant exposure to litigation.

5. **Report from Closed Session**

Mr. Brownstein reported the Committee met in Closed Session to confer with legal counsel regarding anticipated litigation and significant exposure to litigation.

6. **Retirement Benefit Program**

Dave Cameron, Chief Financial Officer, and Christine Tomcala, Chief Executive Officer, presented a proposal to modify the retirement options SCFHP offers to employees to better provide market competitive benefits and encourage greater staff participation in retirement savings opportunities.

It was moved, seconded, and unanimously approved to recommend Board approval of the proposed revisions to the retirement benefit programs.

7. **Retiree Health Benefits Resolution**

Ms. Tomcala presented the Committee with a resolution to change the retiree health benefit plan contribution for all new hires after May 1, 2018. The proposal would fix the employer contribution at an equal amount for employees and annuitants via a prospective adjustment of the Plan's contribution for employees.

Mr. Cameron noted that the Plan would essentially cover an individual benefit for such future retired employees with a minimum 12 years' tenure.

It was moved, seconded, and unanimously approved to recommend Board approval of the Resolution Fixing the Employer Contribution at an Equal Amount for Employees and Annuitants under the Public Employees' Medical and Hospital Care Act.

8. **December 2017 Financial Statements**

Mr. Cameron presented the financial statements for December 2017, which reflected a net surplus of $2.7 million for the month and a net surplus of $15.6 million for the first six months of the Plan's fiscal year-to-date (YTD). These represent favorable budget variances of $1.9 million and $12.5 million, respectively.

December membership of approximately 268,000 members reflected an unfavorable budget variance of approximately 5,010 members and a decline of approximately 500 members from the prior month. This

continues a downward enrollment trend that began after October 2016 for which specific cause(s) are unknown. While Medi-Cal enrollment continued to decline, enrollment in Cal Medi-Connect increased slightly.

Revenue reflected a favorable budget variance of $482 thousand (<1%) for the month and a favorable budget variance of $1.2 million (<1%) year-to-date. The December variance was largely related to higher enrollment in LTC and BHT, which offset lower member months.

Medical expense reflected a favorable budget variance of $1.4 million (1.5%) for the month and a favorable budget variance of $10.1 million (1.8%) year-to-date due to lower member months partially offset by higher LTC utilizers and unfavorable inpatient expense vs. budget. The overall medical loss ratio (MLR) was 93.3% for the month of December and year-to-date.

Administrative expense reflected an unfavorable budget variance of $277 thousand (4.2%) for the month and a favorable variance of $463 thousand year-to-date. Much of the current month variance was due to increased usage of consultants and temporary staff.

The balance sheet continues to reflect significant Coordinated Care Initiative (CCI) receivables and payables. The Plan is actively seeking reconciliation and finalization of prior year CCI amounts to DHCS. DHCS continues to recoup prior year overpayments by approximately $18 million per month and the Plan anticipates completion of the MCE rate recoupments by approximately April 2018.The current ratio of 1.2 exceeds the DMHC minimum of 1.0.

Tangible Net Equity (TNE) of $173.9 million was 485% of the Department of Managed Health Care (DMHC) minimum requirement of $35.8 million.

Capital assets of $10.5 million have been acquired during the fiscal year-to-date, largely the 50 Great Oaks building. The Capital Budget includes total annual expenditures of $17.3 million.

A motion was made to accept the December financial statements, was seconded, and was unanimously approved.

> **It was moved, seconded and** the December 2017 Financial Statements were **unanimously approved** as presented.

9. New Building Update

Mr. Cameron reported that the construction team continues to meet weekly to review the improvements and cost estimates on the build-out.

10. Network Detection and Prevention Report

Jonathan Tamayo, Chief Information Officer, reported on firewall intrusion, detection, and prevention efforts.

11. CEO Update

Mr. Cameron reported that Misdirected Claims are compliant at 98% for the last measurement period. He further reported that Provider Dispute Resolution timeliness was also compliant .

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, noted that there is a new real-time reporting system in place that tracks misdirected claims on a daily basis.

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

12. Adjourn to Closed Session

a. <u>Conference with Labor Negotiators</u>
The Committee met in Closed Session to confer with its Designated Representative(s) regarding negotiations with the unrepresented employee, Chief Executive Officer.

13. Report from Closed Session

Mr. Brownstein reported that the Committee met in closed Session to confer with its unrepresented employee, the Chief Executive Officer.

14. Adjournment

The meeting was adjourned at 1:37 pm.

_____
Michele Lew, Chair

Santa Clara
Family Health Plan

The Spirit of Care

Unaudited
Financial Statements
For Six Months Ended December 2017

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Financial Highlights

- **Net Surplus –** December $2.7 million surplus ($1.9 million favorable to budget) and year-to-date (YTD) $15.6 million surplus ($12.5 million favorable to budget). YTD surplus is mostly driven by lower medical expenses than budget.
- **Enrollment –** December membership 267,942 (1.8% unfavorable to budget) and YTD: 1,622,148 member months (1.4% unfavorable to budget and 3.5% lower than YTD last year). While Medi-Cal enrollment has continually declined since October 2016, Cal MediConnect (CMC) membership exhibited month over month growth for the first time since March, 2017.
- **Revenue –** Favorable to budget by $0.5 million for the month (0.5%) and favorable to budget by $1.2 million (0.2%) YTD
- **Medical Expenses –** Favorable to budget by $1.4 million for the month (1.5%) and favorable to budget by $10.1 million (1.8%)
- **Administrative Expenses –** Unfavorable to budget by $0.3 million (-6.9%) and favorable YTD budget by $0.5 million (+1.8%)
- **Tangible Net Equity –** $173.9 million or 485% of minimum required Tangible Net Equity (TNE) of $35.8 million per Department of Managed Health Care (DMHC)
- **Capital Expenditure –** YTD capital investments of $10.5 million versus $17.3 million per annual budget, largely building purchase

	Month	YTD
Revenue	$99 million	$595 million
Medical Costs	$93 million	$555 million
Medical Loss Ratio	93.3%	93.3%
Administrative Costs	$4.3 million (4.3%)	$24.9 million (4.2%)
Other Income/ Expense	$259,153	$299,497
Net Surplus (Loss)	$2,651,793	$15,560,688

Cash on Hand	$243 million
Net Cash Available to SCFHP	$225 million
Receivables	$537 million
Current Liabilities	$634 million
Tangible Net Equity	$174 million
Percent Of DMHC Requirement	**485%**

Risks and Opportunities

- **Risks**
  - Fiscal Year 2017-18 YTD enrollment is below budget. Medi-Cal enrollment has been declining since October 2016.
  - Claim inventory build-up due to conversion of claims payments system is causing some volatility in claims payment and in estimation of total monthly medical expenses. The claims inventory returned to a normal level by December 2017.
  - Delay in revenue receipts due to rate differential vs. budget requires some estimation and accruals.
  - Rate reconciliation timing by Department of Healthcare Services (DHCS) for Coordinated Care Initiative (CCI) program.

- **Opportunities**
  - Continued growth in CCI membership.
  - Continue to fill open positions to replace temporary staff and consultant usage.
  - With convergence of claims processing to QNXT, all claims are processed on one system, which should allow for increased auto-adjudication rates and better efficiency.

Member Months

For the month of December 2017, total membership was lower than budget by 5,017 (-1.8%). For YTD, total member months were lower than budget by 23,259 (-1.4%). Medi-Cal membership has declined since October 2016 while CMC membership continued its marginal growth that began in November 2017.

In the six months since the end of the prior fiscal year (FY), 6/30/2017, membership in Medi-Cal decreased by 2.9 %, membership in Healthy Kids program decreased by 10.4%, and membership in CMC program decreased by 2.0%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Dec 2017			For Six Months Ending Dec 31, 2017				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**Change FY18 vs. FY17**
Medi-Cal	258,106	262,659	(1.7%)	1,563,221	1,583,607	(1.3%)	1,614,671	(3.2%)
Healthy Kids	2,447	2,800	(12.6%)	14,550	16,800	(13.4%)	19,267	(24.5%)
Medicare	7,389	7,500	(1.5%)	44,377	45,000	(1.4%)	46,972	(5.5%)
Total	267,942	272,959	(1.8%)	1,622,148	1,645,407	(1.4%)	1,680,910	(3.5%)

Santa Clara Family Health Plan Enrollment by Network
December 2017

Network	**Medi-Cal**		**Healthy Kids**		**CMC**		**Total**	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	28,811	11%	298	12%	7,389	100%	36,498	14%
SCVHHS, Safety Net Clinics, FQHC Clinics	131,889	51%	1,065	44%	-	0%	132,954	50%
Palo Alto Medical Foundation	7,374	3%	82	3%	-	0%	7,456	3%
Physicians Medical Group	47,472	18%	807	33%	-	0%	48,279	18%
Premier Care	16,053	6%	195	8%	-	0%	16,248	6%
Kaiser	26,507	10%	-	0%	-	0%	26,507	10%
Total	**258,106**	**100%**	**2,447**	**100%**	**7,389**	**100%**	**267,942**	**100%**
Enrollment at June 30, 2017	265,753		2,732		7,543		276,028	
Net Change from Beginning of FY18	-2.9%		-10.4%		-2.0%		-2.9%	

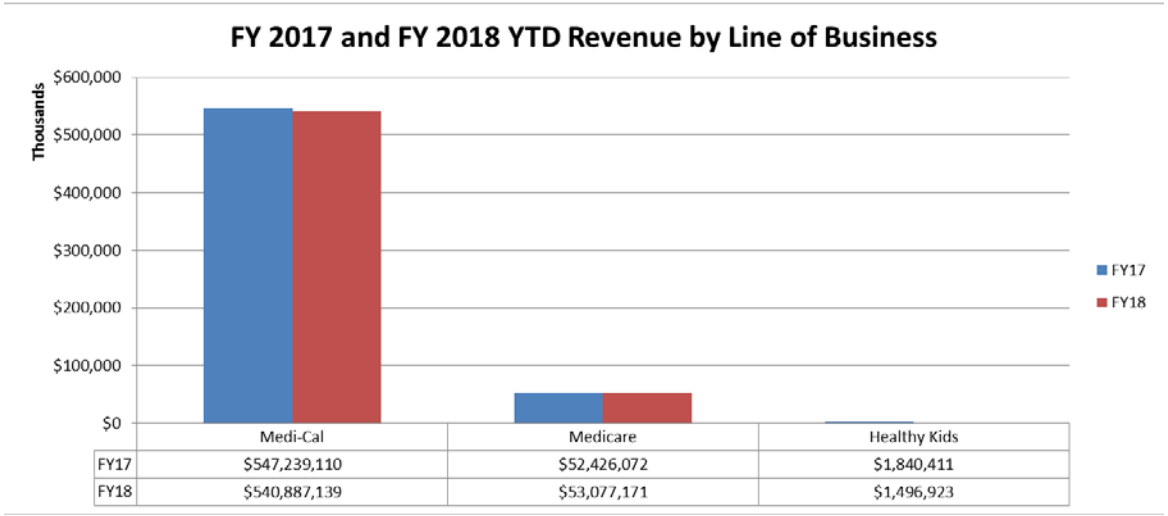
SCVHHS = Santa Clara Valley Health & Hospital System
FQHC = Federally Qualified Health Center

Revenue

Santa Clara Family Health Plan (SCFHP or The Plan) recorded net revenue of $99.4 million for the month of December 2017, compared to budgeted revenue of $98.9 million, resulting in a favorable variance from budget of $0.5 million, or +0.5%. For YTD December 2017, the Plan recorded net revenue of $595.5 million, compared to budgeted revenue of $594.2 million, resulting in a favorable variance from budget of $1.2 million, or +0.2%.

Major revenue variances for December 2017, which net to $0.5 million were:

1. Long Term Care (LTC) revenue favorable by $1.7 million due to both higher member months and rate differential.
2. BHT revenue favorable by $1.2 million due to both higher member months and rate differential.
3. Assembly Bill (AB 85) revenue unfavorable by $1.2 million (no impact on net income).
4. Other smaller unfavorable variances in Medicaid Coverage Expansion (MCE) (lower member months), Medi-Cal CMC (lower member months), and Hepatitis C (both lower member months and rate differential) total $1.3 million.



	Medi-Cal	Medicare	Healthy Kids
FY17	$547,239,110	$52,426,072	$1,840,411
FY18	$540,887,139	$53,077,171	$1,496,923

Medical Expenses

For the month of December 2017, medical expense was $92.7 million compared to budget of $94.0 million, resulting in a favorable budget variance of $1.4 million, or +1.5%. For year to date December 2017, medical expense was $555.3 million compared to budget of $565.4 million, resulting in a favorable budget variance of $10.1 million, or +1.8%.

Major medical expense variances for December 2017, which net to $1.4 million were:

1. Pharmacy expenses ($1.9 million) and capitation expenses ($1.2 million) were favorable largely due to lower member months than budget.
2. IHSS expense is favorable by $1.2 million primarily due to budgeted monthly $1.0 million loss for risk to the plan not yet recorded for FY18. Similar to IHSS expense, AB85 expense is favorable by $1.2 million. Both favorable medical expense variances largely match the corresponding unfavorable variance in revenue.
3. Inpatient expenses were unfavorable by $3.7 million due to retroactive application of the increased contract rates as well as seasonal increase in utilization.

YTD medical expense favorability of $10.1 million is largely driven by:

1. The Plan had recorded a net IHSS loss for FY 17. Based on this experience, a $1.0 million monthly net IHSS expense ($6.0 million YTD) was budgeted for FY18 for the potential risk the Plan still carries. This expense is under evaluation for FY18.
2. Capitation expense favorable by $4.6 million due to lower member months vs. budget.

YTD medical expense summary:

Medical Expense	Amount	% of Total
Network Capitation	$198,514,535	36%
IHSS	$89,599,922	16%
Pharmacy	$72,908,276	13%
Inpatient, Emergency, and Maternity	$71,562,517	13%
Institutional Extended Care	$64,663,311	12%
Outpatient and Other	$58,087,325	10%
Total Medical Expense	**$555,335,886**	

Administrative Expenses

Administrative costs were unfavorable to budget by $0.3 million (-6.9%) for the month of December 2017 and favorable to budget by $0.5 million (+1.8%) for YTD December 2017.

Major administrative expense variances for December 2017 (and also YTD) were:

1. Consulting expenses are higher by $225K due to a higher use of consulting services than budgeted.
2. Temporary staff expenses are higher by $155K due to a higher use of temporary services than budgeted. Most of the unfavorable variance is due to in-sourcing of a previously outsourced case management function as well as the planned effort to bring claims inventory to a normal level.
3. Remaining variance is due to smaller unfavorable variances in printing, and translation services offset by favorable variances in benefits, postage, and information services due to timing.

Overall administrative expenses were 4.2% of revenue for YTD December 2017 (0.1% favorable to budget).

Administrative Expense
Actual vs. Budget
For the Current Month & Fiscal Year to Date - Dec 2017
Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$ 2,258,790	$ 2,306,581	$ 47,791	2.1%	Personnel	$ 13,150,618	$ 13,607,868	$ 457,251	3.4%
2,045,636	1,720,813	(324,823)	-18.9%	Non-Personnel	11,713,536	11,719,800	$ 6,263	0.1%
4,304,426	4,027,394	(277,032)	-6.9%	Total Administrative Expense	24,864,154	25,327,668	463,514	1.8%

Balance Sheet

- Current assets totaled $787.7 million compared to current liabilities of $633.6 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0. Working capital (current assets minus current liabilities) increased by $2.2 million for the six months of the fiscal year.

- Cash as of December 31, 2017 decreased by $121.8 million compared to the cash balance as of year-end June 30, 2017. The overall cash position decreased largely due to:
    1. recoupment of FY2015-17 MCE overpayments (~$18 million per month) by DHCS.
    2. increase in net receivables by $62.6 million due to a delay in receipt of payments for Duals Recast differential revenue, Managed Care Organization (MCO) tax revenue, and Supplemental revenue.
    3. payment of MCO tax for FY17 and prior years.
    4. purchase of a new building.
    5. voluntary funding of future pension and retiree benefits liabilities.

- SCFHP moved $140.0 million of its cash to the county investment pool in order to achieve higher interest income while still maintaining the liquidity of its funds. With the commencement of monthly recoupment of MCE overpayments by the State beginning in June's capitation, the Plan will need to withdraw ~$50 million of these funds in January 2018.

- Liabilities decreased by $60.6 million during the six months ended December 31, 2017. Liabilities decreased primarily due to the disbursement of pass-through funds to hospitals, payment of MCO tax for FY17 and prior years, and recoupment of FY2015-17 MCE overpayments by DHCS.

Tangible Net Equity (TNE)

TNE was $173.9 million at December 31, 2017 or 485% of the most recent quarterly DMHC minimum requirement of $35.8 million. TNE trends for SCFHP are shown below.

Santa Clara County Health Authority
Tangible Net Equity - Actual vs. Required
As of Period Ended:

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	12/31/2017
Actual Net Position / Reserves	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	158,380,560	173,941,248
Required Reserve per DMHC	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	35,898,000	35,831,907
200% of Required Reserve	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	71,796,000	71,663,814
Actual as % Required	722%	410%	419%	357%	377%	310%	441%	485%

Reserves Analysis

- At the September 2016 Governing Board meeting, a policy was adopted for targeting the organization's capital reserves to include a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

- As of December 31, 2017, the Plan's TNE was $48.5 million above the low-end Equity Target and $104.9 million above the low-end Liquidity Target. The Plan's TNE was $5.2 million below the high-end Equity Target and $64.9 million above the high-end Liquidity Target (see calculations below).

SCFHP RESERVES ANALYSIS DECEMBER 2017

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$173,941,248
Current Required TNE	$35,831,907
Excess TNE	$138,109,341
Required TNE Percentage	485%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$125,411,674
500% of Required TNE (high end)	$179,159,534
TNE Above/(Below) SCFHP Low End Target	**$48,529,574**
TNE Above/(Below) SCFHP High End Target	**($5,218,286)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$242,799,014
Less Pass-through Liabilities:	
Payable to State of CA*	-
Other Pass-through Liabilities	(17,962,917)
Total Pass-through Liabilities	(17,962,917)
Net Cash Available to SCFHP	$224,836,097
SCFHP Target Liquidity:	
45 days of Total Operating Expenses	($119,983,725)
60 days of Total Operating Expenses	($159,978,299)
Liquidity Above/(Below) SCFHP Low End Target	**$104,852,373**
Liquidity Above/(Below) SCFHP High End Target	**$64,857,798**
*Pass-Throughs from State of CA (excludes IHSS)	
Receivables Due to SCFHP	164,523,331
Payables Due from SCFHP	(113,873,497)
Net Receivable/(Payable)	$50,649,834

Capital Expenditure

Capital investments of $10.5 million were made during the six months ended December 31, 2017, largely due to the purchase of a new building (in order to lower the long term occupancy costs in an ever increasing rental rate situation in the current location). The YTD capital expenditure includes:

Expenditure	YTD Actual	Annual Budget
New Building*	$9,787,867	$14,300,000
Systems	119,881	1,595,000
Hardware	388,166	611,500
Software	20,647	587,000
Furniture and Fixtures	135,935	173,515
Automobile	0	33,000
Leasehold Improvements	0	10,000
TOTAL	**$10,452,495**	**$17,310,015**

**Budget includes $4.5 million of renovation expend associated with 50 Great Oaks building*

The Plan expects to incur the bulk of the remaining expenditures later in the FY 2018.

Santa Clara Family Health Plan
Enrollment by Aid-Category

		2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12
NON DUAL	Adult (over 19)	31,072	30,836	30,479	30,204	29,921	29,651	28,985	29,301	29,051	28,722	28,252	28,072
	Adult (under 19)	106,719	106,926	106,305	106,181	105,945	106,082	104,658	105,129	104,328	103,793	103,224	103,047
	Aged - Medi-Cal Only	10,371	10,400	10,400	10,520	10,538	10,674	10,776	10,693	10,722	10,801	10,778	10,782
	Disabled - Medi-Cal Only	11,016	11,045	11,060	11,075	11,064	10,902	10,888	10,836	10,816	10,823	10,843	10,819
	Child (HF conversion)	973	921	879	845	280	192	74	59	52	57	53	40
	Adult Expansion	83,031	82,715	82,618	82,751	82,420	82,349	80,300	80,741	80,470	79,998	79,232	79,207
	Other	34	38	38	39	35	38	33	35	45	61	82	92
	Long Term Care	327	322	325	323	337	353	369	381	395	396	390	379
	Total Non-Duals	243,543	243,203	242,104	241,938	240,540	240,241	236,083	237,175	235,879	234,651	232,854	232,438
DUAL	Aged	15,325	15,915	16,068	16,199	16,191	16,372	16,297	16,677	16,782	16,805	16,813	16,726
	Disabled	6,353	6,478	6,506	6,507	6,458	6,518	6,474	6,502	6,522	6,547	6,555	6,552
	Other	1,727	1,686	1,621	1,427	1,389	1,370	1,271	1,235	1,241	1,233	1,144	1,142
	Long Term Care	1,166	1,183	1,241	1,233	1,240	1,252	1,266	1,282	1,277	1,282	1,267	1,248
	Total Duals	24,571	25,262	25,436	25,366	25,278	25,512	25,308	25,696	25,822	25,867	25,779	25,668
	Total Medi-Cal	268,114	268,465	267,540	267,304	265,818	265,753	261,391	262,871	261,701	260,518	258,633	258,106
	Healthy Kids	2,585	2,780	2,752	2,794	2,757	2,732	2,633	2,618	2,243	2,288	2,321	2,447
CMC	CMC Non-Long Term Care	7,225	7,301	7,333	7,278	7,257	7,263	7,255	7,142	7,126	7,071	7,100	7,142
	CMC - Long Term Care	302	297	289	289	288	280	270	263	257	255	249	247
	Total CMC	7,527	7,598	7,622	7,567	7,545	7,543	7,525	7,405	7,383	7,326	7,349	7,389
	Total Enrollment	**278,226**	**278,843**	**277,914**	**277,665**	**276,120**	**276,028**	**271,549**	**272,894**	**271,327**	**270,132**	**268,303**	**267,942**

Santa Clara County Health Authority
Income Statement for Six Months Ending December 31, 2017

	For the Month of Dec 2017					For Six Months Ending Dec 31, 2017				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 90,686,097	91.3%	$ 89,978,887	91.0%	$ 707,210	$ 540,887,139	90.8%	$ 540,884,764	91.0%	$ 2,375
HEALTHY KIDS	$ 252,924	0.3%	$ 252,000	0.3%	$ 924	$ 1,496,923	0.3%	$ 1,512,000	0.3%	$ (15,077)
MEDICARE	$ 8,411,604	8.5%	$ 8,637,957	8.7%	$ (226,353)	$ 53,077,171	8.9%	$ 51,827,744	8.7%	$ 1,249,426
TOTAL REVENUE	$ 99,350,625	100.0%	$ 98,868,845	100.0%	$ 481,780	$ 595,461,232	100.0%	$ 594,224,509	100.0%	$ 1,236,724
MEDICAL EXPENSES										
MEDI-CAL	$ 85,992,863	86.6%	$ 85,521,110	86.5%	$ (471,753)	$ 507,909,161	85.3%	$ 514,397,698	86.6%	$ 6,488,537
HEALTHY KIDS	$ 228,738	0.2%	$ 240,242	0.2%	$ 11,504	$ 1,342,539	0.2%	$ 1,441,451	0.2%	$ 98,912
MEDICARE	$ 6,431,957	6.5%	$ 8,267,243	8.4%	$ 1,835,287	$ 46,084,187	7.7%	$ 49,603,459	8.3%	$ 3,519,273
TOTAL MEDICAL EXPENSES	$ 92,653,558	93.3%	$ 94,028,595	95.1%	$ 1,375,038	$ 555,335,886	93.3%	$ 565,442,609	95.2%	$ 10,106,722
MEDICAL OPERATING MARGIN	$ 6,697,067	6.7%	$ 4,840,249	4.9%	$ 1,856,818	$ 40,125,346	6.7%	$ 28,781,900	4.8%	$ 11,343,446
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 2,258,790	2.3%	$ 2,306,581	2.3%	$ 47,791	$ 13,150,618	2.2%	$ 13,607,868	2.3%	$ 457,251
RENTS AND UTILITIES	$ 123,961	0.1%	$ 111,735	0.1%	$ (12,226)	$ 810,652	0.1%	$ 712,319	0.1%	$ (98,333)
PRINTING AND ADVERTISING	$ 84,462	0.1%	$ 58,150	0.1%	$ (26,312)	$ 249,901	0.0%	$ 623,500	0.1%	$ 373,599
INFORMATION SYSTEMS	$ 98,190	0.1%	$ 217,714	0.2%	$ 119,524	$ 962,679	0.2%	$ 1,306,283	0.2%	$ 343,604
PROF FEES / CONSULTING / TEMP STAFFING	$ 1,228,581	1.2%	$ 776,577	0.8%	$ (452,004)	$ 6,796,038	1.1%	$ 5,415,126	0.9%	$ (1,380,912)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 338,949	0.3%	$ 349,145	0.4%	$ 10,196	$ 2,043,309	0.3%	$ 2,082,914	0.4%	$ 39,605
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 72,450	0.1%	$ 109,411	0.1%	$ 36,961	$ 318,912	0.1%	$ 919,068	0.2%	$ 600,156
MEETINGS / TRAVEL / DUES	$ 99,044	0.1%	$ 85,562	0.1%	$ (13,482)	$ 489,834	0.1%	$ 564,821	0.1%	$ 74,987
OTHER	$ -	0.0%	$ 12,520	0.0%	$ 12,520	$ 42,211	0.0%	$ 95,768	0.0%	$ 53,557
TOTAL ADMINISTRATIVE EXPENSES	$ 4,304,426	4.3%	$ 4,027,394	4.1%	$ (277,032)	$ 24,864,154	4.2%	$ 25,327,668	4.3%	$ 463,514
OPERATING SURPLUS (LOSS)	$ 2,392,641	2.4%	$ 812,855	0.8%	$ 1,579,786	$ 15,261,192	2.6%	$ 3,454,232	0.6%	$ 11,806,960
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (59,780)	-0.1%	$ -	$ (358,678)	-0.1%	$ (358,678)	-0.1%	$ -
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (450,000)	-0.1%	$ (450,000)	-0.1%	$ -
INTEREST & OTHER INCOME	$ 393,932	0.4%	$ 65,153	0.1%	$ 328,780	$ 1,108,175	0.2%	$ 390,916	0.1%	$ 717,259
NET SURPLUS (LOSS) FINAL	$ 2,651,793	2.7%	$ 743,228	0.8%	$ 1,908,565	$ 15,560,688	2.6%	$ 3,036,470	0.5%	$ 12,524,218

Santa Clara County Health Authority
Balance Sheet

	DEC 17	NOV 17	OCT 17	JUN 17
Assets				
Current Assets				
Cash and Marketable Securities	$ 242,799,014	$ 285,180,287	$ 357,109,019	$ 364,609,248
Premiums Receivable				
In Home Support Services (IHSS)	372,463,251	357,111,472	339,579,401	282,168,565
All Other	165,020,333	166,363,472	87,217,376	192,697,632
Prepaid Expenses and Other Current Assets	7,417,269	6,802,123	7,531,826	7,070,619
Total Current Assets	787,699,867	815,457,354	791,437,623	846,546,064
Long Term Assets				
Equipment	31,721,382	31,596,931	31,587,323	21,268,887
Less: Accumulated Depreciation	(12,546,390)	(12,257,068)	(11,965,083)	(10,761,759)
Total Long Term Assets	19,174,992	19,339,863	19,622,240	10,507,128
Total Assets	$ 806,874,859	$ 834,797,217	$ 811,059,863	$ 857,053,192
Deferred Outflow of Resources	$ 14,405,010	$ 9,287,513	9,287,513	9,287,513
Total Deferred Outflows and Assets	821,279,869	844,084,730	820,347,376	866,340,705
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 6,515,940	$ 5,833,810	$ 5,890,149	$ 6,157,039
Deferred Rent	54,804	61,103	67,402	92,597
Employee Benefits	1,386,017	1,344,252	1,276,273	1,262,108
Retirement Obligation per GASB 45	5,177,037	5,117,257	5,057,478	4,818,359
Advance Premium - Healthy Kids	54,641	42,696	55,358	53,439
Deferred Revenue - Medicare				8,372,938
Whole Person Care	2,065,180	2,065,180	2,065,180	2,065,180
Payable to Hospitals (SB90)				0
Payable to Hospitals (SB208)				0
Payable to Hospitals (AB 85)	11,060,140	11,049,602	11,067,353	27,378,335
Due to Santa Clara County Valley Health Plan and Kaiser	4,837,597	9,117,449	7,379,033	9,456,454
MCO Tax Payable - State Board of Equalization	8,799,433	25,445,080	25,566,157	33,865,555
Due to DHCS	105,074,063	121,349,747	120,989,438	207,658,770
Liability for In Home Support Services (IHSS)	390,514,952	375,163,173	357,631,102	300,220,266
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	95,712,093	100,194,202	98,182,526	90,922,381
Total Current Liabilities	633,626,422	659,158,076	637,601,974	694,697,947
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	7,307,370	7,232,370	7,157,370	6,857,370
Total Liabilities	646,853,292	672,309,946	650,678,844	707,474,817
Deferred Inflow of Resources	485,329	485,329	485,329	485,329
Net Position / Reserves				
Invested in Capital Assets	10,083,469	10,171,607	10,349,463	10,507,128
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	147,991,740	147,903,603	147,725,747	89,480,978
Current YTD Income (Loss)	15,560,688	12,908,895	10,802,643	58,087,104
Net Position / Reserves	173,941,248	171,289,455	169,183,203	158,380,560
Total Liabilities, Deferred Inflows, and Net Assets	$ 821,279,869	$ 844,084,730	$ 820,347,376	$ 866,340,705

Santa Clara Family Health Plan
Statement of Cash Flows
For Six Months Ending Dec 31, 2017

Cash flows from operating activities		
Premiums received	$	405,193,017
Medical expenses paid	$	(464,870,346)
Administrative expenses paid	$	(52,788,585)
Net cash from operating activities	$	(112,465,914)
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(10,452,495)
Cash flows from investing activities		
Interest income and other income, net	$	1,108,175
Net (Decrease) increase in cash and cash equivalents	$	(121,810,234)
Cash and cash equivalents, beginning of year	$	364,609,248
Cash and cash equivalents at Dec 31, 2017	$	242,799,014
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	14,452,514
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	1,784,631
Changes in operating assets and liabilities		
Premiums receivable	$	(62,617,386)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	(346,650)
Deferred outflow of resources	$	(5,117,497)
Accounts payable and accrued liabilities	$	(23,886,237)
State payable	$	(127,650,829)
Santa Clara Valley Health Plan and Kaiser payable	$	(4,618,857)
Net Pension Liability	$	450,000
Medical cost reserves and PDR	$	4,789,712
Deferred inflow of resources	$	-
Total adjustments	$	(126,918,427)
Net cash from operating activities	$	(112,465,914)

Santa Clara County Health Authority
STATEMENT OF OPERATIONS
BY LINE OF BUSINESS (INCLUDING ALLOCATED EXPENSES)

For Six Months Ending Dec 31, 2017

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$527,302,309	$66,662,000	$1,496,923	**$595,461,232**
MEDICAL EXPENSES	494,155,061	59,838,287	1,342,539	**555,335,886**
(MLR)	93.7%	89.8%	89.7%	**93.3%**
GROSS MARGIN	33,147,249	6,823,713	154,384	**40,125,346**
ADMINISTRATIVE EXPENSES	22,018,101	2,783,547	62,506	**24,864,154**
(% of Revenue Allocation)				
OPERATING INCOME/(LOSS)	11,129,147	4,040,166	91,878	**15,261,192**
OTHER INCOME/(EXPENSE)	265,215	33,529	753	**299,497**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$11,394,362	$4,073,695	$92,631	**$15,560,688**
PMPM (ALLOCATED BASIS)				
REVENUE	$337.32	$1,502.17	$102.88	**$367.08**
MEDICAL EXPENSES	316.11	1,348.41	92.27	**342.35**
GROSS MARGIN	21.20	153.77	10.61	**24.74**
ADMINISTRATIVE EXPENSES	14.09	62.72	4.30	**15.33**
OPERATING INCOME/(LOSS)	7.12	91.04	6.31	**9.41**
OTHER INCOME / (EXPENSE)	0.17	0.76	0.05	**0.18**
NET INCOME / (LOSS)	$7.29	$91.80	$6.37	**$9.59**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*1,563,221*	*44,377*	*14,550*	***1,622,148***
Revenue by LOB	*88.6%*	*11.2%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the Coordinated Care Initiative (CCI) data

Santa Clara
Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority
Compliance Committee

Thursday, February 22, 2018
1:00 PM – 2:30 PM
210 E. Hacienda Avenue
Campbell CA 95008

Minutes

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
Jonathan Tamayo, Chief Information Officer

Staff Present

Beth Paige, Director, Compliance
Jordan Yamashita, Compliance Mgr
Ron Smothers, Medicare Compliance Mgr

Members Absent

Jeff Robertson, Chief Medical Officer

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:43 pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the November 16, 2017 Regular Compliance Committee Meeting**

   Minutes of the November 2017 regular Compliance Committee meeting were approved as presented.

4. CMC Health Risk Assessment Performance Improvement Plan

Ms. Larmer discussed the status of work under the Health Risk Assessment Performance Improvement Plan. Staff has maintained the process and performance improvements resulting from implementation of the PIP and is working to close out the remaining open items. The Health Services Team has achieved and sustained a 100% timely completion rate for new HRAs.

5. Compliance Report

a. Compliance Activities

Ms. Larmer presented the Quarterly Compliance Report highlighting the activities of the Compliance Department:

- In December 2017, SCFHP received a CMS Warning Letter for late submission of two reports, Payments to Providers and Rewards and Incentives Programs in February 2017.
- Because SCFHP did not pass its 2017 Medicare Data Validation Audit, in December 2017, SCFHP received a request from CMS for a Corrective Action Plan to address the identified deficiencies.
- SCFHP is preparing a response to DMHC network adequacy inquiries regarding its measurement year 2016 Timely Access Filing.

b. CMC and Medi-Cal Compliance Monitoring Report

Ms. Larmer presented the CMC and Medi-Cal Operational Compliance Report. Business units are working with Compliance to evaluate areas of suboptimal performance, and where warranted, develop process improvement plan(s). Compliance will verify implementation and monitor effectiveness of improvements.

A **motion** was made to approve the Quarterly Compliance Report and the CMC and Medi-Cal Operational Compliance Reports; the motion was **seconded and unanimously approved**.

6. Regulatory Corrective Action Plans

a. Misdirected Claims

The Plan's Misdirected Claims Workgroup continues to meet regularly as part of the Plan's voluntarily extended Corrective Action Plan. The interventions implemented in early 2018 yielded a significant and immediate improvement in timely misdirected claims performance, including new reporting, root cause assessment, provider outreach, additional vendor support, and engagement of additional consulting staff.

b. Data Validation

Work on the Plan's internal Medicare Data Validation CAP is at approximately 95% completion. With respect to the current Data Validation cycle:

- The Plan is scheduled for audit in April 2018.
- The Plan's Part C & D data was reported to CMS on 2/5/18. All other reporting requirements required for the MDV audit will be completed on February 26, 2018.
- On April 1, 2018, the Plan will submit its audit universe to Advent.
- The virtual onsite audit will occur in mid-April.
- The Plan expects to receive its final audit report by June 30, 2018.

c. DHCS Audit

On February 2, 2018, the Plan received a CAP closeout letter from DHCS regarding the Plan's 2017 audit. Based on the additional information provided throughout the CAP process, DHCS found that all items were in compliance.

A **motion** was made to approve the CAP report; the motion was **seconded and unanimously approved.**

d. Regulatory Updates

Ms. Larmer provided an update on pending regulatory activity.

e. Fraud, Waste, and Abuse Report

Ms. Larmer presented the Fraud, Waste, and Abuse report:

- The FWA vendor continues to mine data to identify suspected fraud, waste and abuse. The Plan is developing action plans to address the concerns identified as a result of the data mining.

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

f. Adjournment

The meeting was adjourned at 2:15 pm.

Santa Clara Family Health Plan
Operational Compliance Report
Calendar Year Q3 & Q4 2017

Santa Clara Family Health Plan
The Spirit of Care

Cal MediConnect	Goal	Q3 Results	Q4 Results
ENROLLMENT			
Enrollment Materials			
% of New member packets mailed within 10 days of effective Date	100%	Met	Not Met
% of New Member ID cards mailed within 10 days of effective date	100%	Met	Met
Out of Area Members			
% Compliance with OOA Member Process	100%	Met	Met
CUSTOMER SERVICE			
Combined Call Stats			
Member			
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met
Member Abandonment Rate	≤5%	Not Met	Not Met
Member Service Level	80% in ≤30 Seconds	Not Met	Not Met
HEALTH SERVICES			
Pre-Service Organization Determinations			
Standard Part C			
% of Timely Decisions made within 14 days	100%	Met	Met
Expedited Part C			
% of Timely Decisions made within 72 Hours	100%	Not Met	Not Met
Post Service Organization Determinations			
% of Timely Decisions made within 30 days	100%	Met	Not Met
QUALITY & CASE MANAGEMENT			
HRAs and ICPs			
% of HRAs completed in 45 days for High Risk Members	100%	Not Met	Met
% of HRAs completed in 90 days for Low Risk Members	100%	Not Met	Not Met
% of ICPs completed within 30 days for High Risk Members	100%	Not Met	Not Met
% of ICPs completed within 30 working days for Low Risk Members	100%	Not Met	Not Met
Quality of Care/Service			
% of PQI Extended cases that received an extension letter within 30 Days	100%	Report Pending	Report Pending
% of Resolution Letters sent within 30/44 days	100%	Report Pending	Report Pending
CLAIMS			
Non-Contracted Providers			
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Not Met	Not Met
Contracted Providers			
% of Claims to Contracted Providers processed within 45 days	90%	Met	Met
% of Claims to Contracted Providers processed within 90 days	99%	Met	Met
% of Claims to Contracted Providers processed beyond 90 days	≤1%	Not Met	Not Met

Medi-Cal	Goal	Q3 Results	Q4 Results
ENROLLMENT			
Enrollment Materials			
% of New member packets mailed within 7 days of effective Date	100%	Met	Met
% of New Member ID cards mailed within 7 days of effective date	100%	Met	Met
CUSTOMER SERVICE			
Call Stats			
Member Queue			
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met
Member Abandonment Rate	≤5%	Not Met	Not Met
Member Service Level	80% in ≤30 Seconds	Not Met	Not Met
HEALTH SERVICES			
Medical Authorizations			
Routine Authorizations			
% of Timely Decisions made within 5 Business Days of request	95%	Met	Met
Expedited Authorizations			
% of Timely Decisions made within 72 Hours of request	95%	Met	Met
Concurrent Review			
% of Timely Decisions made within 24 Hours of request	95%	Met	Met
Retrospective Review			
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	Met	Met
QUALITY & CASE MANAGEMENT			
Initial Health Assessment			
% of High Risk SPD Members who completed HRA in 45 days	100%	Report Pending	Report Pending
% of HRAs completed in 90 days for Low Risk SPD Members	100%	Report Pending	Report Pending
% of HRAs completed in 45 days for High Risk MLTSS Members	100%	Report Pending	Report Pending
% of HRAs completed in 90 days for Low Risk MLTSS Members	100%	Report Pending	Report Pending
Facility Site Reviews			
% of FSRs completed timely	100%	Met	Not Met
CLAIMS			
Non-Contracted Providers			
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Not Met	Not Met
Contracted Providers			
% of Claims to Contracted Providers processed within 45 working days	90%	Met	Not Met
Provider Claim Dispute Requests (Contracted & Non-Contracted)			
% of Contracted Provider Disputes Processed within 45 days	100%	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan
Operational Compliance Report
Calendar Year Q3 & Q4 2017

Santa Clara Family Health Plan
The Spirit of Care

Cal MediConnect (continued)	Goal	Q3 Results	Q4 Results
PHARMACY - PART D			
Standard Part D Authorization Requests			
% of Standard Prior Authorizations completed within 72 Hours	100%	Met	Met
Expedited Part D Authorization Requests			
% of Expedited Prior Authorizations completed within 24 Hours	100%	Met	Met
Other Pharmacy Requirements			
Formulary posted on website by 1st of the month	100%	Met	Met
Step Therapy posted on website by 1st of the month	100%	Met	Met
PA criteria posted on website by 1st of the month	100%	Met	Met
GRIEVANCE & APPEALS			
Grievances, Part C			
Standard Grievances Part C			
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Not Met	Not Met
% of Standard Grievances resolved within 30/44 days	100%	Not Met	Not Met
Expedited Grievances Part C			
% of Expedited Grievances resolved within 24 hours	100%	Met	Met
Grievances, Part D			
Standard Grievance Part D			
% of Acknowledgement Letters sent within 5 days	100%	Not Met	Not Met
% of Grievances processed within 30 days	100%	Not Met	Not Met
Expedited Grievance Part D			
% of Expedited Grievances processed within 72 hours	100%	Met	Met
Reconsiderations, Part C			
Standard Post-Service Part C			
% of Standard Post-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Not Met	Not Met
% of Standard Post-Service Reconsiderations resolved within 60 days	100%	Met	Not Met
Standard Pre-Service Part C			
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Not Met	Not Met
% of Standard Pre-Service Reconsiderations resolved within 30 days	100%	Met	Not Met
Expedited Pre-Service Part C			
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100%	Report Pending	Report Pending
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	Met	Met
Redeterminations, Part D			
Standard Part D			
% of Standard Redeterminations resolved within 7 calendar days	100%	Not Met	Not Met

Medi-Cal (continued)	Goal	Q3 Results	Q4 Results
PHARMACY			
Standard Authorization Request			
% of Standard Prior Authorizations completed within 1-Business Day	95%	Met	Met
Expedited Authorization Request			
% of Expedited Prior Authorizations completed within 1-Business Day	95%	Met	Met
GRIEVANCE & APPEALS			
Grievances			
Standard Grievances			
% of Grievances resolved within 30 days	100%	Not Met	Not Met
Expedited Grievances			
% of Expedited Grievances resolved within 72 hours	100%	Not Met	Not Met
% of Expedited Grievances that received Oral Notification within 72 hours	100%	Report Pending	Report Pending
% of Expedited Grievances that received Resolution Letters within 72 hours	100%	Report Pending	Report Pending
Appeals			
Standard Appeals			
% of Acknowledgement Letters sent within 5 calendar days	100%	Not Met	Not Met
% of Standard Appeals resolved within 30/44 calendar days	100%	Not Met	Not Met
Expedited Appeals			
% of Expedited Appeals Resolved within 72 hours	100%	Not Met	Not Met
% of Expedited Appeals that received Oral Notification within 72 hours	100%	Report Pending	Not Met
% of Expedited Appeals that received Resolution Letters within 72 hours	100%	Report Pending	Not Met
Non-Contracted Provider Standard Appeals			
% of Non-K Standard Provider Appeals Processed within 45 days	100%	Report Pending	Report Pending
State Fair Hearings			
% of State Fair Hearing Decisions Overturn Plan Decision	<15%	Report Pending	Report Pending

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan
Operational Compliance Report
Calendar Year Q3 & Q4 2017

Santa Clara Family Health Plan
The Spirit of Care

Cal MediConnect (continued)	Goal	Q3 Results	Q4 Results
Expedited Part D			
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	100%	Report Pending	Report Pending
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	100%	Report Pending	Report Pending
COMPLAINT TRACKING MODULE (CTM) COMPLAINTS			
% Resolved Timely	100%	Not Met	Not Met
PROVIDER RELATIONS			
Provider Directories updated monthly by the first day of the month	100%	Met	Met
Quarterly Provider Network Adequacy	100%	Met	Met
Monthly Excluded Provider Screening Completed (Independent Providers)	100%	Met	Met
MARKETING			
% of Marketing Materials Submitted for Approval	100%	Met	Met
% of Events Submitted for Approval	100%	Met	Not Met
FINANCE			
Monthly submission of encounters	100%	Met	Met
% of Encounters submitted to CMS within 180 days of date of Service	80%	Met	Met
% of RAPS records successfully submitted to CMS (not duplicate)	95%	Met	Met

Medi-Cal (continued)	Goal	Q3 Results	Q4 Results
PROVIDER NETWORK MANAGEMENT			
% of New Independent Providers Rec'd Orientation within 10 days	100%	Met	Met
Monthly Excluded Provider Screening Completed	100%	Met	Met
Timely Access Surveys (due in June)	100%	Met	Met
DHCS/DMHC Quarterly Network Assessment	100%	Met	Met
INFORMATION TECHNOLOGY			
% Encounter Files Successfully Submitted to DHCS by end of month	100%	Met	Met
% Monthly Eligibility Files successfully submitted to Delegates Timely	100%	Met	Met
% Provider File submitted to DHCS by last Friday of Month	100%	Met	Met

Company Wide Compliance	Goal	Q3 Results	Q4 Results
COMPLIANCE TRAINING			
% New Employee Training Completed Timely	100% completed within 3 business days	Met	Met
% Annual Employee Training Completed Timely	100% completed by year end	Annual Measure	Annual Measure
BOARD OF DIRECTORS TRAINING			
% Annual Board Training Completed Timely	100% completed by year end	Annual Measure	Annual Measure
INTERNAL AUDITS			
% of Internal Audits Completed	100% completed by year end	Annual Measure	Annual Measure
DELEGATION OVERSIGHT			
% of Scheduled Audits Completed	100%	Met	Met
HUMAN RESOURCE			
Excluded Individual Screening Completed Monthly	100%	Met	Met
REPORTING			
% of CMC Routine Reports Submitted Timely	100%	Met	Met
% of Medi-Cal Routine Reports Submitted Timely	100%	Met	Met
FILINGS			
% of Key Personnel Filings Timely	100%	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara
Family Health Plan

The Spirit of Care

QUALITY PROGRAM
2018 Summary of Changes

Santa Clara Family Health Plan (SCFHP) is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to Quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs.

The Quality Team reviews the QI Program on an annual basis and makes updates as needed to ensure compliance with all regulatory requirements. The QI Program is reviewed and approved by the Quality Improvement Committee (QIC). The following is a high level list of changes made to this year's QI Program.

- **Section V. Goals**- Specific goals found in the 3-way contract were added to this section.
- **Section VI. Functions**- this entire section was removed because the information was redundant with information found in other sections.
- **Section X QI Methodology**- Principles of Continuous Quality Improvement were added to this section.
- **Section XI. Quality Issue Identification**- Items A. Ambulatory, and B. Institutional Settings were removed as unnecessary.
- **Section XI. Quality Issue Identification**- the In-Home Support Services and Long Term Care Facilities sections were removed as unnecessary.
- **Section XIV. Committee Overview**- The reporting relationship graph was corrected to indicate the Grievance and Appeals subcommittee reports to the QIC Committee.
- **Section XV. Committee Structure**- the description of the Governing Board was clarified and expanded.
- **Section XVI. Role of Participating Practitioners**- the Pharmacy Services section was removed as unnecessary.
- **Section XVIII. Utilization Management**- the detail in this section was mostly removed and instead the section references the Utilization Management Program for more detailed information.
- **Section XIX**. **Care of Members with Complex Needs**-this section was reduced to include only elements required to be in the QI Program by NCQA with a reference to the Case Management Program for more detailed information.

Santa Clara Family Health Plan

Quality Improvement Program 2018

Table of Contents

I. Introduction

The Santa Clara County Health Authority, operating business as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP commenced providing health care to children enrolling in the Healthy Kids Program. In 2015, Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP for the Cal MediConnect (CMC)/Dual Demonstration Project Medicare-Medicaid Plan (MMP).

SCFHP is dedicated to improving the health and well-being of the residents of Santa Clara County and shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. SCFHP is accountable for the quality of all covered services.

II. Mission Statement

The Mission of (SCFHP) is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with select practitioners and providers, SCFHP acts as a bridge between the health care system and those who need coverage.

One of SCFHP's core values is our belief that as a local, public, not-for-profit health plan, we have a unique responsibility to continually improve the health status of the community by incorporating a comprehensive approach to health care and wellness. SCFHP maintains a comprehensive Quality Improvement (QI) Program that systematically monitors and continually drives improvements to the quality of care to our members, provides for culturally and linguistically appropriate services, identifies over- and under- utilization and substandard care, monitors member satisfaction and member safety and takes corrective actions and interventions when necessary.

III. Authority and Accountability

The Santa Clara County Health Authority is an independent public agency that governs Santa Clara Family Health Plan (SCFHP). Appointed by the County Board of Supervisors, the 13-member Governing Board seeks to improve access to quality health care, maintain and preserve a health care safety net for Santa Clara County, and ensure the fiscal integrity of SCFHP. With the health care industry rapidly evolving, SCFHP benefits greatly from the innovative ideas and perspectives of this diverse group of people with backgrounds in business, finance, managed care, hospital administration, information technology, medicine, health care policy, and law.

SCFHP's Governing Board assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function as a Board committee. This supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QI Program Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer.

IV. Purpose

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple customers (members, health care providers, and community agencies):

A. It is organized to identify and analyze significant opportunities for improvement in care and service.
B. It will foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
C. It is focused on QI activities carried out on an ongoing basis to promote efforts which support quality of care issues are identified and corrected.

SCFHP recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, the Plan will provide for the delivery of quality care with the primary goal of improving the health status of Plan members. Where the member's condition is not amenable to improvement, the Plan will implement measures to possibly prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. The QI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Plan's QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members, and services received promoting patient safety at all levels of care.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Governing Board has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Governing Board.

V. Goals

The goal of Quality Improvement is to deliver care that enables members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

A. Quality of physical health care, including primary and specialty care.
B. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation.
C. Quality of Long Term Support Services(LTSS)
D. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS provides and services.
E. Continuity and coordination of care across all care and settings, and for transitions in care.
F. Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.\

Additional goals and objectives are to monitor, evaluate and improve:

A. The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
B. The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risk, and disease profiles for both acute and chronic illnesses, and preventive care
C. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners
D. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
E. The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of grievances
G. Risk prevention and risk management processes
H. Compliance with regulatory agencies and accreditation standards
I. The effectiveness and efficiency of the Medi-Cal and CMC internal operations
J. The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
K. The effectiveness of aligning ongoing quality initiatives and performance measurements with the organization's strategic direction in support of its mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
N. Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers

O. Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care.

VI. Objectives

The objectives of the QI Program Description include to:

A. Keeping members healthy
B. Managing members with emerging risk
C. Patient safety or outcomes across settings
D. Managing multiple chronic illnesses
E. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
F. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
G. Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
H. Measure the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance
I. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improve performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
    a. Establishing performance standards
    b. Monitoring performance through regular reporting
    c. Evaluating performance annually
J. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
    a. Medical record review
    b. Rates of referral to specialists
    c. Hospital discharge summaries in office charts
    d. Communication between referring and referred-to physicians
    e. Analysis of member complaints
    f. Identification and follow-up of non-utilizing members
    g. Practice Pattern Profiles of physicians
    h. Performance measurement of practice guidelines
K. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through grievances.

L. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    a. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    b. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
M. Analysis of the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)
N. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals
O. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve health outcomes. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
P. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VII. Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and SCFHP employees.

All departments participate and collaborate in the quality improvement process. The Chief Medical Officer and the Director of Quality integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
B. All activities will reflect the member population in terms of age groups, disease categories and special risk status
C. The scope of the QI Program includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
    a. Access to Preventive Care (HEDIS)
    b. Behavioral Health Services
    c. Continuity and Coordination of Care
    d. Emergency Services
    e. Grievances

f. Inpatient Services
g. Maintenance of Chronic Care Conditions (HEDIS)
h. Member Experience and Satisfaction
i. Minor Consent/Sensitive Services
j. Perinatal Care
k. Potential Quality of Care Issues
l. Preventive Services for children and adults
m. Primary Care
n. Provider Satisfaction
o. Quality of Care Reviews
p. Specialty Care

D. Refer to the Utilization Management Program and the Case Management Program for QI activities related to the following:
   a. UM Metrics
   b. Prior authorization
   c. Concurrent review
   d. Retrospective review
   e. Referral process
   f. Medical Necessity Appeals
   g. Case Management
   h. Complex Case Management
   i. Disease Management
   j. California Children's Services (CCS)

VIII. QI Work Plan

The QI Program guides the development and implementation of an annual QI Work Plan that include:

A. Quality of clinical care
B. Quality of Service
C. Safety of clinical care
D. QI Program scope
E. Yearly objectives
F. Yearly planned activities
G. Time frame for each activity's completion
H. Staff responsible for each activity
I. Monitoring of previously identified issues
J. Annual evaluation of the QI Program
K. Priorities for QI activities based on the specific needs of SCFHP's organizational needs and specific needs of SCFHP's populations for key areas or issues identified as opportunities for improvement

L. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement
M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified (PQI)
N. The work plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

There is a separate Utilization Management Work Plan that supports the UM Program Description and the monitoring and evaluation activities conducted for UM related functions.

IX. QI Methodology

SCFHP applies the principles of Continuous Quality Improvement (CQI) to all aspects of the service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

A. Quantitative and qualitative data collection and data-driven decision-making.
B. Up-to-date evidence=-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.
C. Feedback provided by members and providers in the design, planning, and implementation of its CQI activities.
D. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS.
E. Issues identified by SCFHP, DHCS and/or CMS.
F. Ensure that the QI requirements of this contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

A. Areas for improvement identified through continuous delegated and internal monitoring activities, including, but not limited to, (a) potential quality concern review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
B. Measures required by DHCS for Medi-Cal members such as Performance Improvement Projects (PIPs)
C. Measures required by the California DMHC, such as access and availability
D. Measures required by Centers for Medicare and Medicaid Services (CMS) such as Quality Improvement Activities (QIAs), Quality Improvement Projects (QIP's) or Performance Improvement Projects (PIP's)

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services

A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
B. Case Management
C. Coordination and continuity of care for Seniors and Persons with Disabilities
D. Provisions of complex care management services
E. Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

A. Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
C. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
D. Project coordination occurs through the various leadership structures: Governing Board, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
E. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

<u>QI Project Quality Indicators</u>

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

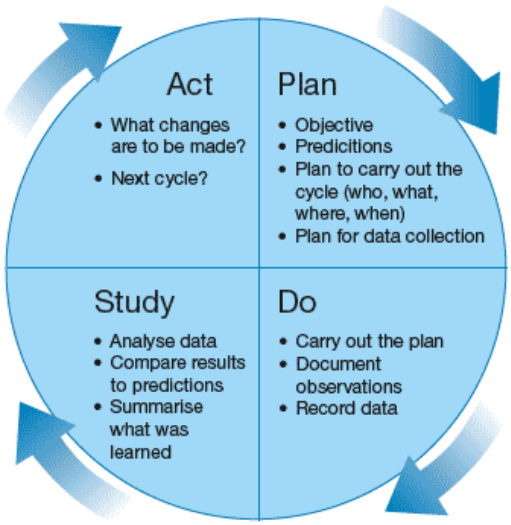
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on SFCHPs' previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

SCFHP uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:



Plan 1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do 1) Communicate change/plan

2) Implement change plan

Study 1) Review and evaluate result of change

2) Communicate progress

Act 1) Reflect and act on learning

2) Standardize process and celebrate success

X. QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Adverse Event monitoring. An Adverse event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Adverse events can include:

A. Potential Quality Issues (PQI)
B. Unexpected death during hospitalization
C. Complications of care (outcomes), inpatient and outpatient
D. Reportable events for long-term care (LTC) facilities include but are not limited to falls, suspected abuse and/or neglect, medication errors, pressure sores, urinary tract infections, dehydration, pneumonia, and/or preventable hospital admissions from the LTC facilities
E. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and deaths that occur in the CBAS center and unusual occurrences reportable pursuant to adult day health care licensing requirements.

Sentinel event monitoring includes patient safety monitoring across the entire continuum of SCFHP's contracted providers, delegated entities, and health care delivery organizations. The presence of a Sentinel event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All substantiated medically related cases are reviewed by the Credentialing and Peer Review Committee to determine the appropriate course of action and/or evaluate the actions recommended by delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to delegates for incorporation in their re-credentialing process.

Data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

A. Claims information/activity
B. Encounter data

C. Utilization
D. Case Management
E. Pharmacy Data
F. Group Needs Assessments
G. Results of Risk Stratification
H. HEDIS Performance
I. Member and Provider Satisfaction
J. Quality Improvement Projects (QIPs)
K. Performance Improvement Projects (PIPs)
L. Health Risk Assessment data
M. Consumer Assessment of Healthcare Providers & Systems (CAHPS)
N. Health Outcomes Survey (HOS)
O. Regulatory Reporting

Protocol for Using Quality Monitors Screens

Case Management and Referrals staff apply the quality monitor screens to each case reviewed during pre- certification and concurrent review. Contracted LTC facilities and CBAS centers must report all identified reportable events to the Director of Medical Management. All potential quality issues are routed to the Quality Department. When it is decided that medical records are required, the Quality staff contacts the appropriate inpatient facility and ambulatory care site to obtain copies of the medical record. It may be necessary for a Quality staff member to visit the facility/site to review the record.

When a case is identified to have potential quality of care issues, the Quality Improvement RN Clinical Review staff will abstract the records and prepare the documents for review by the CMO or Medical Director. The case is routed back to the Quality staff who initiated the review for closure of the case.

When the Chief Medical Officer agrees that a quality of care problem exists, the CMO reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up or corrective action may include referrals to Child or Adult Protective Services.

XI. QI Program Activities

The QI Program's scope includes implementation of QI activities or initiatives. The QI Committee and related committee and work groups select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

Prioritization

Certain aspects of clinical care and service data may identify opportunities to maximize the use of quality improvement resources. Priority will be given the following:

A. The annual analysis of member demographic and epidemiological data
B. Those aspects of care which occur most frequently or affect large numbers of members
C. Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated
D. Those processes involved in the delivery of care or service that, through process improvement interventions, could achieve a higher level of performance

Use of Committee Findings

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient practice. The vast majority of practicing physicians provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Governing Board and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Clinical Practice Guidelines

SCFHP utilizes evidence-based practice guidelines to establish requirements and measure performance on a minimum of three practice guidelines (chronic and behavioral health) annually to strive to reduce variability in clinical processes. Practice guidelines are developed with representation from the network practitioners. The guidelines are implemented after input from participating practitioners of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

Preventive Health/HEDIS Measures

The Quality Improvement Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually based on product type, i.e. Medi-Cal or CMC. Initiatives, such as for Pap Smear education and compliance, are put in place to encourage member compliance with preventive care.

Disease Management Programs

The health care services staff, Quality Improvement Committee (QIC) and network practitioners identify members with, or at risk for, chronic medical conditions. The QIC is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner- patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual CM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs.

Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

A. Primary care services
B. Behavioral health care services
C. Inpatient hospitalization services
D. Home health services
E. Skilled nursing facility services

The continuity and coordination of care received by members includes medical care in combination with behavioral health care. SCFHP collaborates with behavioral health practitioners to promote the following activities are accomplished:

A. Information Exchange – Information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely, and confidential manner.
B. Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral for treatment of behavioral health disorders commonly seen in their practices, i.e., depression.
C. Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use, and to reduce the incidence of adverse drug reactions.
D. Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
E. Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XII. QI Organizational Structure

Quality Improvement Department

The Department support and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

A. Monitor, evaluate and act on clinical outcomes for members
B. Conduct review and investigations for potential or actual Quality of Care matters
C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective
    e. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

Chief Medical Officer (CMO)

The Chief Medical Officer has an active and unrestricted license in the state of California. The CMO is responsible to report to the Governing Board at least quarterly on the Quality Improvement program including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QI Program to SCFHP leadership and staff via Staff meetings, executive team meetings, and other internal meetings.

Medical Director

The Medical Director(s) has an active unrestricted license in accordance with California state laws and regulations and serves as medical director to oversee and be responsible for the proper provision of core benefits and services to members, the quality improvement program, the utilization management program, and the grievance system. The Medical Directories key in the review of potential quality of care cases or potential quality issues.

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions, including resolving grievances related to medical quality of care. A Medical Director is the only Plan person authorized to make a clinical denial based on medical necessity. The Plan pharmacist(s) may make a denial based on medical necessity regarding pharmaceuticals.

Director of Quality

The Director of Quality is a licensed clinician or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality reports to the Chief Medical Director and is responsible for directing the activities of the Plan's quality improvement staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of Quality assists the Plan's executive staff, both clinical and non-clinical, in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of Quality coordinates the Plan's QIC proceedings in conjunction with the CMO; report to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; review statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

Quality Improvement Manager

The Quality Improvement Manager is a person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Quality Improvement Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality improvement staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement Manager assists the Director of Quality in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. ~~Additionally, the Quality Improvement Manager facilitates the Plan's QI Committee proceedings in conjunction with the CMO; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable~~.

QI Nurse, RN

The QI Nurse reports to the Quality Improvement Manager and oversees the investigations of member grievances, supports HEDIS medical record reviews, investigates and prepares cases for potential quality issues (PQI) for the medical director or CMO review. The QI Nurse also assists with ongoing QI studies and reviews which include but are not limited to Performance Improvement Projects (PIP) and Chronic Care Improvement Projects (CCIP), as well as supports the Health Education Program with clinical perspective. The QI Nurse can also be a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Assessments (IHAs), and assists with other QI activities at the direction of the Quality Improvement Manager.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of Quality Improvement Projects, PIPs, CAHPS and HOS Surveys. In addition this this position is responsible for developing and maintaining processes that enhance the operationalization of QI processes, , and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

HEDIS Project Manager

The HEDIS Project Manager provides leadership, coordination, and management of HEDIS and HEDIS-related quality improvement projects. This position is responsible for developing and maintaining processes that enhance the operationalization of HEDIS processes, management of software applications(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

Health Educator

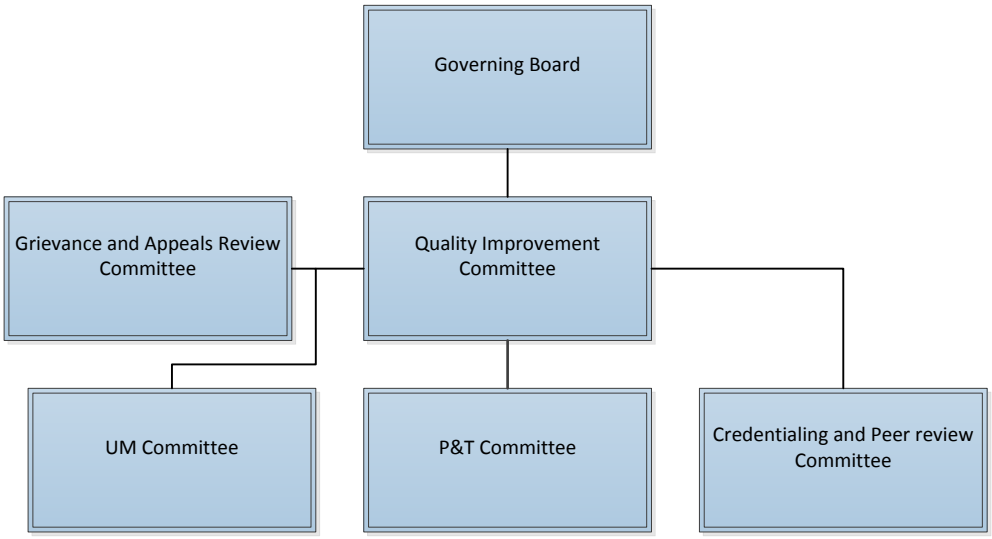
The Health Educator is a Certified Health Education Specialist (CHES) responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance to state and federal regulatory requirements concerning health education and cultural and linguistic services. The Health Educator works under the general direction of the Quality Improvement Manager and works in cooperation with other departments.

QI Coordinator

Quality Improvement Coordinators are staff with significant experience in a health care setting; experience with data analysis and/or project management preferred. QI Coordinators report to the Quality Manager and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The QI Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews.

XIII. Committee Structure Overview

Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Governing Board.



Each committee is driven by a Committee Charter which outlines the following;

A. Voting members
B. Plan support staff
C. Quorum
D. Meeting frequency
E. Meeting terms
F. Goals
G. Objectives

XIV. Committee Structure

Governing Board

The Governing Board is responsible to review, act upon and approve the overall QI Program, Work Plan, and Annual Evaluation. The Governing Board routinely received reports from the QIC describing actions

taken, progress in meeting quality objectives and improvements made. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Quality is responsible for the coordination and distribution of all quality improvement related data and information. The Quality Improvement Committee reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The Chief Executive or the Chief Medical Officer communicates the QIC activities to the Board. The Board reviews the QI activities and any concerns of the Board are communicated back to the source for clarification or resolution.

Quality Improvement Committee

The QI Committee is the foundation of the QI program. The QI Committee assists the CMO and administration in overseeing, maintaining, and supporting the QI Program and Work Plan activities.

The purpose of the QI Committee is to monitor and assess that all QI activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although Delegation Oversight is overseen by the Plan's Compliance Committee, the QI Committee oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QI Committee includes a participating Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QI Committee provides overall direction for the continuous improvement process and evaluates for activities that are consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach and adequate resources for the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided the highest quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QI Committee.

SCFHP involves a contracted network licensed behavioral specialist who is a psychiatrist or Ph.D. level psychologist to serve on the QI Committee and the UM Committee and as an advisor to the QI Program structure and processes. The designated behavioral health practitioner advises the Clinical Quality Improvement Committee to support efforts that goals, objectives and scope of the QI Program are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

Providers', practitioners', and contracted groups practice patterns are evaluated, and recommendations are made to promote practices that all members receive medical care that meets SCFHP standards.

The QI Committee shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QI Committee also recommends strategies for dissemination of all study results to SCFHP-contracted providers and practitioners, and contracted groups.

The QI Committee provides overall direction for the continuous improvement process and monitors that activities are consistent with SCFHP's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

In addition the Grievance/Appeals Committee conducts analysis and intervention and reports to the QI Committee.

Utilization Management Committee

The Utilization Management Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's UM Committee is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and UM/QI staff may also attend the UMC as appropriate.

The (UMC) monitors the utilization of health care services by SCFHP and through delegated entities to identify areas of under- or over- utilization that may adversely impact member care as well as practice patterns of network practitioners and other QI monitors as defined by the Utilization Management Program and UM Work Plan.

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as adoption of evidence based Clinical Practice Guidelines (CPG) and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UMC is also responsible for annual adoption of preventive care guidelines and medical necessity criteria. The Committee meets quarterly and reports to the QIC.

The UMC is responsible for the review and adoption of applicable utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns

of potential or actual inappropriate under - or over- utilization which may impact health care services, coordination of care and appropriate use of services and resources, continuity of medical to medical care, continuity and coordination of medical and behavioral health care, as well as member and practitioner satisfaction with the UM process.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program.

In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes practicing physicians and the contracted provider networks. A majority of the members of the P&T Committee are physicians (including both Plan employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties including a Behavioral Health practitioner, in order to adequately represent the needs and interests of all plan members.

The P&T Committee involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacological drugs.

The P&T Committee also involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.

The Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the QIC.

Credentialing and Peer Review Committee

Peer Review Committee is coordinated through the Credentialing. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases will be presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and no further action is required. The QI Department also tracks, monitors, and trends service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the Credentialing and Peer Review Committee at time of re- credentialing. Quality of care case referral to the QI Department is based on referrals to the QI Department originated from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

Participating practitioners, including a behavioral health practitioner who is either a medical doctor or PHD/PsyD, serve on the QI Program Committees as necessary to support each committee's function. Through these committees' activities, network practitioners:

A. Review, evaluate and make recommendations for credentialing and re-credentialing decisions
B. Review individual cases reflecting actual or potential adverse occurrences
C. Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures
D. Review proposed QI study designs
E. Participate in the development of action plans and interventions to improve levels of care and service
F. Are involved with policy setting
G. Participate with the following committees
    a. Quality Improvement Committee
    b. Pharmacy and Therapeutics Committee
    c. Utilization Management Committee
    d. Credentialing and Peer Review Committee
    e. Additional committees as requested by the Plan

XVI. Behavioral Health Services

SCFHP will monitor and improve the quality of behavioral health care and services provided through and based on applicable contract requirements. The QI program includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our network of practitioners and providers. The quality of Behavioral Health services may be determined through, but not limited to the following:

A. Access to Care
B. Availability of practitioners
C. Coordination of care
D. Medical record and treatment record documentation
E. Complaints and grievances
F. Appeals
G. Utilization Metrics
    a. Timeliness
    b. Application of criteria
    c. Bed days

d. Readmissions
e. Emergency Department Utilization
f. Inter-rater reliability

H. Compliance with evidence-based clinical guidelines
I. Language assistance

Reporting to the CMO, the Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Director shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues.

XVII. Utilization Management

Please refer to the Utilization Management Program Description for Utilization Management activities and related UM activities including Case Management, and Disease Management programs and processes.

XVIII. Care of Members with Complex Needs

Please refer to the Case Management program description for complete details on care of members with complex SCFHP is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

A. Provide case management teams that focus on members who have had an organ transplant, with HIV/AIDS, progressive degenerative disorders and metastatic cancers.
B. Improve access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions
C. Coordinate care for members who receive multiple services.
D. Identify and reduce barrios to services for members with complex conditions.

XIX. Cultural and Linguistics

SCFHP will monitor that services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

SCFHP is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Identified needs and planned interventions involve member input and are vetted through the Customer Advisory Committee prior to full implementation as determined by the plan's Health Educator.

All individuals providing linguistic services to SCFHP members shall be adequately proficient in the required language to both accurately convey and understand the information being communicated. This policy applies to SCFHP staff, providers, provider staff, and professional translators or interpreters. Monitoring of compliance ability to serve as an interpreter will be maintained by the Plan.

Interpreter services are provided to the member at no charge to the member.

SCFHP offers programs and services that are culturally and linguistically appropriate by:

A. Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved to reduce health care disparities in clinical areas
B. Conducting patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity and language specific risks to improve cultural competency in materials
C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications as determined by the plan's Health Educator
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

SCFHP has designated the Director of Quality to provide oversight for meeting the objectives of service to a culturally and linguistically diverse population through the following:

A. Translation services
B. Interpretation services
C. Proficiency testing for bilingual staff
D. Cultural competency trainings such as:
    a. Cultural Competency annual online training for plan staff
E. Provider newsletter articles on a variety of cultural and linguistic issues
F. Health education materials in different languages and appropriate reading levels
G. Provider office signage on the availability of interpretation services

XX. Credentialing Processes

SCFHP conducts a Credentialing process that is in compliance withal regulatory and oversight requirements. SCFHP contracts with an NCQA Certified Vendor Organization (CVO). The Plan credentials all new applicants prior to executing a contract to see members and credentials network practitioners at least every 36 months.

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the SCFHP contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, allied health and midlevel practitioners, which include, but are not limited to practitioners who work independently including behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and direct contracts.

Healthcare Delivery Organizations

SCFHP performs credentialing and re-credentialing of ancillary providers and health care delivery organizations (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and as applicable, accreditation status.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the Re-credentialing process. Should an egregious quality of care issue be identified mid-cycle, the Credentialing and Peer Review Committee may select to review the practitioner between routine re-credentialing cycles.

Monitoring for Sanctions and Complaints

SCFHP has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

XXI. Facility Site Review, Medical Record and Physical Accessibility Review

SCFHP does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted groups. The Plan does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 14-004. SCFHP assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated groups.

SCFHP collaborates with the delegated entities to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and SCFHP policies.

Medical records of new providers shall be reviewed within ninety (90) calendar days of the date on which members are first assigned to the provider. An additional extension of ninety (90) calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

SCFHP conducts an additional DHCS-required facility audit for American with Disabilities Act for compliance of Seniors and Persons with Disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

Medical Record Documentation Standards

SCFHP requires that its contracted groups make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All member data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of the Plan's contracts with CMS and DHCS.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or state law.

XXII. Member Safety

The monitoring, assessment, analysis and promotion of member safety matters are integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part our quality and risk management functions. Our member safety efforts are clearly articulated both internally and externally, and include strategic efforts specific to member safety. The QI Program Description is based on a needs assessment, and includes the areas:

A. Identification and prioritization of patient safety-related risks for all SCFHP members, regardless of line of business and contracted health care delivery organizations
B. Operational objectives, roles and responsibilities, and targets based on the risk assessment
C. Plans to conduct appropriate patient safety training and education are available to members, families, and health care personnel/physicians
D. Health Education
E. Group Needs Assessment
F. Over- and Under- Utilization monitoring
G. Medication Management
H. Case Management and Disease Management outcomes
I. Operational Aspects of Care and Service

Member Safety prevention, monitoring and evaluation include:

A. Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
B. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to ensure timely and accurate communication
C. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
D. Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is identifying and remediate potential and actual safety issues, and to monitor ongoing staff education.

A. Ambulatory setting
    a. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    b. Annual blood-borne pathogen and hazardous material training
    c. Preventative maintenance contracts to promote that equipment is kept in good working order
    d. Fire, disaster, and evacuation plan, testing, and annual training

B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    a. Falls and other prevention programs
    b. Identification and corrective action implemented to address post-operative complications
    c. Sentinel events identification and appropriate investigation and remedial action
    d. Administration of Flu/Pneumonia vaccine
C. Administrative offices
    a. Fire, disaster, and evacuation plan, testing, and annual training

XXIII. Member Experience and Satisfaction

SCFHP supports continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring member and provider complaints, member and provider satisfaction, and member and provider call center performance. The plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, depending upon the intervention.

SCFHP solicits feedback from members, medical centers, and caregivers to assess satisfaction using a range of approaches, such as NCQA's Consumer Assessment of Healthcare Providers, HOS and (CAHPS) member satisfaction survey, monitoring member complaints and direct feedback from the Member Policy Committee. The Quality Department is responsible for coordinating the HOS and CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the Quality Improvement Committee with specific recommendations for performance improvement interventions or actions.

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. Plan also uses another approach to obtain more real-time data related to new provider satisfaction.

<u>Member Grievances and Provider Complaints</u>

The QI Department investigates and resolves all member quality of care concerns and grievances. All grievances related to quality of care and service are tracked, classified according to severity, reviewed by Plan Medical Directors, categorized by the QI Department, and analyzed and reported on a routine basis to Plan's QI Committee. The QI Committee will recommend specific physician/provider improvement activities.

All administrative member grievances are tracked and resolution is facilitated by the Appeals and Grievance Coordinator. Data is analyzed and reported to the QIC on a regular basis to identify trends

and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QI Committee at least quarterly, along with recommendations for QI activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Network Department. Data is reported to and analyzed by the QI Committee on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QI Committee at least quarterly, along with recommendations for QI activities based on results.

XXIV. Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are reviewed through the Plan's Compliance Committee. The Delegation Committee reports to compliance. The portion of Delegation Oversight specific to the QI Program are the reporting submitted by the delegated entities and the functional operational area overseeing corrective action plans.

Through Delegation Oversight, the Plan monitors include, but are not limited to, the following:

A. On-going monitoring via quarterly, semi-annual, and annual reports. Focus reviews are conducted when applicable
B. Annual site visits Annual Review of the delegates' policies and procedures
C. Annual review, feedback and approval of the delegates' Quality and Utilization Management Program Plans
D. Annual Review, approval, and feedback to the delegates on QI and utilization management work plans
E. Review and approval, by Compliance Committee, of sub-delegate's delegation agreement/s prior to implementation of such an agreement for sub-delegation
F. Sub-delegation reports
G. Review of case management program and processes Review of quality of care monitoring processes, results of QI Activities, and peer review processes
H. Review of credentialing and re-credentialing processes, working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
I. Providing educational sessions
J. Evaluating and monitoring improvement
    a. Monthly and quarterly analysis of reports and utilization benchmarks by with results communicated to delegate, results reported on quarterly basis

The Plans' audit procedures drive the process with the delegates with the following:

A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services can be delegated and how they can be delegated or not delegated
B. Providing input into contractual language necessary for delegation

C. Providing tools and designating appropriate measurement and reporting requirements for monitoring of delegated activities
D. Providing support in the analysis of data obtained from reporting and other oversight activities
E. Assisting in the development of corrective action plans and tracking of their effectiveness
F. Providing structure and methodology in the development and administration of incentives and sanction for delegate's performance.

When a delegate is determined to be deficient in an area or areas, the issue is referred to the Delegation Oversight Committee, which reports to the Compliance Committee, for its review and discussion, with recommendations to the Compliance Department for action.

The Compliance Department presents the issue to the Plan's Compliance Committee for decisions and final recommendations, which could include de-delegation.

XXV. Data Integrity/Analytics

The Clinical Data Warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The data warehouse is maintained by the Information Systems (IS) Department. The data warehouse allows IS to provide analytic support to the QI Program. The data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures, and outcomes measures. SCFHP staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

A. Identify and stratify members with certain disease states
B. Identify over/under utilization of services
C. Identify missing preventive care services
D. Identify members for targeted interventions

<u>Identification and Stratification of Members</u>

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Potential of Over- and Under- Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days. Additional data will be available through UM Metrics such as hospital bed days, length of stays, Emergency Department utilization, readmissions, and UM referrals.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50, or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to SCFHP to fit our unique needs. By using the standard clinical rules and customizing SCFHP specific rules, the database will be the primary conduit for targeting and prioritizing heath education, disease management, and HEDIS-related interventions.

By analyzing data that SCFHP currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide SCFHP in not only targeting the members, but also the delegated entities, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals will be utilized. Training for each data element (quality indicator) will be accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be coordinated by the Director of Quality or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, will be maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

A. Be clearly defined and outlined
B. Have specific objectives and timelines
C. Specify responsible departments and individuals
D. Be evaluated for effectiveness
E. Be tracked through the QI Program

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring), and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
    a. Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.
B. Sustained Compliance with Improvement
    a. Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory (CMS, DHCS, DMHC) reporting requirement related to that project. SCFHP may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

A. Project description, including relevance, literature review (as appropriate), source, and overall project goal.
B. Description of target population
C. Description of data sources and evaluation of their accuracy and completeness

D. Description of sampling methodology and methods for obtaining data
E. List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
F. Baseline data collection and analysis timelines
G. Data abstraction tools and guidelines
H. Documentation of training for chart abstraction
I. Rater to standard validation review results
J. Measurable objectives for each quality indicator
K. Description of all interventions including timelines and responsibility
L. Description of benchmarks
M. Re-measurement sampling, data sources, data collection, and analysis timelines
N. Evaluation of re-measurement performance on each quality indicator

Key Business Processes, Functions, Important Aspects of Care and Service

SCFHP provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the SCFHP model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include: Clinical Care and Service:

A. Access and Availability
B. Continuity and Coordination of Care
C. Preventive care, including:
    a. Initial Health Risk Assessment
    b. Behavioral Assessment
D. Patient Diagnosis, Care, and Treatment of acute and chronic conditions
E. Complex Case Management: SCFHP coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management Department, which details this process in its Utilization Management and Case Management Programs and other related policies and procedures.
F. Drug Utilization
G. Health Education
H. Over- and Under- Utilization monitoring
I. Disease Management Outcomes

Administrative Oversight:

A. Delegation Oversight
B. Member Rights and Responsibilities
C. Organizational Ethics
D. Effective Utilization of Resources
E. Management of Information
F. Financial Management
G. Management of Human Resources
H. Regulatory and Contract Compliance
I. Customer Satisfaction
J. Fraud and Abuse* as it relates to quality of care

* SCFHP has adopted a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the SCFHP Compliance Program.

XXVI. Conflict of Interest

Network practitioners serving on any QI Program related Committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues.

All employees and committee participants sign a Conflict of Interest statement on an annual basis.

Fiscal and clinical interests are separated. SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

XXVII. Confidentiality

SCFHP maintains policies and procedures to protect and promote the proper handling of confidential and privileged member information. Upon employment, all SCFHP employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

In addition, all Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the Quality Improvement Committee and other QI Program related committees, which involve member- or practitioner-specific information are confidential, and are

subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act.

All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting.

XXVIII. Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QI Committee quarterly in order to facilitate communication along the continuum of care. The QI Committee reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. QI Committee participants are responsible for communicating pertinent, non-confidential QI issues to all members of SCFHP staff.

Communication of QI trends to SCFHP's contracted entities, members, practitioners and providers is through the following:

A. Practitioner participation in the QIC and its subcommittees
B. Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
C. Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on the Plan's website, in addition to the annual article in both practitioner and member newsletter.
D. The information to be shared with practitioners and members includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service.
E. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
F. Included in annual practitioner education through Provider Relations and the Provider Manual

XXIX. Annual Evaluation

The QI Committee conducts an annual written evaluation of the QI Program and makes information about the QI Program available to members and practitioners. Applicable QI related committees contribute to the annual evaluation which is ultimately reviewed and approved by the Governing Board.

The Plan conducts an annual written evaluation of the QI program and activities that include the following information

A. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
B. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
C. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices
D. Barrier analysis

The evaluation addresses the overall effectiveness of the QI program, including progress that was made toward influencing network-wide safe clinical practices and includes assessment of:

A. The adequacy of QI Program resources
B. The QI Committee structure
C. Amount of Practitioner participation in the QI Program, policy setting, and review process
D. Leadership involvement in the QI Program and review process
E. Identification of needs to restructure or revise the QI Program for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

2018 Complex Case Management Program Description

The SCFHP Complex Case Management (CCM) Program applies to the highest risk individuals identified with having complex conditions, for both Cal MediConnect and Medi-Cal Seniors and Persons with Disabilities (SPD) members. CCM is part of the overarching Population Health Management (PHM) program and includes initiatives specific to the Institute for Healthcare Improvement's (IHI) Triple Aim objectives which focus on improving member experience of care, improving the health of populations and reducing the per capita cost of healthcare. The CCM program is a voluntary service offered to members with multiple or complex health care problems to obtain supportive assistance with access to care and services, and coordination of care to address their health care conditions. Members may decline or opt out of the program at any time. The CCM Program has detailed policies and procedures for the identification, assessment and the ongoing management of member's health care needs, including behavioral health and Long Term Services & Support (LTSS). Members not identified for participation in CCM will follow SCFHP's Population Health Program Plan for placement in a less intensive level of case management.

Goals and Objectives

The objectives of the Complex Case Management (CCM) Program are to regain optimum health and improved functional capability, facilitate access to community resources to meet the needs of members with serious health problems and multiple co-morbidities, identify members who may qualify for and benefit from Long Term Services and Supports (LTSS), optimize available health plan benefits, in the right setting and in a cost-effective manner. Optimal outcomes are achieved through early identification of members at high risk for preventable adverse outcomes and costly care that is amenable to case management intervention; and collaboration with the member, family and physician(s) or other health care providers to address health care needs. The CCM Program involves assessing member needs through the use of a comprehensive health risk assessment; facilitating access to appropriate cost-effective care including community based services; determining the availability of benefits and resources; developing and implementing an individualized care plan (ICP) to include person-centered prioritized goals. Each individualized plan is monitored to assess progress against the goals. The care plan is updated as determined by the member's progress or a sentinel event such as an acute inpatient admission. An annual Member experience survey specific to CCM participation will be conducted at least once annually, to evaluate for any areas needing improvement and/or to improve member satisfaction and engagement.

The program specific goals and effectiveness measures for the CCM population include:

- Keeping members healthy
- Managing members with emerging risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Evidence used to develop the program

The CCM program (Tier 1 within SCFHP's Population Health Program Plan) is focused on the identification of members based on the following criteria to prompt the Complex Case Management (CCM) process:

- Members that have had 3 or more hospitalizations within the past year together with one of the following additional CCM program criteria:
    - 3 or more chronic conditions (at least one which is uncontrolled*),
    - Hospitalized within the past 180 days
    - Age 75 or older with at least 3 ADL needs identified,
    - 3 or more Emergency Dept visits in the past year.

*Uncontrolled is defined as 1 ED visit or Inpatient stay within the past year, with a primary diagnosis related to the member's chronic condition.

This algorithm will be applied at the time of member's initial eligibility, using member pre-eligibility historical Fee for Service (FFS) claims data and at least once annually thereafter to monitor ongoing claims and/or utilization not requiring prior authorizations.

Established members may be identified for CCM thru Transition of Care post discharge assessments, medical conditions related to a catastrophic sentinel event are included for complex case management consideration due to the need for complex discharge planning (e.g. inpatient rehabilitation, long term acute care), coordination of multiple services to meet treatment plan, individual care plan including LTSS, and intensive support for member, caregiver, and family.

To facilitate an initial screening of a member's health status, SCFHP has developed and implemented the use of an comprehensive Health Risk Assessment (HRA) tool which is required to be completed within specific regulatory timeframes after a member's initial enrollment and again at least once annually, thereafter. The HRA includes questions specific to member's self-reported cultural needs, preferences or limitations, social determinants of health, activities of daily living, cognitive function, caregiver needs or supports, assessment of available benefits, assessment of potential barriers and self-management needs, behavioral health needs, etc…

SCFHP's case management policies and procedures detail steps related to proper documentation for the evaluation of member's clinical history, assessment of activities of daily living, assessment for behavioral health needs, social determinants of health life-planning activities, visual and hearing needs, evaluation of caregiver resources, community resources, individualized care plan including related goals and interventions, any identified barriers, referrals to available resources, follow-up schedule, development and communication of self-management plans and processes for assessing member progress.

SCFHP's case managers or personal care coordinators will assist with resolving access to care barriers related to:

- Initiation and compliance with the treatment plan;
- Social determinants such as housing, financial assistance, etc… which may impact members needs
- Prior authorization for in home services and equipment;
- Medical high cost utilization; and,

- Increased frequency of inpatient admissions and Emergency room utilization

SCFHP's case management platform "Essette", supports the documentation and workflow for case management and includes evidenced based assessment tools and care plan templates to monitor that goals and objectives are either met or in progress. This case management platform also allows for automatic identification of the date/time and staff identification of all documentation input to a member case file. Additional capabilities include automated, dated tasks to ensure timely follow up for all interventions.

To help SCFHP determine the appropriate criteria considerations for members who may be appropriate for CCM participation, we referenced the Centers for Disease Control and Prevention data which has identified that more than two-thirds of deaths in the United States are the result of chronic diseases. Heart disease, cancer, respiratory diseases and stroke are the leading killers of Americans; the top two alone account for nearly half of all deaths annually. Diabetes is on the rise among Americans, and follows close behind as the seventh leading cause of death.

The prevalence of chronic disease has increased steadily among people of all ages in recent years. At the turn of the century, 125 million Americans had at least one chronic condition; by 2005 that number had grown to 133 million and by 2020, experts project that 157 million will be affected.
These diseases affect more than one in two adults and more than one in four children in the United States. More than 25 percent live with multiple chronic conditions. The incidence of multiple, concurrent diseases is also on the rise. People with multiple chronic conditions have more complicated health needs than their peers—adding another layer of complexity and cost to their health care. Due to the nation's rapidly aging population and a nationwide increase in risk factors for chronic disease—such as obesity—this trend shows no sign of abating.6
(http://www.ncsl.org/documents/health/chronicdtk13.pdf/Accessed 12/04/15)
The case manager will provide interventions that may maintain or improve the member's quality of life to include:

- Maintain a healthy diet
- How to support and manage daily activities of living such as personal care, meal preparation and/or functional mobility .
- Ways to make life easier and safer at home.
- How to handle mental health issues such as depression, anxiety and psychosis.
- Providing resources and support for the caregiver.

Identification Criteria

The identification and referral process begins when a Member is identified based on internal data sources or a referral is received from any internal or external sources. Identification and referral sources include but are not limited to the following:

- Data Sources for Identification-Regulatory risk algorthims used at time of enrollment, Inpatient facility census, medical claims data, hospital discharge data, pharmacy authorization data, HRA response data, HCC Risk Adjustment assessment data, Health Information Form-Member Evaluation Tool (HIF-MET) assessment response data.
- Internal Referral Sources – Concurrent Review staff, Customer Service staff, Sales staff.
- External Referral Sources - Health Information Line (Nurse 24 line), Physicians, other external providers conducting In-home assessments (FocusCare, Advanced Health), LTSS Providers (Community Based Adult Services (CBAS,),Multipurpose Senior Services Program (MSSP, In-Home Supportive Services (IHSS) or acute or skilled facility staff, Member/family self-referral.

Description of Data Sources for Identification:

1. **Claims or encounter data.** Member identification criteria for Complex Case Management uses medical and pharmacy claims to target diagnoses to identify current-high risk/high cost members (predictive modeling). Members are also identified when they have admitted for highly complex conditions including but not limited to: spinal cord injury, traumatic brain injury, severe burns and multi-trauma requiring intensity of coordinated care at the inpatient level and post-discharge to an alternate level of care and/or the home setting.
2. **Hospital discharge data.** Hospital discharge data within authorization record is used to identify members meeting readmission criteria for transition activities and member outreach.
3. **Pharmacy data.** Pharmacy authorization data is used to identified members with multiple chronic and complex illnesses.
4. **Data collected through the UM process.** Authorization data is used to identify members meeting CCM criteria as a result of a new inpatient admission to an acute hospital or skilled facility and/or post-discharge Transition of Care Assessments.
5. **Data supplied by members or caregivers.** Data obtained from member or Caregiver completed Health Risk Assessments (HRA's) is used to identify members based on defined high risk criteria. The CCM identification criteria using the HRA data prompts the referral for appropriate care plan goals and interventions.
    a. New Cal MediConnect and Medi-Cal SPD members who have a completed HRA and are identified for complex case management based on HRA responses indicating high risk (e.g., readmission or depression score, ADL/functional needs or limitations) or certain conditions (e.g. Cardiovascular issues, Diabetes, Severe Mental Illness (SMI)).
    b. Existing Cal MediConnect and Medi-Cal SPD members identified as high risk thru completed annual HRA Reassessments.
6. **Data supplied by providers.** Copies of additional assessments and care plans created for members by external medical, behavioral health or LTSS and community providers are obtained and included in the HRA evaluation and care planning process, as might be appropriate**.** SCFHP is in the process of implementing a Provider portal which will allow for an enhanced exchange of clinical information that will allow clinical and/or case management information to be received from and shared with providers electronically. Future plans include development and implementation of an Electronic Data Warehouse (EDW) specific for storing Authorization and claims data, assessment data, pharmacy data, member historical data, etc… This data will have multiple uses to include member identification for clinical care programs.

Services offered to individuals

When a member is identified for Case Management, a non-clinical screening is completed to confirm active eligibility with SCFHP as the member's primary health plan. Referral source information and other clinical or utilization data, as available, are reviewed in preparation for the initial outreach with member. Upon initial contact with the member, the program is explained, and clinical screening completed to determine eligibility for CCM or other care program. A new HRA will be completed if a current one is not already on file. The member's consent to participate in the CCM program is obtained, or their refusal to participate or affirmative Opt-Out is identified and documented. If the member consents to participation in the program, a clinical assessment is completed that identifies primary care, specialty care, durable medical equipment, medications, LTSS and other needs to develop an individualized plan of care in

collaboration with the member, the member's family (subject to member's authorization) and the care team.
The coordination of services provided by the Case Manager in collaboration with the member, to include interventions within Care Plan, include but not limited to:

- Outreach with member for health needs assessment, individualized care plan development with member prioritized goal setting. SCFHP uses evidence based assessment tools with auto generated care plan options. The auto generated care plan is individualized based on member needs and preferences as well as manually created care plan goals and interventions for issues identified subsequent to an assessment.
- One on one case management (Registered Nurse or Licensed Clinical Social Worker) support to provide education and resources related to member's specific needs and preferences.
- Facilitation with care coordination needs to promote timely access to benefits and services. Examples include complex discharge planning, access to health plan network providers and navigation through benefit requirements such as transportation assistance or authorization process for specialty medications.
- Multidisciplinary team approach to address certain needs identified in care plan, to include as applicable, internal LCSW case manager, Pharmacist, Behavioral Health or LTSS case manager, Medical Director, and other external providers, as requested by the member.
- Ongoing monitoring according to member needs and preferences to evaluate progress, update care plan, promote and facilitate member's ability to self-manage their condition.

Case Management Integration

Our member centric strategy includes tools and business processes to enable our care management teams to engage members with a holistic approach to their health and wellness needs. To ensure better coordination of care with our team, the physician, and our member it is important to have a view and understanding of all of a member's health and social support needs and to address each in a coordinated and collaborative manner. In 2017, SCFHP implemented a new utilization and care management platform, "Essette". This one platform supports care management processes to drive member centric workflows, to support our overall Population Health strategy.

The platform enables a primary case manager (CM) model with one nurse or social worker orchestrating a multidisciplinary approach as appropriate to the member's individual care plan. The Primary CM may engage other internal SCFHP staff to address specific interventions in the care plan, e.g., social worker, Behavioral health staff, LTSS staff and medical director supports. The platform allows for a shared care plan among the health care team. For example, if a member is being managed within a specific case management program and requires behavioral health support, a referral can be made to that team who can then address care plan interventions from their assessment of the member and any other interventions that are pertinent when they are addressing the member's needs.

Through interactions with the member/family, physician and other health care providers including behavioral health and LTSS, and with utilization data that is available within SCFHP systems, management of the "whole person" may include referral to other available programs that would benefit the member/family. This may include referrals to other internal or external case management teams, although one care coordinator remains the primary contact until case management goals are met. This enables a member-centric approach that supports the management of a coordinated care plan for the

member which addresses co-morbidities across disease entities and integration of multiple programs including a process to identify referrals needed to appropriate community resources and other agencies for services outside the scope of the health plan benefits (such as personal care, housing, meals, energy assistance). Case managers collaborate with the member's physicians, home health agencies and other vendors to ensure that there is no duplication of services and pertinent information shared to support the member's health care goals.

When the member's initial touch-point for CCM consideration is due to a hospital admission, Utilization Review and Discharge Planning nurses are the member's primary contact thru completion of the post discharge Transition of Care assessment. In this instance, a clinical review nurse works with the provider/facility care team and member or their caregiver (when appropriate) to coordinate utilization review, and discharge planning. The clinical review nurse identifies when the member/family might also benefit from other programs or resources including LTSS and refers the member to the appropriate Case Management program following the workflow processes within Essette.

SCFHP's Case management staff has received training on motivational interviewing techniques. Licensed clinical staff and non-licensed administrative Care Coordinators work to build relationships with members or their caregivers and providers, encourage self-management, share decision-making, and tailor interventions and goals based on member input. Instead of telling members what to do, they guide them on making decisions by motivating them to become more educated, self-reliant health care consumers. Care Coordinators use every interaction with members to collect data and evaluate for needs not previously identified in an individualized care plan. If the Care Coordinator determines that the member could benefit from assistance through other programs, that individual provides education on appropriate care or services, which may include referrals to other internal Case Management teams.

When case management referrals are received from external sources such as Providers, FocusCare, New Directions, Advanced Health, Nurse 24 Advice line, etc…Member case files will be reviewed, attempts to obtain an updated HRA will be initiated and inter-disciplinary clinical case reviews will be conducted to determine placement in the most appropriate case management program within SCFHP's Population Health Program plan.

Santa Clara
Family Health Plan

Health Education Program

2018

Santa Clara
Family Health Plan

2018 HEALTH EDUCATION PROGRAM

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I. INTRODUCTION

Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public health agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program. Most recently in 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families.

II. STATEMENT OF PURPOSE

The purpose of the Health Education Program is to deliver general health education, health promotion, and patient education to assist SCFHP beneficiaries to maintain and improve their health and manage their illnesses. SCFHP's Health Education Program complies with the Health Education requirements outlined in the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS and the SCFHP Medi-Cal contract. The Health Education Program supports SCFHP's Population Health Management (PHM) strategy.

III. PROGRAM SCOPE

The Health Education Program provides organized programs, services, functions, and resources necessary to deliver health education, health promotion, and patient education. It includes assessment, monitoring, and evaluation of all services provided by SCFHP and contracted Vendors.

IV. PROGRAM GOALS AND OBJECTIVES

Health Education

- Keeping beneficiaries healthy through appropriate use of health care services, including: managed health care, preventive and primary health care, obstetrical care, health education services, and complementary and alternative care.
- Managing beneficiaries with emerging risk through risk reduction and healthy lifestyles, including: tobacco use and cessation, alcohol and drug use, injury

prevention, prevention of sexually transmitted diseases, HIV and unintended pregnancy, nutrition, weight control, and physical activity, and parenting.

- Managing multiple chronic illnesses through self-care and management of health conditions, including: pregnancy, asthma, diabetes, and hypertension.
- Beneficiaries receive point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracted medical providers in the delivery of health education services for beneficiaries.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for beneficiaries to have an IHA within 120 days of being eligible with the health plan.
- Ensure all written beneficiary information is provided at a sixth grade reading level

V. PROGRAM STRUCTURE AND ORGANIZATION

The Health Education Program is under the direction of a full-time health educator with a Master's degree in Public Health with specialization in health education.

The Health Education Program is part of the Quality Improvement Department. Health Education Program activities will be coordinated and integrated with SCFHP's overall PHM strategy and quality improvement plan.

VI. PROGRAM IMPLEMENTATION

Health Education Classes

The Health Education Department will provide programs, classes and/or materials free of charge to beneficiaries including, but not limited to the following topics:

1. Nutrition
2. Healthy weight maintenance and physical activity
3. Individual and group counseling and support services
4. Parenting
5. Smoking and Tobacco use cessation
6. Alcohol and drug use
7. Injury prevention
8. Prevention of sexually transmitted diseases, HIV and unintended pregnancy
9. Chronic disease management, including asthma, diabetes, and hypertension
10. Pregnancy care

SCFHP also offers other self-management tools through the Member Portal.

Point of Service Beneficiary Education

Individual beneficiaries will receive point of service health education as part of their preventive and primary health care visits. Health risk behaviors, health practices and health education needs related to health conditions are identified. Educational intervention, including counseling and referral for health education services will be conducted and documented in the beneficiary's medical record (DHS PL 02-04).

Provider Education and Training

SCFHP will provide education, training, and program resources to contracted medical providers and other allied health care providers to support delivery of effective health education services for beneficiaries.

Provider training will cover:

1. Group Needs Assessment findings
2. Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) requirements
3. Techniques to enhance effectiveness of provider/patient interaction
4. Educational tools, modules, materials and staff resources
5. Plan-specific resource and referral information
6. Health Education requirements, standards, clinical practice guidelines, and monitoring

Medical providers will use the Staying Healthy Assessment (SHA) tool and other relevant clinical evidence to identify beneficiary's health education needs and conduct educational intervention. SCFHP will provide resource information, educational material and other program resources to assist contracting medical providers to provide effective health education services for beneficiaries. (DHS PL 02-04)

SCFHP will ensure contracted providers are trained and administering the Initial Health Assessment (IHA) with the SHA for all beneficiaries within 120 days of enrollment.

SCFHP will ensure contracted providers have the preventative care disease-specific and plan services information necessary to support member education in an effort to promote compliance with treatment directives and to encourage self-directed care.

SCFHP will also implement a comprehensive risk assessment tool for all pregnant female beneficiaries that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record. (DHCS PL 08-003)

VII. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

Program Standards, Evaluation, Monitoring, and Quality Improvement
SCFHP shall ensure the organized delivery of Health Education Programs using educational strategies and methods that are appropriate for beneficiaries and effective in achieving behavioral change for improved health.

The Health Education Program will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of training, evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving Health Education Program goals and objectives. Policies and procedures will be in place for ensuring providers receive training on a continuing basis regarding DHCS developed cultural awareness and sensitivity instruction for Senior and Persons with Disability (SPD) beneficiaries.

Monitoring
SCFHP will monitor the performance of providers contracted to deliver Health Education Programs and services to beneficiaries. Strategies will be implemented to improve provider performance and effectiveness (SCFHP/Medi-Cal contract Exhibit A, Attachment 10 Scope of Services).

Facility Site Reviews
The Quality Improvement Department monitors PCP's IHA and SHA process during periodic site reviews. Facility Site Reviews (FSR) will include medical chart reviews to monitor if providers are compliant with IHA requirements. IHA requirements will be included in providers' corrective action plans (CAP) for providers not passing any section of their FSR's.

Group Needs Assessment
A group needs assessment will be conducted every 5 years or as often as required by DMHC or DHCS to identify the health education and cultural and linguistic needs of our beneficiaries. Multiple reliable data sources, methodologies, techniques, and tools will be used to conduct the group needs assessment. The findings will be utilized for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Documentation will be maintained of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

Population Assessment
SCFHP annually assesses the characteristics and needs, including social determinants of health, of its member population. This includes review of relevant beneficiary sub-populations, child and adolescents, beneficiaries with disabilities, and beneficiaries with serious and persistent mental illness.

SCFHP annually uses the population assessment to review and update its Population Health Management activities, resources, and community resources for integration into program offerings to address beneficiary needs.

Community Advisory Committee

SCFHP shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876(c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers. SCFHP will ensure CAC is included and involved in policy decisions related to Quality Improvement educational, operational, and cultural competency issues affecting groups who speak a primary language other than English.

VIII. CONFIDENTIALITY AND CONFLICT OF INTEREST

Confidentiality of practitioner, provider, and member identifying information is ensured in the administration of Health Education Services.

Santa Clara
Family Health Plan

The Spirit of Care

CULTURAL AND LINGUISTIC SERVICES PROGRAM 2018

I. INTRODUCTION

The Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program. Most recently in 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, SCFHP works to ensure that everyone in our county can receive the care they need for themselves and their families.

II. STATEMENT OF PURPOSE

The Cultural and Linguistic (C&L) Services Program is designed to improve access and eliminate disparities in quality of care for individuals with limited English proficiency (LEP), diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity. It also ensures that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner. (DHCS Medi-Cal Contract Exhibit A, Attachment 4, 7.F)

SCFHP is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries with LEP or sensory impairment. SCFHP's Cultural

and Linguistic Services comply with 42, C.F. R. Section 440.262; Title VI of the Civil Rights Act of 1964; (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS. The goal of the C&L Services Program is to ensure that SCFHP beneficiaries, especially LEP and sensory impaired beneficiaries receive equal access to health care services that are culturally and linguistically appropriate.

III. METHODOLOGY

Culturally and Linguistically Appropriate Services (CLAS) Standards

The Office of Minority Health (OMH) in the U.S. Department of Health & Human Services (DHHS) require that health care professionals and organizations take responsibility for providing culturally and linguistically appropriate services (CLAS) as a means to improve health care access, quality of care and health outcomes. Defining CLAS as "health care services that are respectful of and responsive to cultural and linguistic needs," the OMH has issued a set of 14 CLAS standards that include "mandates, guidelines and recommendation intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate services." [1]

At SCFHP, we have chosen the 14 National CLAS Standards as the guiding principles of our C&L Services Program.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (4-7) and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: federal mandates, guidelines (recommended by OMH to be federal mandates) and recommendations. Standards 4-7 are mandates, Standards 1-3 and 8-13 are guidelines and Standard 14 is a recommendation. The CLAS standards are:

Culturally Competent Care

1. Health care organizations should ensure that patients/consumers receive from all staff effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate services delivery.

[1] DHHS, OMH, National Standards for CLAS, 2001.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the

CLAS standards and to provide public notice in their communities about the availability of this information.

IV. GOALS, STRATEGIES AND OBJECTIVES

The goal of the SCFHP C&L Services Program is to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with LEP, sensory impairment, diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity.

The Program ensures that beneficiaries have access to covered services delivered in a manner that meets their needs. It also ensures processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. The program formalizes ongoing efforts to provide CLAS at all clinical and administrative points of contact in a consistent and measurable fashion. Since the effort to provide culturally and linguistically competent care is an on-going process, the C&L Services staff periodically identifies new objectives and activities based on the findings of the Health Education and C&L Group Needs Assessment (GNA) which is administered every 3 years or as often as required by DMHC or DHCS. SCFHP also incorporates beneficiary, provider and staff feedback expressed at Consumer Advisory Committee (CAC), Provider Advisory Committee (PAC), and Quality Improvement Committee (QIC) meetings, area demographic research and organizational priorities into the development of its C&L Services Program.

An illustration of the reporting relationships for SCFHP identifies key staff with overall responsibility for the operation of the Cultural and Linguistic Services Program (Appendix A).

SCFHP's Executive Team and Compliance Departments are responsible for promoting a culturally competent health care and work environment for SCFHP. They ensure that all Plan policies and procedures for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. It also ensures SCFHP's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

The Quality Department is responsible for developing, implementing and evaluating SCFHP's C&L Services Program in coordination with the Provider Network Management, Customer Service, Marketing and Communications, Health Services and Compliance Departments.

The Provider Network Management Department is responsible for ensuring that the composition of the provider network continuously meets beneficiaries' ethnic, cultural

and linguistic needs of its beneficiaries on an ongoing basis (DHCS Medi-Cal Contract, Exhibit A, Attachment 6, 13). Language capabilities of clinicians and other provider office staff are identified during the credentialing process and through periodic surveys to update SCFHP's provider directory. Provider Network Management is also responsible for conducting initial and periodic provider network C&L training, as well as the PAC.

The Customer Service Department records updates to beneficiaries' cultural and linguistic capabilities and preferences, including standing requests for material in alternate languages and formats. Beneficiaries are informed they have access to free oral interpretation in their language and written materials translated into SCFHP's threshold languages or provided in alternative formats. Written materials translation is available in non-threshold languages upon request.

Marketing and Communications is also responsible for supporting SCFHP's CAC in accordance with Title 22, CCR, Section 53876 (c). The purpose of the CAC is to provide a link between SCFHP and the community. Meetings are chaired by designated SCFHP staff and composed of SCFHP beneficiaries and community advocates. The CAC advises SCFHP on the development and implementation of its cultural and linguistic accessibility standards and procedures. Committee responsibilities include advising on cultural competency, educational and operational issues affecting beneficiaries, including seniors, persons with LEP and disabilities. CAC reports directly to the SCFHP Governing Board.

Health Services (including Case Management, Managed Long Term Support Services, Behavioral Health, Utilization Management, and Pharmacy) is responsible for ensuring cultural competent care coordination for all beneficiaries.

V. PROGRAM SCOPE

The C&L Services Program is comprehensive, systematic and ongoing. It includes assessment, monitoring and enhancement of all services provided directly by the Health Plan, as well as all services provided by contracted providers, including pharmacies and ancillary services.

Assessment of Beneficiary Cultural and Linguistic Needs
SCFHP regularly assesses beneficiary cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. Specifically, SCFHP:

- Documents in the Health Plan's Information System the reported ethnicity and preferred language of eligible beneficiaries provided by DHCS/CMS for Medi-Cal or Cal Mediconnect beneficiaries and the internal application process for Healthy Kids beneficiaries in the uploads of beneficiary data.
- Documents beneficiary requests to change their reported ethnicity or preferred language.

- Documents a beneficiary's standing request for materials in another language or in an alternate format in the Health Plan's Information Systems.
- Instructs providers to offer no cost interpreter services and document the beneficiary's preferred language in addition to requests for, and refusals of, interpreter services in the patient chart.
- Tracks and analyzes utilization of telephone and face-to-face interpreter services at all points of contact.
- Conducts a Cultural & Linguistic and Health Education GNA every three years to identify C&L needs, and periodically update the assessment based on additional beneficiary input through beneficiary surveys, focus groups and grievances.
- Elicits and documents input from the CAC regarding beneficiaries' C&L needs (for details see Consumer Advisory Committee Charter).
- SCFHP makes reasonable changes to policies, procedures, and practices to provide equal access for individuals with disabilities.

Assessment of linguistic capabilities of SCFHP employees, providers, and subcontractors

SCFHP continuously assesses the linguistic capabilities of its employees, providers and subcontractors to reduce language barriers increase the quality of care LEP beneficiaries receive, and ensure the plan's ability to meet beneficiaries' ethnic, cultural and linguistic needs. SCFHP makes every effort to ensure that providers are assigned with the ability to meet beneficiaries' C&L needs. Activities that contribute to the assessment process include:

- Employees
    - Hire staff that demonstrates appropriate bilingual proficiency as needed for their role by passing a language professional test at time of hire.
    - Maintain Human Resource records on staff linguistic skills and relevant training, certification and/or proficiency results.
    - Assess the performance of employees who provide linguistic services.
- Providers
    - PCP and Specialists are required to ensure access to care for LEP speaking beneficiaries through the provider's own multilingual staff or through cultural and linguistic services facilitated by SCFHP.
    - Identify language proficiency of bilingual providers and office staff through documentation of certification of proficiency or self-assessment.
    - Report provider and office staff language capabilities for inclusion in the Provider Directory.
- Subcontractors
    - Execute agreements with subcontractors that are in compliance with the business requirements for all lines of business.
    - Execute agreements with contracted translators and interpreters that require staff to be tested for proficiency and experience.

- Maintain records in the Health Education department of community health resources throughout the counties we serve, including the language in which the programs are offered.

Access to Interpreter Services and Availability of Translated Materials
Linguistic services are provided by SCFHP to non-English speaking or LEP beneficiaries for population groups. Services include, but are not limited to, the following:

- No cost linguistic services are provided to beneficiaries accurately and timely and protect the privacy and independence of the individual with LEP.
    - Oral interpreters, signers or bilingual providers and provider staff at all key points of contact are available in languages spoken by beneficiaries. Linguistic services are provided in all languages spoken by beneficiaries, not just the threshold or concentration standards languages. Key points of contact include:
        - Medical care settings
        - Telephone, Nurse Advice Line, urgent care transactions, and outpatient encounters with healthcare providers, including: pharmacists.
        - Non-medical care settings: member services, orientations, and appointment scheduling.
    - Written informational materials are fully translated into all threshold languages within 90 days after the English version is approved by the state. Materials in non-threshold languages are made available upon request within 30 days of the request. (Refer to Policy QI.08.02 for more information on translation into non-threshold languages) Materials include:
        - Evidence of Coverage Booklet and/or Beneficiary Handbook and Disclosure Forms. The contents of these documents includes:
            - Enrollment and disenrollment information
            - Information regarding the use of health plan services, including access to screening and triage, after-hours emergency, and urgent care services
            - Access and availability of linguistic services
            - Primary care provider (PCP) selection, auto-assignment, and instructions for transferring to a different PCP
            - Process for accessing covered services requiring prior authorizations
            - Process for filing grievances and fair hearing requests.
        - Provider listings or directories
        - Formulary/Prescription Drug List

        - Marketing materials
        - Form letters (i.e. authorization notice of action letters, grievance and appeals, including resolution letters)
        - Plan-generated preventive health reminders (i.e. appointments and immunization reminders, initial health examination notices, and prenatal care follow-up)
        - Beneficiary surveys
        - Newsletters
    - California Relay Services for hearing impaired.

SCFHP ensures access to interpreter services for all LEP beneficiaries. SCFHP provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. SCFHP beneficiaries can, with advance notice, utilize in-person language and sign language interpreter services. All interpreter services are provided at no charge to beneficiaries. SCFHP requires, through contractual agreement, that contracted interpreters are tested for proficiency and experience. (For more detail please refer to Procedure QI.08.02 Language Assistance Program). SCFHP ensures access to interpreter services for all LEP and sensory impaired beneficiaries through several mechanisms:

- Inform new enrollees of available linguistic services in welcome packets.
- Provide a Quick Reference Guide for providers about accessing SCFHP's interpreter services.
- Provide an interpreter for scheduled appointments when requested by the provider or beneficiary.
- Ensure beneficiaries can use face-to-face language and sign language interpreters with advance notice.
- Make 24-hour/7 days a week access to telephonic interpreter services available for all medical and non-medical points of contact as defined in the contract or regulations.
- Monitor the interpreter request process to avoid unreasonable or unnecessary delays when the service is requested by the beneficiary or provider.
- Encourage the use of qualified interpreters rather than family beneficiaries or friends. The beneficiary may choose an alternative interpreter at his/her cost after being informed of the no cost service.
- Discouraging the use of minors as interpreters except in extraordinary circumstances.
- Maintain records in the Customer Service Department of translated beneficiary informational materials. SCFHP translates beneficiary informing materials into all threshold languages identified by the Department of Health Care Services (DHCS). Translation into non-threshold languages is available upon request. Alternate formats, such as braille, large print, and audio are available upon request.

- Ensure beneficiaries are made aware they have the right to file a complaint or grievance if their linguistic needs are not met.

SCFHP complies with the non-discrimination requirement set forth under Section 1557 of the Affordable Care Act (ACA). SCFHP does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (APL 17-011). This includes:

- Posting of the Notice of Non-Discrimination, including Non-Discrimination Statements, in all beneficiary communications and publications, including written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits.
- Posting the Notice on-site at SCFHP and on the SCFHP website in a conspicuous location and conspicuously visible font size.
- Posting taglines in a conspicuously visible font size in English and at least he top 16 non-English languages spoken by individuals with LEP in California. These taglines inform individuals with LEP of the availability of language assistance services in all beneficiary communications and publications.
    - Languages include: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese.

Staff and Provider Cultural Competency and Diversity Training

SCFHP provides cultural competency, sensitivity, or diversity training for staff, Network Providers, and First Tier, Downstream and Related Entities with direct beneficiary interaction. SCFHP conducts annual cultural competency trainings for SCFHP employees. Network providers receive C&L training as part of Provider Orientation. SCFHP also provides regular training and information sessions to ensure employees and providers are informed and aware of SCFHP's policies and procedures regarding the provision of CLAS. Training includes DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. (DHCS Medi-Cal Contract, Exhibit A, Attachment 7, 5.B). Training on culturally and linguistically appropriate care and care coordination is made available to SCFHP staff. Specifically, SCFHP offers:

- Department-specific periodic trainings on C&L issues on topics such as health literacy, utilization of interpreter services, identifying and handling C&L grievances, customer service to a diverse membership, etc.
- New provider orientations that cover the Culturally Competency Toolkit and SCFHP C&L policies and procedures, specifically addressing provider responsibilities for providing CLAS and utilization of interpreter services.
- One-on-one provider and provider office staff training on C&L issues when a need is identified to improve provider effectiveness in meeting beneficiaries' C&L needs.
- Training, educational materials and tools regarding various cultures and CLAS are made available to SCFHP staff and network providers.

Monitoring, Evaluation and Enforcement

To ensure that SCFHP employees and providers adhere to its C&L services policies and procedures, and that these policies and procedures result in services that are effective in providing CLAS, SCFHP conducts regular monitoring and enforcement activities regarding staff, provider, and interpreter performance that include, but are not limited to:

- Consumer/beneficiary satisfaction surveys
- Review of beneficiary grievances
- Provider assessments and provider site reviews
- Provider satisfaction surveys
- Feedback on services from CAC, the Provider Advisory Council and Provider Office Staff Committee, QIC, SCFHP staff and network providers, community-based organization partners, and other focus group reports
- Audits of delegated provider groups
- Data from utilization reports
- Analysis of health outcomes

Health disparities and utilization patterns by race, ethnicity, and language are investigated by SCFHP's Quality Improvement Department and appropriate interventions are implemented as needed.

APPENDIX A

Santa Clara Family Health Plan- Cultural and Linguistic Oversight and Staff:

Christine Tomcala, Chief Executive Officer

Jeff Robertson, MD, Chief Medical Officer

Chris Turner, Chief Operating Officer

Johanna Liu, Pharmacy and Quality Director

Robin Larmer, Chief Compliance and Regulatory Affairs Officer

Laura Watkins, Director of Marketing, Communications and Outreach

TBD, Director of Provider Network Management

Tanya Nguyen, Director of Customer Service

Andres Aguirre, Quality Manager

Mariana Ulloa, Quality Improvement Project Manager

Divya Shah, Health Educator

Jasmine Brooks, Quality Improvement Coordinator

Pat Smith, Quality Improvement Nurse

Kim Engelhart, Quality Improvement Nurse

The Quality Department staff is responsible for developing, implementing and evaluating SCFHP's Cultural and Linguistic Services in coordination with Provider Network Management, Customer Service, Compliance, and Health Services Departments. The Quality Improvement Project Manager, Health Educator and Quality Improvement Nurses report to the Quality Manager. The Quality Manager reports to the Pharmacy and Quality Director, who in turn reports to the Chief Medical Officer. The Chief Medical Officer reports to the Chief Executive Officer. The Compliance Officer, Director of Marketing, Communications and Outreach, Director of Provider Network Management and the Director of Customer Service report to the Chief Operations Officer.

The Director of Marketing, Communications and Outreach has oversight of the Consumer Advisory Committee.

Santa Clara
Family Health Plan

Policy Title:	**Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care**	**Policy No.:**	QI.23
Replaces Policy Title (if applicable):	Screening, Brief Intervention and Referral for Treatment for Misuse of Alcohol	**Replaces Policy No. (if applicable):**	QI.12
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☐ CMC

I. Purpose

The Santa Clara Family Health Plan (SCFHP) primary care providers will provide Alcohol Misuse: Screening and Behavioral Counseling (AMSC) Interventions in Primary Care settings for members 18 years of age and older who misuse alcohol.

II. Policy

A. SCFHP's policy is to support the contracted network in providing an expanded alcohol screening for members 18 years of age and older who answer "yes" to the alcohol question in the Individual Health Education Behavioral Assessment (IHEBA).
B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) expanded contractual requirements for identification of potential alcohol misuse problems.
C. Providers in SCFHP primary care settings must offer and document AMSC services are offered.
D. The SCFHP will allow each member at least three behavioral counseling interventions per year. Beneficiaries who meet criteria for an alcohol use disorder or whose diagnosis is uncertain, are to be referred for further evaluation to the County Gateway program at 1-800-488-9419

III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance with the policy and to collaborate with the assistance of the Health Education, Provider Services and Behavioral Health Departments to train/educate providers in the provision of the AMSC.

IV. References

DHCS All Plan Letter 17-016 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
Title 42 CFR Requirements with the Mental Health Parity Rule

V. 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)
1	Original			

Santa Clara
Family Health Plan

Policy Title:	**Outpatient Mental Health Services: Mental Health Parity**	**Policy No.:**	QI.24
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose:

To define the contractual responsibilities of Santa Clara Family Health Plan (SCFHP) for the provision of services to adults and children with mental health disorders resulting in mild to moderate distress in the areas of mental, emotional or behavioral functioning. The responsibilities also include referring to and coordinating with the Santa Clara County Behavioral Health Services Department (CBHSD).

II. Policy

It is the policy of SCFHP to provide access to outpatient mental health services for beneficiaries who do not meet the criteria for Specialty Mental Health Services (SMHS). These mild to moderate services will be provided by licensed mental health professionals, in addition to primary care physicians within their scope of practice. The treatment limitations will not be more restrictive than the treatment limitations applied to medical or surgical benefits to ensure parity in access to mental health services. SCFHP will not restrict access to an initial mental health assessment by requiring a prior authorization. SCFHP will be responsible for the arrangement and payment of an initial mental health assessment performed by a network mental health provider unless there is no in-network provider available who can provide the necessary service.

III. Responsibilities

SCFHP will ensure that authorization determinations are based on medical necessity in a manner which is consistent with current evidence-based clinical practice guidelines.
These policies and procedures will be consistently applied to medical/surgical, mental health and substance use disorders.
SCFHP will be responsible for outpatient mental health services as follows:

1. Individual and group mental health evaluation and treatment
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies and supplements (excluding carded out medications)
5. Psychiatric consultation

IV. References

All Plan Letter 17-018, Dated 10/27/2017
Mental Health Parity Final Rule (CMS-2333-F)
Title42, CFR 438.915 (a) (b)
CA Health and Safety Code 1367.01

V. 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)
1	Original			

Santa Clara
Family Health Plan

Policy Title:	**Intensive Outpatient Palliative Care**	**Policy No.:**	QI.25
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☐ CMC

I. Purpose

To promote access to appropriate and effective symptom management and palliative care in accordance with Final Draft All Plan Letter (APL) 17-015 and Senate Bill (SB) 1004, with the intent that members facing serious illness may achieve optimal quality of life.

II. Policy

A. The Intensive Outpatient Palliative Care (IOPC) program is established to provide processes and procedures that enable SCFHP to improve the health and health care of its members with palliative care needs.
B. To define the fundamental components of SCFHP palliative care services, which include: Advance Care Planning; Palliative Care Assessment and Consultation; Plan of Care; Palliative Care Team; Care Coordination; Pain and Symptom Management; and Mental Health and Medical Social Services. The structure of the IOPC program is organized to promote quality palliative care, client satisfaction and cost efficiency through the use of collaborative patient-centered palliative care services, evidence-based guidelines and protocols, and targeted goals and outcomes.
C. SCFHP defines the process of how the plan coordinates palliative care services for members with serious illness and helps them access needed resources and care.

III. Responsibilities

Health Services collaborates with other SCFHP departments (IT, Claims, Benefits, Provider Services, and Member Services) as well as contracted IOPC providers and member providers and delegates to identify, coordinate services, coordinate benefits, and provide eligible members with IOPC palliative care services.

IV. References

California Welfare and Institutions Code (WIC) Section 14132.75
Final Draft APL 17-015, October 2017

V. 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)
1	Original			

Santa Clara
Family Health Plan

Policy Title:	**Managed Long Term Services and Supports (MLTSS) Care Coordination**	**Policy No.:**	QI.16
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) identifies members that are possibly at risk for institutional placement, that are currently placed in nursing facilities or those that want to move to a lower level of care. The Plan promotes coordination of services with the goal of achieving optimal well-being and functionality at the least restrictive level of care most beneficial to individual members.

II. Policy

A. In addition to following the Comprehensive Case Management policy, the Plan coordinates and monitors access, availability, continuity and coordination of care to Managed Long Term Services and Supports (MLTSS) for members. Additional procedures are specific to this form of care coordination.

B. The Plan defines MLTSS procedures to include:
- LTSS Assessment Review
- Community Based Adult Services (CBAS): Eligibility/Determination and Coordination, Referrals
- Referrals and Coordination for Multipurpose Senior Services Program
- LTC Case Management and Care Transitions
- Home and Community-Based Services (HCBS) Coordination
- Individual Care Team (ICT): Specific providers required
- Individual Care Plan (ICP): Specific requirements
- Training: Additional needs for providers and staff

C. The Plan maintains procedures specific to the above mentioned areas as well as Comprehensive Case Management and Utilization Management procedures that provide details.

III. Responsibilities

Health Services collaborates with internal departments (IT, Claims) to identify members for MLTSS Care Coordination and to coordinate services as well as contracted providers, community resources and facilities.

IV. References

3 Way Contract.
APL 17-012 Care Coordination Requirements for Managed Long-Term Care Services and Supports
APL 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
DPL 15-001 Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

DPL 16-002 Continuity of Care
DPL 16-003 Discharge Planning for Cal MediConnect
DPL 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
SCFHP Procedures: QI 16.02-IHSS, QI 16.03-MSSP and QI 16.04-CBAS.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Lori Andersen	Signature Jeff Robertson, MD
Name Director of MLTSS	Name Chief Medical Officer
Title 08/09/2017	Title 08/09/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0 v2.0	**Original 08/05/2016; Reviewed 08/09/2017 Revised 2/13/18**	**Quality Improvement**	**Approve: 08/09/2017**	

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: October 4, 2017

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	46	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	7	
Number practitioners recredentialed within 36-month timeline	7	
% 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 3/31/17	190	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	22	13	25	55	16	4
Total # of Recreds	258	129	76	179	16	7
(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	792	695	716	699	377	114

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.

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: December 6, 2017

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	22	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	19	
Number practitioners recredentialed within 36-month timeline	19	
% 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 11/30/17	198	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	154	93	33	81	9	5
Total # of Recreds	172	111	43	182	15	9
(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	769	780	732	700	380	118

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
Pharmacy & Therapeutics Committee
Thursday, September 21, 2017
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)	Y
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	N
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
Christine Tomcala	SCFHP Chief Executive Officer	N
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Darryl Breakbill	SCFHP Grievance and Appeals Manager	Y

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:05 PM. Introduced new committee members Dolly Goel, MD and Xuan Cung, PharmD. Dr. Robertson reviewed the Brown Act Meeting requirements with the committee.	
2	**Past Meeting Minutes**	
	The SCFHP 2Q2017 P&T Minutes from June 15, 2017 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 2Q2017 P&T Minutes from June 15, 2017 were approved as submitted and will be forwarded to the QI

		Committee and Board of Directors.
3	**Public Comment**	
	No public comment.	
4	**Informational Updates**	
	Health Plan Updates Dr. Robertson shared that SCFHP completed a claims system conversion from Xpress to QNXT for all lines of business. Small glitches on claims payments. Received results of DHCS audit. There were two pharmacy related findings (Emergency Prescription Access Monitoring and Denial Notices Member Language). **Membership** Dr. Robertson shared that total membership is currently down to 271,328 members. There has been a slight decrease in membership since June in both Medi-Cal and CMC lines of business. Medi-Cal membership is at 261,702 and CMC is at 7,383. Speculation that the slight drop in membership may be due to concerns regarding immigration. No market forces are impacting membership.	
	Appeals & Grievances Mr. Breakbill presented the Appeals and Grievances report. Small spike around May for Pharmacy Medi-Cal appeals. Average approximately 1700/month. Over half of appeals are upheld. There was a spike in MediCare appeals in May (100 to 120 PA/month). Almost 50% overturned due to submission of additional documentation.	Next report list higher utilized drugs.
	Adjourn to Closed Session Committee adjourned to closed session at 6:25 p.m. to discuss the following items: Pharmacy Dashboard, MTM Oversight (2017Q1 & 2017Q2), Emergency Rx Access Monitoring, Formulary Modifications and Prior Authorization Criteria, New Drugs and Class Reviews, as well as Drug Utilization and Spend Review.	
5	**Pharmacy Dashboard** Dr. Otomo presented the Pharmacy Dashboard for Medi-Cal and CMC. For Medi-Cal, PA volume has been relatively steady from June to August. Above 95% turnaround time for both urgent and standard PAs. For CMC, above 95% turnaround time for both urgent and standard PA's. Prior authorization approval rate for Standard PA's is at 51% and approval rate for Expedited PA's is at 60% as of August. Oversight is done on PBM to make sure following CMS approved criteria. Inter rater reliability is done on prior authorizations. Every individual must pass inter rater reliability by 80%. Pass rate is 100% April through June. Dr. Huynh presented the pharmacy claim count from Q2 2017. In Medi-Cal, there were 549,455 approved claims and 229,922 denied claims. In	Dr. Liu and Dr. Huynh to verify computational methodology on prior authorization approval rate with other similar plans. Revise Goal column for next report.

	Healthy Kids, there were 1,086 approved claims and 1,557 denied claims. In CMC, there were 79,550 approved claims and 34,778 denied claims.	
	MTM Oversight (2017Q1 & 2017Q2) Dr. Otomo presented the Medication Therapy Management (MTM) Oversight update. Comprehensive medication review (CMR) completion rate was at 23% as of August; no data yet for September. On track for goal of 22% completion rate at year end.	
	Emergency Rx Access Monitoring Dr. Huynh presented the Emergency Prescription Access Report. Procedure will be updated. DHCS recommended being more proactive regarding prescriptions that were not received (one of the findings, other finding was around prior authorization language needing to be more "member friendly"). Asked for committee feedback on prior authorization letters. Should one be issued specific to provider and one letter specific to member? No preference from committee members.	
	Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria Dr. Huynh presented an overview of the MedImpact 2Q2017 P&T minutes as well as the MedImpact 3Q2017 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 2Q2017 P&T Minutes, and MedImpact 3Q2017 P&T Part D Actions were approved as submitted.
	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. Notable changes included remove nystatin oral powder, Biltricide, Mistassist from formulary. Add generic fluticasone/salmeterol respiclick to formulary with QL 1/30 days. Change ST on Symbicort to look for 5/180 days of generic fluticasone/salmeterol. Add QL 10.2/30 days to Symbicort. Add Gilenya to formulary with PA and QL 1/day for PO option of MS treatment. Change QL on diltiazem 12 hr ER to 2/day. Change refill threshold on narcotic analgesics from 85% to 90% to prevent opioid overutilization. Add age limit for use in ≥ 12 years to all tramadol containing products. Recommendation by committee member Peter Nguyen that health plan notify all providers about formulary changes regarding top ten medications prescribed. Asked if committee would like formulary changes sent monthly or quarterly. Committee requested quarterly.	Upon motion duly made and seconded, formulary modifications were approved as presented.

Santa Clara Family Health Plan

	Prior Authorization Criteria
	- Dr. Otomo presented the following PA criteria for approval by the committee:
	  - Reauthorization-Opioids
	  - Hepatitis C
	  - Tymlos (abaloparatide)
	  - Adapalene(Differin)
	  - Proventil HFA (albuterol sulfate)
	  - Calcipotriene (Dovonex)
	  - Darifenacin (Enablex)
	  - Glatopa (glatiramer acetate)
	  - Modafinil (Provigil)
	  - Nicotine inhaler/nasal spray (Nicotrol/Nicotrol NS)
	  - Lovaza (omega-3-Acid Ethyl Esters)
	  - Elmiron (pentosan polysulfate sodium)
	  - Lyrica (pregabalin)
	  - Testosterone gel (Androgel)
	  - Tetrabenazine (Xenazine)
		Upon motion duly made and seconded, prior authorization criteria were approved as requested.

	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented the DHCS Medi-Cal Updates and Comparability. For June 2017, five drugs added and one dosage form added. No proposed action for June 2017. For July 2017, one drug with quantity restriction added, two with strength added, and one with dosage form added. No proposed action for July 2017. For August 2017, one drug with prior authorization required added, two with dosage form added. No proposed action for August 2017.	Upon motion duly made and seconded, all recommendations were approved and presented.

	New Drugs and Class Reviews
	New Drug Reviews
	Dr. McCarty presented the following new drug reviews:
	  - Bevyxxa (betrixaban) –Extended duration VTE prophylaxis in acutely ill medical patients at high risk of VTE.
	  - COPD – Trelegy Ellipta-Remain non-formulary with trial of up to 2 preferred COPD inhaler(s).
	  - Tremfya (guselkumab) - New moderate-to-severe plaque psoriasis treatment.
	  - Hepatitis C – Vosevi and Mavyret, Add Mavyret to preferred for specific genotype w/ prior authorization guideline
	  - Glaucoma-Vuyzulta, Rhopressa, and Roclatan; CRL and FDA filing.
	  - ADHD-Proposed actions-Continue Focalin XR, Concerta, Metadate CD, and Strattera as formulary with added quantity limit of 1 per day. Metadate ER quantity limit
		Upon motion duly made and seconded, all recommendations were approved as presented.

	2/day. Remove step for Focalin XR. Remove age limit restriction in adults for Strattera.	
	Drug Utilization and Spend Review Dr. McCarty presented the Drug Utilization and Spend Review report. MediCal top drug categories by Plan Paid were Diabetes, Infectious Disease-Viral, Inflammatory Disease, and Asthma/COPD. Top drug categories by prescription count were Hypertension, Allergy, Diabetes, Vitamin D or mineral deficiency. Cal MediConnect top drug categories by Plan Paid were Diabetes, Asthma/COPD, Behavioral Health-other, and Infectious Disease-viral. Top drug categories by prescription count were Hypertension, Diabetes, Lipid Irregular, and Behavioral Health-other.	
	Reconvene in Open Session Committee reconvened to open session at 7:55 p.m.	
6	**Discussion Items**	
	Pharmacy Policies - PH11 340B Program Compliance policy was created to make sure Pharmacy Department will comply with all requirements and restrictions of the Public Health Service Act Section 340B pertaining to managed care organization (MCO) and the prohibition against duplicate discount/rebates under Medicaid pertaining. - PH14 Medications for Cancer Clinical Trial policy was created to define the process that provides prescription drug coverage to members diagnosed with cancer and accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer with therapeutic intended endpoints and not exclusively defined to test toxicity.	Upon motion duly made and seconded, policies PH11 and PH14 were approved as presented.
	P&T Charter Dr. Liu reviewed the P&T Charter with the committee. No changes, informational only.	
	Generic Pipeline – Informational Only	
7	**Adjournment at 8:02 PM**	

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 18, 2017

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	N
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	N
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:10 PM. There was a motion to approve the July 19, 2017 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update	Christine Tomcala , CEO discussed the following items: The Santa Clara Family Health Plan received interim NCQA accreditation this year. We are now in the process of obtaining full NCQA accreditation within the next 18 months. The health plan received a Quality award from the state for most improved on DHCS results. SCFHP has purchased a building and will move after build out completed.	None.

ITEM	DISCUSSION	ACTION REQUIRED
V. Discussion Items/Follow Up Items	a. What percentage of those in SNF become Long Term Care As a follow up item from our last meeting, we calculated the LTC conversion from SNF for the time period January 1st 2017 to September 30th 2017. We looked at skilled admissions authorizations requiring Long Term Care authorization for custodial purposes. Of the 773 admitted to Skilled Nursing Facilities, 400 converted to Long Term Care. The UM committee members discussed how high these numbers are. b. Can there be a member service representative script for members changing PCP's (item for follow up from last meeting)? A script currently exists with member services. Detailed workflow that corresponds with the script. Involves notification of eligibility department, changing information in database.	None.
VI. Action Items	a. Prior Authorization Grid CY2018: Ms. Carlson presented the updated Cal MediConnect and Medi-Cal prior authorization grids for 2018. Staff in UM streamlined Medi-Cal and Cal MediConnect items needing prior authorization so it is standardized. Removed neuropsych testing from requiring prior authorization. As per our DHCS CAP finding, we changed PA requirements and removed colonoscopy-removed from Medi-Cal prior authorization grid. Penile implants removed from Medi-Cal authorization grid. SCFHP is no longer requiring preventive procedures have a prior authorization. After further review, initially the motion passed. However Dr. Tobaggi wanted a redline copy of the changes and moved to undo and NOT approve the PA grid changes. SCFHP staff will bring the redline copies to a next meeting for final review and approval. .	Bring redline version of grids to Q12018 UM Committee meeting.
	b. HS.01.08 Non-Emergency Medical Transportation Policy There is a noted error on the agenda. The NEMT is not a Policy but a procedure. Ms. Carlson presented the Non-Emergency Medical Transportation Procedure. Note: Not an action item. Procedure, not policy, presented. DHCS mandated that all health plans had to have transportation services policy in place following a new APL that had been released. Authorization expands Non-Emergency Medical Transportation for public services. Largest change from Utilization Management standpoint is that non-emergency medical transportation ordered by MD requires written attestation for medical necessity by ordering physician.	No action required. Informational only.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	a. Membership Ms. Tomcala presented an update on membership. Membership has remained stable since last report. Lost about 1200 members. Healthy Kids membership is 2288, Medi-Cal 260,518, CMC is 7,326. Compared membership with other health plans across the state. Only county that lost a large amount of membership. May be due to the high cost of living in this county. b. UM Reports 2017 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. For Cal MediConnect, 14 calendar day turnaround time for routine, for urgent 72 hours. Percent of timely decisions made within 14 days is 100% for September. Percent of timely decisions made within 72 hours is 99%. For Medi-Cal, 5 business day turnaround time for routine, for urgent 72 hours. Percent of timely decisions made within 5 business days of request is 100% for September. Percent of timely decisions made within 72 hours of request is 98.6% for September. ii. Standard Utilization Deferred to 1st Quarter 2018. c. Interrater Reliability (IRR, Q3) Dr. Boris presented the Interrater Reliability report for 3rd Quarter 2017. In accordance with Policy HS.09, the 2nd bi-annual Calendar Year 2017, Santa Clara Family Health Plan (SCFHP) scheduled IRR testing is complete. This is required twice a year. IRR testing is scheduled for SCFHP 1st and 2nd half of the calendar year. In accordance with NCQA/DHCS, DMHC guidelines, and SCFHP policy, 10 random UM authorizations are selected to test all of our Utilization Management (UM) staff. Our UM staff consist of non-licensed Care Coordinators (CC), RN/LVN, and Medical Directors (MD). LTSS staff included. Test all functions. In the 2nd testing, 63% or 10/16 of staff are proficient while the remaining 37% or 6/16 are not proficient and will require remediation. Inability to identify line of business was most common deficiency. The corrective action plan after identifying the common findings are mandatory remedial training scheduled for October 25th as well as mandatory bi-annual review of guidelines and criteria. d. Annual Specialty Referral Tracking of Procedures HS.01.02 Deferred to 1st Quarter 2018.	SCFHP is working to add timeliness of letter notification to report.

ITEM	DISCUSSION	ACTION REQUIRED
	e. Annual Out of Network Report YTD 2017 Dr. Boris presented the Annual Out of Network Report for 2017. Based on authorizations. Review annually the utilization of out of network services. All networks from 4/2016 to 9/2017. The top three were Acute Hospital at 34%, Ambulatory Surgery Center at 10%, and Family Practice plus Internal Medicine at 9%. Recommend look at hospitalizations less than 2 days. A description of the OON report is as follows: for the 18 month time period studied, the OON report shows the following trends: 1. 34% of OON network utilization is for members using acute non contracted hospitals. 2. Two hospitals Regional Medical Center and UCSF account for 56% of the utilization 3. Inpatient approved authorizations are largely through the Emergency Room. This was 100% true for UCSF. 4. For UCSF: the 23 outpatient authorizations were for a. 11 authorizations were for 3 patients (well known to UM Medical Directors). b. 3 authorizations were requested by second opinion from Stanford. c. 2 authorizations were overturns after a Peer to Peer discussion occurred. d. This accounts for 70% of the UCSF elective outpatient authorizations. 5. For the second category of authorizations to freestanding ASC's. Bay Area Surgery Centers has been contracted. 6. For the Family Practice / Internal Medicine categories: it was discovered that when the migration of authorizations occurred from Xpress to QNXT in June 2012, these providers initially showed as non-contracted. This has since been corrected. Recommendations - The Plan continues its efforts to contract with RMC. The plan is pursuing standing Letters of Agreement with CA surgicenter Mountain View, Surgicenter of Palo Alto, and Peninsula eye surgery center since these facilities are preferred by providers in Sutter's Palo Alto Medical Foundation (PAMF). The plan has recently completed a standing LOA agreement with Fremont Ambulatory Surgery Center. f. HS.04.01 Reporting Quality Monitoring of Plan Auths, Denials, etc. (Q2 & Q3) Dr. Boris presented the Quality Monitoring Report for 2nd and 3rd Quarter 2017. Quality Monitoring of Plan Authorizations, Denials, etc. For the 2nd quarter review of 2017, the findings are as follows: For the dates of services and denials for April, May and June of CY 2017 were pulled in the 2nd quarter sampling year. 30 unique authorizations were pulled with a random sampling. ▪ 50% or 15/30 Medi-Cal and 50% or 15/30 CMC ▪ Of the sample 100% or 30/30 were denials ▪ Of the sample 37% or 11/30 were expedited; 63% or 19/30 were standard	

ITEM	DISCUSSION	ACTION REQUIRED
	• 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours • 95% or 18/19 of the standard authorizations met timeliness factors o Case was Member Initiated Org Determination ▪ 53% or 16/30 of the denials were medical necessity denials ▪ 57% or 14/30 of the denials were Non-Contracted Providers redirect back into network ▪ 100% or 30/30 of cases received physician review, or pharmacist reviewer ▪ 100% or 30/30 of the files had the correct letter template ▪ 100% or 30/30 have evidence of clear denial language. For the 3rd quarter review of 2017, the findings are as follows: For the dates of services and denials for July, August, and September of CY 2017 were pulled in the 3rd quarter sampling year. 30 unique authorizations were pulled with a random sampling. ▪ 50% or 15/30 Medi-Cal LOB and 50% or 15/30 CMC LOB ▪ Of the sample 100% or 30/30 were denials ▪ Of the sample 37% or 11/30 were expedited request; 63% or 19/30 were standard request • 100% or 11/11 of the expedited authorizations were processed within 72 calendar hours • 100% or 19/19 of the standard authorizations met regulatory TAT ▪ 47% or 14/30 of the denied auth did not meet medical necessity ▪ 53% or 16/30 of the denials were Non-Contracted Providers with services available in network or non-covered benefit. ▪ 100% or 30/30 of cases were denied by MD or pharmacist. ▪ 100% or 30/30 of the files had the correct letter template ▪ 100% or 30/30 have evidence of clear denial language. g. Quarterly RN advice line statistics (CMC and Medi-Cal) Ms. Carlson presented the RN Advice line statistics report. Total calls to Nurse Advice Line for July 1, 2017 thru September 30, 2017 is 38. Total calls to Nurse Advice Line for September 1 to September 30th, 2017 is 664. Age range specific to calls: Age 0-17 years of age: 216 Age 18 to 75 years of age and above: 449 Many are just customer service calls such as requests for transportation.	

ITEM	DISCUSSION	ACTION REQUIRED
	h. Notice to MD offices about RN Advice Line Care Net provides RN advice line to both lines of business. All dispositions will be communicated same day to case management team. Provide more education to primary care physicians and members on when to use Nurse Advice Line.	
VIII. Adjournment	Meeting adjourned at ____7:35 PM__	
NEXT MEETING	The next meeting is scheduled for Wednesday, January 17, 2018, 6:00 PM	

Prepared by: Caroline Alexander Date 2/14/18
Caroline Alexander
Administrative Assistant

Reviewed and approved by: Jimmy Lin, M.D. Date 2/14/2018
Committee Chairperson

Santa Clara
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Quality Improvement Committee 2/21/18
Cal MediConnect Consumer Advisory Board – Member Feedback
Q4 - 2017

Member Update: Recruitment for CMC CAB membership was done in the past quarter and 3 new members were added to the Board. Below are issues or questions were raised by al SCFHP members at their monthly meetings in QU4. SCFHP is required to share this member input with the QI Committee quarterly.

Summary of Issues:

- Community Based Adult Services: Two SCFHP members encountered some challenges using CBAS services. They found that their language was not spoken at the CBAS near their homes, and the CBAS site without a language barrier was too far away.
- Fitness Benefit: Members continue to ask if SCFHP will provide free fitness services.
- Valley Medical Center - Valley Connections process: Member complained about the protocol of Valley Connections on how to leave a message to their physician or how to ask a question. Member was informed she had to log in the "My Help Line" to get her question answered. Member stated she has trouble using the navigation of the services. Charlene suggested the member could call Member Services and they can call Valley Connections together to ask how to navigate "My Help Line".
- Call Center Delays
  Member complained about the wait time when calling Member Services; you receive a recording "No calls ahead of you" and the member still has a wait time of 5 to 10 minutes.

Questions:

- Out of Town Medical Needs

Member asked about travel out of county to visit family and the need to go the clinic for PICC Line dressing changes weekly. The question about paying for services if seen by an out of area clinic was raised and Member was referred to the SCFHP Customer Services to facilitate coordination with the physicians' office for authorizing member's visits out of town.

- Durable Power of Attorney for Heath Care

Member asked about designating a DPA for Health Care if they do not have any family members or friends they can appoint. A referral to the Health Insurance Counseling and Advocacy (HICAP) program was made.

- Member Assessments

Clarification was sought by several members about the differences between Health Risk Assessment, other assessments and the annual PCP visit and exam, as well as the overall process including phone calls and mailings.

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Regular Meeting of the
Santa Clara County Health Authority
Consumer Advisory Committee

Tuesday, March 13, 2018
6:00 – 7:00 pm
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes - DRAFT

Committee Members Present
Mr. Paul Murphy, Chair
Ms. Brenda Taussig, Chair
Ms. Rachel Hart
Ms. Margaret Kinoshita
Ms. Danette Zuniga

Staff Present
Ms. Laura Watkins, Director of Marketing, Outreach and Enrollment
Ms. Sherita Gibson, Marketing Coordinator
Ms. Chelsea Byom, Marketing and Communications Manager
Ms. Divya Shah, Health Educator
Ms. Christine Tomcala, Chief Executive Officer
Ms. Chris Turner, Chief Operating Officer

1. **Call to Order**

   Christine Tomcala, CEO, called the meeting to order at 6:05 p.m. A quorum was established.

2. **Roll Call and Introductions**

   Introductions were made.

3. **Public Comment**

   There were no public comments.

4. **Review and Approval of December 12, 2017 Minutes**

   Ms. Kinoshita moved and Ms. Zuniga seconded the motion to approve the minutes from the meeting held on December 12, 2017. The motion passed unanimously.

5. Introduction of new CAC chairs

Ms. Tomcala introduced the new chairs, Brenda Taussig and Paul Murphy. Paul Murphy is presently Whistleblower Program Manager at the County Council's office. Brenda Taussig is Director of Government and Community Relations at El Camino Hospital. The members of the CAC committee introduced themselves and their affiliations with the plan.

6. Health Plan Update

Ms. Tomcala presented an enrollment update: As of March 1, Medi-Cal enrollment is 253,025; Cal MediConnect is 7,409; and Healthy Kids is 3,405 for a total enrollment of 263,839. Membership has declined slightly due to a variety of reasons.

Ms. Tomcala shared that plan has decided to freshen up its logo at the same time we move to the new building. The logo was displayed and well received by the committee.

Ms. Tomcala updated the CAC on our move date, anticipated for mid-July. The June CAC meeting will still be held at 210 E. Hacienda.

Funding extension for the CHIP program was passed through 9/30/2027. We anticipate our Healthy Kids program will continue through that date. Ms. Zuniga asked who will be issuing 1095B forms for CHIP members. Ms. Watkins will reach out to the state to confirm.

7. Member Portal Overview

Ms. Byom announced that SCFHP will be launching a new member portal that will allow members to login and see information about their SCFHP membership. Members will be able to:

- View, request, or print your ID card
- Find a doctor
- Change your PCP
- Request transportation
- Request health education
- View service authorizations and claims information
- Access wellness resources

Protection of health information was brought up. Ms. Watkins stated that the portal will meet industry standards for security. Mr. Murphy stated that the Board is vigilant at monitoring hacking attempts.

The member portal will be mobile compatible. A mobile application will also be launched at a later date. The portal will be available in all threshold languages. Committee members were very positive about the features of the portal and the ability to self-serve.

8. Health Education Brochure

SCFHP covers a variety of health education classes:

- Exercise and Fitness
- Nutrition and weight management
- Counseling and Support Services
- Pre-natal/Safety Programs
- Parent Education
- Smoking Cessation

Ms. Byom led the group in a discussion about the plan's health education offerings. Committee members were asked:

- What would be the best way to inform members about these class offerings?
  Ms. Kinoshita stated she doesn't like scare tactics, but they are effective. Other suggestions included flyers, visuals, radio stations and auditory messages. Billboards also are helpful. Ms. Zuniga agreed that she is more visual, so the newsletter would be useful in sharing information about the classes. Ms. Watkins asked if text messaging would be helpful. Ms. Kinoshita stated she wouldn't like text messages but would rather get a flyer. Ms. Hart stated she would like text messages, because she would look at messages on her phone more than she would a flyer.
- How much information should we provide about the classes?
  Ms. Kinoshita asked about pre-diabetes classes. Ms. Shah stated a prevention program is launching April 1, 2018 for Medicare and January 1, 2019 for Medi-Cal. Ms. Kinoshita stated offering tips could be helpful to inform about classes. Also having the information for the classes more accessible. She stated that when she tried to call for more information she was not able to get the information she needed and gave up trying to find information. Having a way to access more information more easily would help. Ms. Hart asked if they don't have a car what the member can do to get to these classes. Ms. Turner stated transportation to classes is not currently covered, but would look to see if this is possible. Ms. Taussig asked if the classes are in-person or online as well. Ms. Shah stated these are all in-person classes. Ms. Kinoshita suggested having quick advertisements in waiting room clinics and also using quick slogans to make people think, for example, "Did you know it is cheaper to be healthier?"
- Would you be interested in taking any of these classes? If so, which ones and why?
  The committee members expressed interest in Weight Watchers, gym benefits, meal preparation, and yoga. Ms. Shah stated that there are swim lessons and swim passes available for members on first come, first serve basis. Swim lessons are offered for children ages 6 months – 18 years and include 8 sessions. Eleven swim passes are available for ages 11-18 years. Members also requested classes on meal preparation and nutritious cooking.

9. Expanded Food and Nutrition Education Program (EFNEP)

Ms. Shah presented information about the EFNEP which will be launched as a pilot program. It will include education about nutrition, physical activity, planning and budgeting. She will bring additional information back to the committee as it is available.

10. Recent SCFHP Member Communications

Ms. Byom reviewed recent website postings, member materials, community resources and events, and mailings that were distributed to members. She stated that the feedback of this committee has helped determine the content of these communications.

Mr. Murphy suggested adding the Governing Board to the newsletter mailing list.

11. Future Meetings and Agenda Items

The next Consumer Advisory Committee meeting is June 12, 2018. Topics suggested for the next meeting include:

- Update on EFNEP
- Blood pressure – Where can you get free checkups?
- Vision care benefits
- Strep throat treatment and prevention

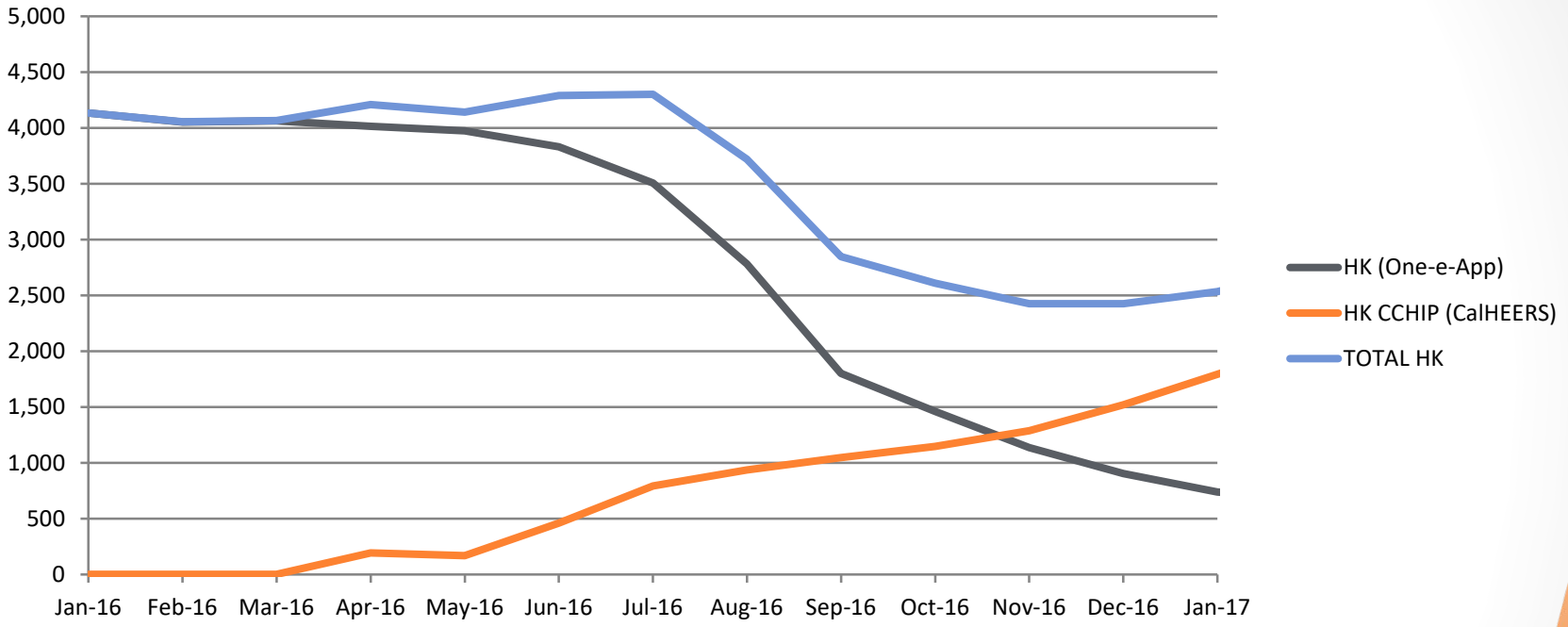
12. Adjournment

Mr. Murphy moved and Ms. Kinoshita seconded the motion to adjourn the meeting at 7:03 pm. The motion passed unanimously.

_____

Christine Tomcala
CEO, Santa Clara Family Health Plan

Healthy Kids Update - Enrollment



- One-e-App (OEA): Transition of to Medi-Cal of eligible undocumented kids is complete; Remaining OEA enrollment is undocumented kids in families that are within 266-300% FPL
- CCHIP: Enrollment increased Nov 17 – Jan 17 due to Covered CA open enrollment

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Healthy Kids Update

- Federal CHIP legislation signed
  - Funding extended through 9/30/2027: States will continue to receive federal funding for CHIP (CHIP in CA provides coverage through Medi-Cal for members formerly in Healthy Families)
  - Maintenance of effort (MOE) extended through 9/30/2027: States that currently offer CHIP (Medi-Cal) or CCHIP (Healthy Kids) are required to continue offering these programs through 9/30/2027
    - Expect DHCS to extend this MOE requirement to three counties providing CCHIP coverage through Healthy Kids – Santa Clara, San Mateo, San Francisco
- Transition to Valley Kids for remaining Healthy Kids OEA members: VHP, SCFHP and SCVHHS working on transition plan for remaining 200 members, per direction from County Board of Supervisors

HEALTHTrust

March 16, 2018

Christine Tomcala, CEO
Santa Clara Family Health Plan
210 E Hacienda Ave
Campbell, CA 95008

Dear Ms. Tomcala,

For more than 20 years, The Health Trust, the Santa Clara Family Health Plan, and other organizations have worked tirelessly to improve health access for community residents who are poor and disenfranchised, and we have seen much success. However challenges persist. Ongoing pressure and stress in the community – housing instability, rise in chronic diseases, and fear of deportation – make health insurance status and access to care an ongoing challenge. To fortify our ability to serve the community during these challenging times, we propose a closer partnership between The Health Trust and the Health Plan that will strengthen efforts to engage and enroll low-income residents in health insurance so they can achieve and maintain health for themselves and their families. We respectfully request financial support of $160,000.00 from the Health Plan to support three activities over the next 14 months: 1) health insurance enrollment; and 2) shared space with the Health Plan at The Health Trust's site in East San Jose, and 3) planning efforts to pursue longer-term co-location of staff and collaboration between our two organizations.

The Health Trust is dedicated to building health equity in Silicon Valley. One way we achieve this is by helping people who are low income and vulnerable to access health insurance, dental insurance and quality health care. We employ effective and culturally appropriate outreach strategies that result in people getting insured and into care. The Health Trust is certified by the State of California to enroll Santa Clara County residents in Medi-Cal and Denti-Cal and other insurance plans. Besides enrollment services, The Health Trust program supports clients to navigate the network of preventive services available within their coverage.

In our office located in East San Jose, our bilingual, bicultural enrollment specialists work closely with clients to review what services are covered by insurance and to help them navigate their insurance plan so they get the care they need. At two and 10 months after enrollment, specialists follow up to be sure clients are utilizing their coverage, and to provide referrals if needed. The Health Trust is the single largest non-governmental enrollment entity in Santa Clara County. We currently enroll and re-enroll over 100 children and adults every month and have been doing so since 2001. Besides enrollment, the navigation support we provide helps ensure that our clients find and use the services they need to stay healthy.

The Health Trust is uniquely situated to reach people in communities most vulnerable to stressors like poverty, housing instability, and uncertain immigration policy. We have a long history of service to tens of thousands of Santa Clara County residents each year with our health education programs, enrollment services, home-delivered meals, housing support and case management for people with HIV. As the founder of the Children's Dental Center (CDC) in the Tropicana Shopping Center, we have established ourselves as a trusted and reliable service provider, and one who ensures access to high quality care. The Tropicana Center is a one-stop shopping plaza serving the Latino community since 1960. Our health insurance enrollment services are located there, at the CDC, where thousands of families take their children for affordable, high quality dental care. Once a month, The Health Trust hosts distribution of fresh and healthy food at no cost, right outside the office. This location is ideal for the Health Plan to explore as a possible hub of service in the East San Jose community. The Health Trust is eager to make space available, as possible, for Health Plan operations, including classes.

In partnership with the Santa Clara Family Health Plan, The Health Trust will sustain and continue to grow its reach to thousands of individuals and families in Santa Clara County. Together, these two organizations will strengthen access to health insurance and health care that vulnerable populations in our community need to achieve and maintain health.

Thank you for your consideration. I look forward to hearing from you about next steps needed to pursue this opportunity.

Sincerely,

Paul Hepfer, Sr. Vice President
The Health Trust

Compliance Department Activity
February 2018

CORE 2.1 Performance Improvement Plan (PIP)
The PIP workgroup, formed to address the low health risk assessment (HRA) completion rates, continues to meet weekly to monitor progress. As part of the PIP, SCFHP is required to submit a monthly HRA report to the regulator that tracks HRA completion rates. Completion rates for HRAs for the past three months is:

- November 2017 – 99.12%
- December – 100 %
- January 2018 – 100%

2017 DHCS Audit Corrective Action (CAP)
SCFHP prepared and submitted a CAP to DHCS responding to the deficiencies identified in the 2017 audit report. DHCS reviewed the Plan's CAP and found the actions and corrections to be compliant. A closing letter was issued for the 2017 Audit findings.

2018 DHCS Audit
SCFHP received notification for its DHCS 2018 audit to be conducted April 9 through April 20, 2018. Audit documents are being collected for submission to DHCS by March 2.

DMHC Timely Access
SCFHP is preparing a response to DMHC network adequacy inquiries regarding its measurement year 2016 Timely Access Filing.

SCFHP's measurement year 2017 Timely Access filing is due March 31, 2018.

Cal MediConnect

- In December 2017, SCFHP received a CMS Warning Letter for late submission of two reports, Payments to Providers and Rewards and Incentives Programs in February 2017.
- Because SCFHP did not pass its 2017 Medicare Data Validation Audit, in December 2017, SCFHP received a request from CMS for a Corrective Action Plan to address the identified deficiencies. The internal CAP is at approximately 95% completion.
- 2018 Medicare Data Validation Update:
    - SCFHP has contracted with the same Data Validation contractor, Advent.
    - Part C & D Grievance data reports were submitted to CMS on February 5. All other required validation measures are due on February 26.
    - The Compliance Department has actively analyzed the data as well as running the data through the self-audit tool to identify any potential audit challenges.
    - The audit data universes are due to Advent on April 1.
    - The virtual onsite meeting with Advent will be held in mid-April; audit samples are due no later than May 1, and a final report is expected by June 30.
- A 2016 PDE data validation audit is underway. SCFHP anticipates a strong performance.

Medi-Cal

- DHCS has created an annual network certification filing. It is similar to DMHC's Timely Access Filing and will evaluate the time and distance standards of SCFHP's entire provider network. The filing also includes policy and procedure review.
- DHCS continues to work on implementation of the Medicaid Health Homes Program. This program was authorized under the ACA and will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination.

  SCFHP has begun a workgroup to prepare for its Phase 2 implementation: January 1, 2019 for members with eligible chronic physical conditions and substance use disorders and July 1, 2019 for members with Specialty Mental Health conditions.

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Unaudited
Financial Statements
For Seven Months Ended January 2018

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Financial Highlights

- **Net Surplus –** January $0.5 million surplus ($1.0 million unfavorable to budget) and year-to-date (YTD) $16.1 million surplus ($11.5 million favorable to budget). YTD surplus is mostly driven by lower medical expenses than budget.
- **Enrollment –** January membership 263,855 (3.2% unfavorable to budget) and YTD: 1,886,003 member months (1.7% unfavorable to budget and 3.7% lower than YTD last year). Medi-Cal enrollment has continually declined since November 2016. CMC membership has stabilized after declining since January 2016.
- **Revenue –** Favorable to budget by $0.9 million for the month (1.1%) and favorable to budget by $2.2 million (0.3%) YTD
- **Medical Expenses –** Unfavorable to budget by $2.0 million for the month (-2.5%) and favorable to budget by $8.1 million (1.3%)
- **Administrative Expenses –** Unfavorable to budget by $0.2 million (-4.0%) and favorable YTD budget by $0.3 million (+1.0%)
- **Tangible Net Equity –** $174.4 million or 493% of minimum required Tangible Net Equity (TNE) of $35.3 million per Department of Managed Health Care (DMHC)
- **Capital Expenditure –** YTD capital investments of $10.5 million versus $17.3 million per annual budget, largely building purchase

	Month	YTD
Revenue	$84 million	$680 million
Medical Costs	$79 million	$635 million
Medical Loss Ratio	94.3%	93.4%
Administrative Costs	$4.4 million (5.3%)	$29.3 million (4.3%)
Other Income/ Expense	$100,578	$400,074
Net Surplus (Loss)	$492,977	$16,053,666

Cash on Hand	$216 million
Net Cash Available to SCFHP	$197 million
Receivables	$542 million
Current Liabilities	$610 million
Tangible Net Equity	$174 million
Percent Of DMHC Requirement	**493%**

Risks and Opportunities

- **Risks**
  - YTD enrollment is below budget. Medi-Cal enrollment has been declining since November 2016.
  - Retroactive provider rate adjustments are causing some volatility in claims payments and in estimation of total monthly medical expenses.
  - Revenue recordation requires some estimation and accruals, including those for the Coordinated Care Initiative (CCI). Much of these funds are expected to be received by the end of the current fiscal year.

- **Opportunities**
  - Continued growth in CCI membership.
  - Continue to fill open positions to replace temporary staff and consultant usage.
  - With convergence of claims processing to QNXT, all claims are processed on one system, which allows for increased auto-adjudication rates and better efficiency.
  - Utilization management with in-house staffing for previously outsourced Health Risk Assessments and Individualized Care Management Plans yields better outcomes for members.

Member Months

For the month of January 2018, total membership was lower than budget by 8,618 (-3.2%). For YTD, total member months were lower than budget by 31,877 (-1.7%). Medi-Cal membership has declined since November 2016 while CMC membership has stabilized in the last three months. Specific causes are under investigation.

Since the end of the prior fiscal year on 6/30/2017, membership in Medi-Cal decreased by 4.7 %, membership in Healthy Kids program increased by 17.5%, and membership in CMC program decreased by 2.0%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Jan 2018			For Seven Months Ending Jan 31, 2018				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**Change FY18 vs. FY17**
Medi-Cal	253,257	262,173	(3.4%)	1,816,478	1,845,780	(1.6%)	1,882,608	(3.5%)
Healthy Kids	3,209	2,800	14.6%	17,759	19,600	(9.4%)	21,852	(18.7%)
Medicare	7,389	7,500	(1.5%)	51,766	52,500	(1.4%)	54,499	(5.0%)
Total	263,855	272,473	(3.2%)	1,886,003	1,917,880	(1.7%)	1,958,959	(3.7%)

Santa Clara Family Health Plan Enrollment by Network
January 2018

Network	**Medi-Cal**		**Healthy Kids**		**CMC**		**Total**	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	28,428	11%	369	11%	7,389	100%	36,186	14%
SCVHHS, Safety Net Clinics, FQHC Clinics	128,876	51%	1,473	46%	-	0%	130,349	49%
Palo Alto Medical Foundation	7,292	3%	76	2%	-	0%	7,368	3%
Physicians Medical Group	46,721	18%	1,063	33%	-	0%	47,784	18%
Premier Care	15,893	6%	228	7%	-	0%	16,121	6%
Kaiser	26,047	10%	-	0%	-	0%	26,047	10%
Total	**253,257**	**100%**	**3,209**	**100%**	**7,389**	**100%**	**263,855**	**100%**
Enrollment at June 30, 2017	265,753		2,732		7,543		276,028	
Net Change from Beginning of FY18	-4.7%		17.5%		-2.0%		-4.4%	

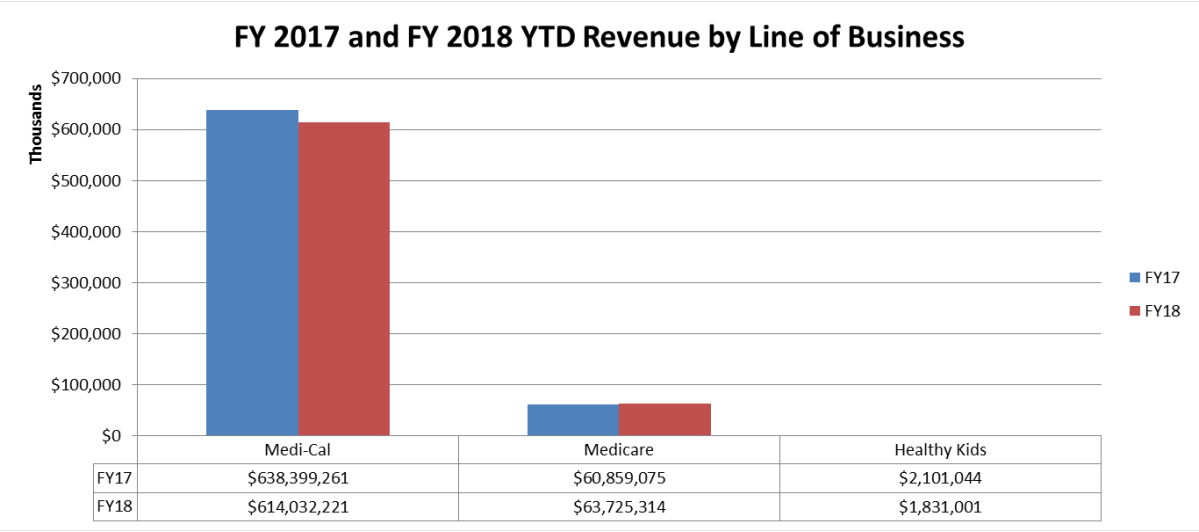
SCVHHS = Santa Clara Valley Health & Hospital System
FQHC = Federally Qualified Health Center

Revenue

Santa Clara Family Health Plan (SCFHP or the Plan) recorded net revenue of $84.1 million for the month of January 2018, compared to budgeted revenue of $83.2 million, resulting in a favorable variance from budget of $0.9 million, or +1.1%. For YTD January 2018, the Plan recorded net revenue of $679.6 million, compared to budgeted revenue of $677.4 million, resulting in a favorable variance from budget of $2.2 million, or +0.3%.

Major revenue variances for January 2018, which net to $0.9 million were:

1. Long Term Care (LTC) revenue was favorable by $1.2 million due to both higher member months and rate differential.
2. Behavioral Health Treatment (BHT) revenue was favorable by $1.0 million due to both higher member months and rate differential.
3. Assembly Bill (AB 85) revenue was unfavorable by $1.2 million (no impact on net income).
4. Medicaid Coverage Expansion (MCE) revenue was unfavorable by $1.0 million (lower member months).
5. Smaller unfavorable variances in Medi-Cal CMC (lower member months) Hepatitis C (both lower member months and rate differential), and Maternity (fewer births) that were offset by small favorable variances in Managed Long-Term Services and Support (MLTSS), Prior Year revenues, and Base Capitation total $0.9 million.



	Medi-Cal	Medicare	Healthy Kids
FY17	$638,399,261	$60,859,075	$2,101,044
FY18	$614,032,221	$63,725,314	$1,831,001

Medical Expenses

For the month of January 2018, medical expense was $79.3 million compared to budget of $77.3 million, resulting in an unfavorable budget variance of $2.0 million, or -2.5%. For YTD January 2018, medical expense was $634.6 million compared to budget of $642.8 million, resulting in a favorable budget variance of $8.1 million, or +1.3%.

Major medical expense variances for January 2018, which net to -$2.0 million were:

1. LTC expense was unfavorable by $2.8 million largely due to higher number of utilizers and retroactive provider rate adjustments.
2. Inpatient expenses was unfavorable by $1.6 million due to retroactive provider rate adjustments as well as seasonal increase in utilization.
3. Network capitation expense was favorable by $1.8 million due to fewer member months.
4. AB85 expense was favorable by $1.2 million (largely matches the corresponding unfavorable variance in revenue)

YTD medical expense favorability of $10.1 million is largely driven by:

1. The Plan had recorded a net IHSS loss for FY 17. Based on this experience, a $1.0 million monthly net IHSS expense was budgeted for FY18 for the potential risk the Plan still carries. This overall $10.1 million favorable YTD expense variance is under evaluation.
2. Higher LTC ($5.5 million), Inpatient ($4.3 million), Out of Area ($2.2 million) expenses were offset by lower AB 85 ($8.7 million), Network Capitation ($6.3 million), and Pharmacy ($1.8 million) expenses.

YTD medical expense summary:

Medical Expense	Amount	% of Total
Network Capitation	$230,506,037	36%
IHSS	$89,593,814	14%
Pharmacy	$85,943,852	14%
Inpatient, Emergency, and Maternity	$84,332,501	13%
Institutional Extended Care	$77,745,442	12%
Outpatient and Other	$66,509,412	10%
Total Medical Expense	**$634,631,058**	

Administrative Expenses

Administrative costs were unfavorable to budget by $0.2 million (-4.0%) for the month of January 2018 and favorable to budget by $0.3 million (+1.0%) for YTD January 2018.

Major administrative expense variances for January 2018 were:

1. Consulting expenses were higher by $173K due to a higher use of consulting services than budgeted.
2. Temporary staff expenses were higher by $145K due to a higher use of temporary services than budgeted. Most of this unfavorable variance is due to in-sourcing of a previously outsourced case management function as well as the planned effort to bring claims inventory to a normal level.
3. Contract Services for Pharmacy Benefits Management fee was higher by $138K due to timing of payments (five weeks in the calendar month).

Overall administrative expenses were 4.3% of revenue for YTD January 2018 (0.1% favorable to budget). Most of the YTD variances are in the same categories as in monthly variances with a corresponding higher or lower magnitude.

Actual vs. Budget
For the Current Month & Fiscal Year to Date - Jan 2018
Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$ 2,445,157	$ 2,541,099	$ 95,942	3.8%	Personnel	$ 15,595,774	$ 16,148,967	$ 553,193	3.4%
1,994,576	1,728,586	(265,990)	-15.4%	Non-Personnel	13,708,112	13,448,386	$ (259,726)	-1.9%
4,439,732	4,269,685	(170,048)	-4.0%	Total Administrative Expense	29,303,886	29,597,352	293,466	1.0%

Balance Sheet

- Current assets totaled $765.3 million compared to current liabilities of $610.4 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.3 vs. the DMHC minimum requirement of 1.0. Working capital (current assets minus current liabilities) increased by $3.1 million for the seven months of the fiscal year.

- Cash as of January 31, 2018 decreased by $148.8 million compared to the cash balance as of year-end June 30, 2017. The overall cash position decreased largely due to:
    1. Recoupment of FY2015-17 MCE overpayments (~$18 million per month) by DHCS.
    2. An increase in net receivables by $67.0 million due to a delay in receipt of payments for Duals Recast differential revenue, Managed Care Organization (MCO) tax revenue, and Supplemental revenue.
    3. Payment of MCO tax for FY17 and prior years.
    4. Purchase of a new building.
    5. Voluntary funding of future pension and retiree benefits liabilities.

- SCFHP moved some of its cash to the County Investment Pool in order to achieve higher interest income while still maintaining the liquidity of its funds. With the commencement of monthly recoupment of MCE overpayments by the State beginning in June's capitation, the Plan withdrew some of these funds in January 2018. The Plan expects to receive a large payment in April for the outstanding Duals Recast differential, MCO taxes, and Supplemental revenues.

- Liabilities decreased by $83.8 million during the seven months ended January 31, 2018. Liabilities decreased primarily due to the disbursement of pass-through funds to hospitals, payment of MCO tax for FY17 and prior years, and recoupment of FY2015-17 MCE overpayments by DHCS.

Tangible Net Equity (TNE)

TNE was $174.4 million at January 31, 2018 or 493% of the most recent quarterly DMHC minimum requirement of $35.3 million. TNE trends for SCFHP are shown below.

Santa Clara County Health Authority
Tangible Net Equity - Actual vs. Required
As of Period Ended:

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	1/31/2018
Actual Net Position / Reserves	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	158,380,560	174,434,226
Required Reserve per DMHC	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	35,898,000	35,347,693
200% of Required Reserve	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	71,796,000	70,695,386
Actual as % Required	722%	410%	419%	357%	377%	310%	441%	493%

Reserves Analysis

- At the September 2016 Governing Board meeting, a policy was adopted for targeting the organization's capital reserves to include: a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

- As of January 31, 2018, the Plan's TNE was $50.7 million above the low-end Equity Target and $76.8 million above the low-end Liquidity Target. The Plan's TNE was $2.3 million below the high-end Equity Target and $36.7 million above the high-end Liquidity Target (see calculations below).

SCFHP RESERVES ANALYSIS JANUARY 2018

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$174,434,226
Current Required TNE	$35,347,693
Excess TNE	$139,086,532
Required TNE Percentage	493%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$123,716,926
500% of Required TNE (high end)	$176,738,466
TNE Above/(Below) SCFHP Low End Target	**$50,717,300**
TNE Above/(Below) SCFHP High End Target	**($2,304,240)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$215,825,024
Less Pass-through Liabilities:	
Payable to State of CA*	-
Other Pass-through Liabilities	(18,798,670)
Total Pass-through Liabilities	(18,798,670)
Net Cash Available to SCFHP	$197,026,354
SCFHP Target Liquidity:	
45 days of Total Operating Expenses	($120,210,934)
60 days of Total Operating Expenses	($160,281,245)
Liquidity Above/(Below) SCFHP Low End Target	**$76,815,420**
Liquidity Above/(Below) SCFHP High End Target	**$36,745,109**
*Pass-Throughs from State of CA (excludes IHSS)	
Receivables Due to SCFHP	166,827,433
Payables Due from SCFHP	(108,370,572)
Net Receivable/(Payable)	$58,456,861

Capital Expenditure

Capital investments of $10.5 million were made during the seven months ended January 31, 2018, largely due to the purchase of a new building (in order to lower the long term occupancy costs in an ever increasing rental rate situation in the current location). The YTD capital expenditure includes:

Expenditure	YTD Actual	Annual Budget
New Building*	$9,809,826	$14,300,000
Systems	119,881	1,595,000
Hardware	392,623	611,500
Software	20,647	587,000
Furniture and Fixtures	135,935	173,515
Automobile	0	33,000
Leasehold Improvements	0	10,000
TOTAL	**$10,478,911**	**$17,310,015**

**Budget includes $4.5 million of renovation expend associated with 50 Great Oaks building*

The Plan expects to incur the bulk of the remaining expenditures later in the FY 2018.

Santa Clara Family Health Plan
Enrollment by Aid-Category

		2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02
NON DUAL	Adult (over 19)	31,072	30,836	30,479	30,204	29,921	29,651	28,985	29,301	29,051	28,722	28,252	28,072	27,527	27,565
	Adult (under 19)	106,719	106,926	106,305	106,181	105,945	106,082	104,658	105,129	104,328	103,793	103,224	103,047	101,198	101,623
	Aged - Medi-Cal Only	10,371	10,400	10,400	10,520	10,538	10,674	10,776	10,693	10,722	10,801	10,778	10,782	10,892	10,906
	Disabled - Medi-Cal Only	11,016	11,052	11,067	11,083	11,075	10,917	10,904	10,852	10,834	10,841	10,857	10,832	10,813	10,824
	Child (HF conversion)	973	921	879	845	280	192	74	59	52	57	53	40	25	25
	Adult Expansion	83,031	82,715	82,618	82,751	82,420	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302
	Other	34	38	38	39	35	38	33	35	45	61	82	92	120	137
	Long Term Care	327	315	318	315	326	338	353	365	377	378	376	366	354	346
	Total Non-Duals	243,543	243,203	242,104	241,938	240,540	240,241	236,083	237,175	235,879	234,651	232,854	232,438	227,852	228,728
DUAL	Aged	15,325	15,921	16,076	16,208	16,200	16,382	16,309	16,690	16,797	16,819	16,823	16,733	16,743	16,827
	Disabled	6,353	6,478	6,506	6,507	6,458	6,518	6,474	6,502	6,522	6,547	6,555	6,552	6,545	6,559
	Other	1,727	1,686	1,621	1,427	1,389	1,370	1,271	1,235	1,241	1,233	1,144	1,142	896	853
	Long Term Care	1,166	1,177	1,233	1,224	1,231	1,242	1,254	1,269	1,262	1,268	1,257	1,241	1,221	1,174
	Total Duals	24,571	25,262	25,436	25,366	25,278	25,512	25,308	25,696	25,822	25,867	25,779	25,668	25,405	25,413
	Total Medi-Cal	268,114	268,465	267,540	267,304	265,818	265,753	261,391	262,871	261,701	260,518	258,633	258,106	253,257	254,141
	Healthy Kids	2,585	2,780	2,752	2,794	2,757	2,732	2,633	2,618	2,243	2,288	2,321	2,447	3,209	3,250
CMC	CMC Non-Long Term Care	7,225	7,301	7,333	7,277	7,256	7,262	7,254	7,141	7,125	7,071	7,096	7,138	7,149	7,183
	CMC - Long Term Care	302	297	289	290	289	281	271	264	258	255	253	251	240	234
	Total CMC	7,527	7,598	7,622	7,567	7,545	7,543	7,525	7,405	7,383	7,326	7,349	7,389	7,389	7,417
	Total Enrollment	**278,226**	**278,843**	**277,914**	**277,665**	**276,120**	**276,028**	**271,549**	**272,894**	**271,327**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**

Santa Clara County Health Authority
Income Statement for Seven Months Ending January 31, 2018

	For the Month of Jan 2018					For Seven Months Ending Jan 31, 2018				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 73,145,082	86.9%	$ 74,307,472	89.3%	$ (1,162,389)	$ 614,032,221	90.4%	$ 615,192,236	90.8%	$ (1,160,015)
HEALTHY KIDS	$ 334,078	0.4%	$ 252,000	0.3%	$ 82,078	$ 1,831,001	0.3%	$ 1,764,000	0.3%	$ 67,001
MEDICARE	$ 10,648,143	12.7%	$ 8,637,957	10.4%	$ 2,010,186	$ 63,725,314	9.4%	$ 60,465,702	8.9%	$ 3,259,612
TOTAL REVENUE	$ 84,127,303	100.0%	$ 83,197,429	100.0%	$ 929,874	$ 679,588,535	100.0%	$ 677,421,938	100.0%	$ 2,166,598
MEDICAL EXPENSES										
MEDI-CAL	$ 69,416,450	82.5%	$ 68,825,356	82.7%	$ (591,094)	$ 577,325,611	85.0%	$ 583,223,055	86.1%	$ 5,897,444
HEALTHY KIDS	$ 321,218	0.4%	$ 240,242	0.3%	$ (80,976)	$ 1,663,757	0.2%	$ 1,681,693	0.2%	$ 17,936
MEDICARE	$ 9,557,503	11.4%	$ 8,267,243	9.9%	$ (1,290,260)	$ 55,641,689	8.2%	$ 57,870,702	8.5%	$ 2,229,013
TOTAL MEDICAL EXPENSES	$ 79,295,171	94.3%	$ 77,332,841	93.0%	$ (1,962,330)	$ 634,631,058	93.4%	$ 642,775,450	94.9%	$ 8,144,392
MEDICAL OPERATING MARGIN	$ 4,832,132	5.7%	$ 5,864,588	7.0%	$ (1,032,456)	$ 44,957,478	6.6%	$ 34,646,488	5.1%	$ 10,310,990
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 2,445,157	2.9%	$ 2,541,099	3.1%	$ 95,942	$ 15,595,774	2.3%	$ 16,148,967	2.4%	$ 553,193
RENTS AND UTILITIES	$ 115,440	0.1%	$ 115,974	0.1%	$ 534	$ 926,091	0.1%	$ 828,293	0.1%	$ (97,799)
PRINTING AND ADVERTISING	$ 107,165	0.1%	$ 69,800	0.1%	$ (37,365)	$ 357,066	0.1%	$ 693,300	0.1%	$ 336,234
INFORMATION SYSTEMS	$ 187,513	0.2%	$ 208,714	0.3%	$ 21,201	$ 1,150,192	0.2%	$ 1,514,997	0.2%	$ 364,805
PROF FEES / CONSULTING / TEMP STAFFING	$ 1,147,203	1.4%	$ 763,740	0.9%	$ (383,464)	$ 7,943,241	1.2%	$ 6,178,866	0.9%	$ (1,764,376)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 327,296	0.4%	$ 358,193	0.4%	$ 30,897	$ 2,370,605	0.3%	$ 2,441,108	0.4%	$ 70,502
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 31,413	0.0%	$ 109,411	0.1%	$ 77,998	$ 350,325	0.1%	$ 1,028,480	0.2%	$ 678,154
MEETINGS / TRAVEL / DUES	$ 68,545	0.1%	$ 95,184	0.1%	$ 26,639	$ 558,379	0.1%	$ 660,005	0.1%	$ 101,626
OTHER	$ 10,000	0.0%	$ 7,570	0.0%	$ (2,430)	$ 52,211	0.0%	$ 103,337	0.0%	$ 51,126
TOTAL ADMINISTRATIVE EXPENSES	$ 4,439,732	5.3%	$ 4,269,685	5.1%	$ (170,048)	$ 29,303,886	4.3%	$ 29,597,352	4.4%	$ 293,466
OPERATING SURPLUS (LOSS)	$ 392,400	0.5%	$ 1,594,903	1.9%	$ (1,202,503)	$ 15,653,591	2.3%	$ 5,049,135	0.7%	$ 10,604,456
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (59,780)	-0.1%	$ -	$ (418,458)	-0.1%	$ (418,458)	-0.1%	$ -
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (525,000)	-0.1%	$ (525,000)	-0.1%	$ -
INTEREST & OTHER INCOME	$ 235,357	0.3%	$ 65,153	0.1%	$ 170,205	$ 1,343,532	0.2%	$ 456,069	0.1%	$ 887,463
NET SURPLUS (LOSS) FINAL	$ 492,977	0.6%	$ 1,525,276	1.8%	$ (1,032,299)	$ 16,053,666	2.4%	$ 4,561,746	0.7%	$ 11,491,920

Santa Clara County Health Authority
Balance Sheet

	JAN 18	DEC 17	NOV 17	JUN 17
Assets				
Current Assets				
Cash and Marketable Securities	$ 215,825,024	$ 242,799,014	$ 285,180,287	$ 364,609,248
Premiums Receivable				
In Home Support Services (IHSS)	372,458,622	372,463,251	357,111,472	282,168,565
All Other	169,372,821	165,020,333	166,363,472	192,697,632
Prepaid Expenses and Other Current Assets	7,645,952	7,417,269	6,802,123	7,070,619
Total Current Assets	765,302,419	787,699,867	815,457,354	846,546,064
Long Term Assets				
Equipment	31,747,798	31,721,382	31,596,931	21,268,887
Less: Accumulated Depreciation	(12,834,925)	(12,546,390)	(12,257,068)	(10,761,759)
Total Long Term Assets	18,912,873	19,174,992	19,339,863	10,507,128
Total Assets	$ 784,215,293	$ 806,874,859	$ 834,797,217	$ 857,053,192
Deferred Outflow of Resources	$ 14,405,010	$ 14,405,010	9,287,513	9,287,513
Total Deferred Outflows and Assets	798,620,303	821,279,869	844,084,730	866,340,705
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 4,171,876	$ 6,515,940	$ 5,833,810	$ 6,157,039
Deferred Rent	48,505	54,804	61,103	92,597
Employee Benefits	1,446,790	1,386,017	1,344,252	1,262,108
Retirement Obligation per GASB 45	5,236,817	5,177,037	5,117,257	4,818,359
Advance Premium - Healthy Kids	58,429	54,641	42,696	53,439
Deferred Revenue - Medicare				8,372,938
Whole Person Care	2,065,180	2,065,180	2,065,180	2,065,180
Payable to Hospitals (AB 85)	11,064,023	11,060,140	11,049,602	27,378,335
Due to Santa Clara County Valley Health Plan and Kaiser	5,669,467	4,837,597	9,117,449	9,456,454
MCO Tax Payable - State Board of Equalization	8,588,820	8,799,433	25,445,080	33,865,555
Due to DHCS	88,717,729	105,074,063	121,349,747	207,658,770
Liability for In Home Support Services (IHSS)	390,510,323	390,514,952	375,163,173	300,220,266
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	90,446,394	95,712,093	100,194,202	90,922,381
Total Current Liabilities	610,398,878	633,626,422	659,158,076	694,697,947
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	7,382,370	7,307,370	7,232,370	6,857,370
Total Liabilities	623,700,748	646,853,292	672,309,946	707,474,817
Deferred Inflow of Resources	485,329	485,329	485,329	485,329
Net Position / Reserves				
Invested in Capital Assets	9,910,932	10,083,469	10,171,607	10,507,128
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	148,164,278	147,991,740	147,903,603	89,480,978
Current YTD Income (Loss)	16,053,666	15,560,688	12,908,895	58,087,104
Net Position / Reserves	174,434,226	173,941,248	171,289,455	158,380,560
Total Liabilities, Deferred Inflows, and Net Assets	$ 798,620,303	$ 821,279,869	$ 844,084,730	$ 866,340,705

Santa Clara Family Health Plan
Statement of Cash Flows
For Seven Months Ending Jan 31, 2018

Cash flows from operating activities		
Premiums received	$	468,405,512
Medical expenses paid	$	(548,603,975)
Administrative expenses paid	$	(59,450,382)
Net cash from operating activities	$	(139,648,845)
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(10,478,911)
Cash flows from investing activities		
Interest income and other income, net	$	1,343,532
Net (Decrease) increase in cash and cash equivalents	$	(148,784,224)
Cash and cash equivalents, beginning of year	$	364,609,248
Cash and cash equivalents at Jan 31, 2018	$	215,825,024
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	14,710,134
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	2,073,166
Changes in operating assets and liabilities		
Premiums receivable	$	(66,965,247)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	(575,332)
Deferred outflow of resources	$	(5,117,497)
Accounts payable and accrued liabilities	$	(26,108,375)
State payable	$	(144,217,776)
Santa Clara Valley Health Plan and Kaiser payable	$	(3,786,987)
Net Pension Liability	$	525,000
Medical cost reserves and PDR	$	(475,987)
Deferred inflow of resources	$	-
Total adjustments	$	(154,358,979)
Net cash from operating activities	$	(139,648,845)

Santa Clara County Health Authority
STATEMENT OF OPERATIONS
BY LINE OF BUSINESS (INCLUDING ALLOCATED EXPENSES)

For Seven Months Ending Jan 31, 2018

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$598,170,543	$79,586,992	$1,831,001	**$679,588,535**
MEDICAL EXPENSES	560,497,532	72,469,769	1,663,757	**634,631,058**
(MLR)	93.7%	91.1%	90.9%	**93.4%**
GROSS MARGIN	37,673,011	7,117,223	167,243	**44,957,478**
ADMINISTRATIVE EXPENSES	25,793,139	3,431,794	78,953	**29,303,886**
(% of Revenue Allocation)				
OPERATING INCOME/(LOSS)	11,879,872	3,685,429	88,291	**15,653,591**
OTHER INCOME/(EXPENSE)	352,143	46,853	1,078	**400,074**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$12,232,016	$3,732,282	$89,368	**$16,053,666**
PMPM (ALLOCATED BASIS)				
REVENUE	$329.30	$1,537.44	$103.10	**$360.33**
MEDICAL EXPENSES	308.56	1,399.95	93.69	**336.50**
GROSS MARGIN	20.74	137.49	9.42	**23.84**
ADMINISTRATIVE EXPENSES	14.20	66.29	4.45	**15.54**
OPERATING INCOME/(LOSS)	6.54	71.19	4.97	**8.30**
OTHER INCOME / (EXPENSE)	0.19	0.91	0.06	**0.21**
NET INCOME / (LOSS)	$6.73	$72.10	$5.03	**$8.51**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*1,816,478*	*51,766*	*17,759*	***1,886,003***
Revenue by LOB	*88.0%*	*11.7%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the Coordinated Care Initiative (CCI) data

SCFHP Grievance & Appeals System Solution
Recommendation to SCFHP Governing Board
March 16, 2018

SCFHP has been evaluating various systems to support our Grievance and Appeals (G & A) processes and extensive regulatory reporting. The 2017/18 FY budget includes $360,000 for a new G & A system.

Current Situation:

SCFHP uses two systems to handle grievances and appeals. Case handling is documented in the QNXT Call Tracking module and then data entry of required case elements are entered into the G & A database to support operational and regulatory reporting. Use of the database has vastly improved our reporting capabilities and quality, but is an inefficient solution from a case-handling/process standpoint. Volumes of grievances and appeals are shown below and equate to approximately 9 cases received daily:

2017 Cases	CMC	Medi-Cal	Total
Grievances	175	787	962
Appeals	417	1040	1457
Total	**592**	**1827**	**2419**

Environment:

Regulatory focus (CMS, DHCS, DMHC) on the appropriate and timely handling and resolution of grievances and appeals has intensified. Monthly, quarterly and annual G & A reporting requirements are an extensive effort with major and minor variations of reports coming from various regulators. CMS requires that we have an outside auditor conduct a data validation audit of our annual reports to validate the accuracy of the information reported. Expectations of our regulators are that 100% of cases are handled in a timely and accurate manner. In addition, there has been a growing emphasis for plans to use their grievance and appeals data to evaluate opportunities for improvement across all areas of operations, and to use this information in the oversight of delegated entities.

Gaps of Existing Systems:

- Document repository for storing documents related to a case
- Limited controls such as drop down menus for categorization and sub-categorization
- No process workflows
- Requires hard copy/paper files
- Duplicate data entry required to document case handling in QNXT & reporting requirements
- Difficult to demonstrate case handling puts SCFHP at risk in an audit to demonstrate effective systems are in place
- Challenging to generate drill down reports to understand G & A activity at a delegate/practice/clinic level.
- Letter generation is 100% manual

Recommendation:

We would like to move forward with contract negotiations for the selected system, a SaaS solution.

- Highly configurable and automated
- Scalable to the needs of SCFHP's enrollment and lines of business
- Easily extracts and prepared required audit universes.
- Automated disposition due dates
- Wizard ensures accuracy of case type and category
- Letter generation from SCFHP developed templates in all threshold languages
- Tracking of all inbound and outbound communications
- Includes an outcomes-based workflow with built in queue assignments
- Case and work item status alerts and notifications
- Dashboard monitoring of key metrics and alerts
- SSAE-16 certified data center for hosting

These attributes will increase productivity, decrease errors, and improve reporting and audit readiness. In addition, this program can also be used by the claims department to resolve Provider Disputes related to claims payments, as these are also currently tracked in a database with manual processes similar to the G & A department.

Price & Implementation:

Pricing from the selected system will need to be finalized based on a Statement of Work (SOW) scope meeting. Initial pricing estimates are well below budget and compare favorably to other systems.

Implementation timelines are expected to be 12-16 weeks.

RESOLUTION
FIXING THE EMPLOYER CONTRIBUTION AT AN EQUAL AMOUNT FOR EMPLOYEES AND ANNUITANTS UNDER THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT

WHEREAS, (1) Santa Clara County Health Authority is a contracting agency under Government Code Section 22920 and subject to the Public Employees' Medical and Hospital Care Act (the "Act"); and

WHEREAS, (2) Government Code Section 22892(a) provides that a contracting agency subject to Act shall fix the amount of the employer contribution by resolution; and

WHEREAS, (3) Government Code Section 22892(b) provides that the employer contribution shall be an equal amount for both employees and annuitants, but may not be less than the amount prescribed by Section 22892(b) of the Act; and

RESOLVED, (a) That the employer contribution for each employee or annuitant shall be the amount necessary to pay the full cost of his/her enrollment, including the enrollment of family members, in a health benefits plan up to a maximum **of the PEMHCA Minimum** per month, plus administrative fees and Contingency Reserve Fund assessments; and be it further

RESOLVED, (b) Santa Clara County Health Authority has fully complied with any and all applicable provisions of Government Code Section 7507 in electing the benefits set forth above; and be it further

RESOLVED, (c) That the participation of the employees and annuitants of Santa Clara County Health Authority shall be subject to determination of its status as an "agency or instrumentality of the state or political subdivision of a State" that is eligible to participate in a governmental plan within the meaning of Section 414(d) of the Internal Revenue Code, upon publication of final Regulations pursuant to such Section. If it is determined that Santa Clara County Health Authority would not qualify as an agency or instrumentality of the state or political subdivision of a State under such final Regulations, CalPERS may be obligated, and reserves the right to terminate the health coverage of all participants of the employer.

RESOLVED, (d) That the executive body appoint and direct, and it does hereby appoint and direct, Vice President of Human Resources to file with the Board a verified copy of this resolution, and to perform on behalf of Santa Clara County Health Authority all functions required of it under the Act.

RESOLVED, (e) That coverage under the Act be effective on June 1, 2018.

Adopted at a regular meeting of the Governing Board at Campbell, this 22nd day of March, 2018.

Signed: _____
Christine Tomcala, Chief Executive Officer

Attest: _____
David Cameron, Chief Financial Officer

RESOLUTION
ADOPTING CAFETERIA PLAN AND HEALTH REIMBURSEMENT ACCOUNT BENEFITS TO SUPPLEMENT THE AMOUNT CONTRIBUTED BY THE EMPLOYER FOR EMPLOYEES AND ANNUITANTS UNDER THE PUBLIC EMPLOYEES' MEDICAL AND HOSPITAL CARE ACT

WHEREAS, (1) Santa Clara County Health Authority (Authority) is a contracting agency under Government Code Section 22920 and subject to the Public Employees' Medical and Hospital Care Act (the "Act"); and

WHEREAS, (2) Government Code Section 22892(a) provides that a contracting agency subject to the Act shall fix the amount of the employer contribution by resolution; and

WHEREAS, (3) Government Code Section 22892(b) provides that the employer contribution shall be an equal amount for both employees and annuitants, but may not be less than the amount prescribed by Section 22892(b) of the Act (PEMHCA Minimum);

WHEREAS, (4) The Authority has held discussions and negotiations with its union bargaining partners regarding the need to gain greater control over and flexibility with respect to the employer's costs of health care premiums for actives and retirees;

WHEREAS, (5) The Authority and its union bargaining partners have agreed to certain changes in the way in which the Authority will pay for and/or reimburse the health insurance premiums for active and retirees (Health Benefit Changes), such Health Benefit Changes consisting of: (A) lowering the Authority's employer contribution under PEMHCA to the "PEMHCA Minimum, (B) adopting changes to the Authority's existing welfare benefits for active employees to provide for a new premium-only cafeteria benefit whereby the Authority will pay for the difference between the PEMHCA minimum and currently established/negotiated cap on Authority-paid health premiums (PEMHCA Shortfall), and (C) establish a new retiree-only health reimbursement account (HRA) to reimburse eligible retirees for their PEMHCA Shortfall;

WHEREAS, (6) The Authority wishes to make such Health Benefit Changes applicable to all union and unrepresented employees and retirees on or about June 1, 2018; and

WHEREAS, (7) Contemporaneously with the adoption of this Resolution, governing board of the Authority has adopted certain resolutions lowering its employer contribution to the PEMHCA Minimum;

RESOLVED, (a) That the various Health Benefit Changes outlined above, as more fully explained to the Authority's Executive Committee by staff during the past serval months, are hereby adopted, approved and ratified with an effective date of June 1, 2018;

RESOLVED, (b) That all actions previously taken by Authority management to plan, negotiate and implement the Health Benefit Changes are hereby approved and ratified;

RESOLVED, (c) That the CEO, CFO, and Vice President of HR are hereby authorized and directed to take any and all actions they deem reasonable and necessary to carry out the purposes of the foregoing resolutions.

Santa Clara
Family Health Plan

SANTA CLARA FAMILY HEALTH PLAN
Retirement Benefit Program
March 2018

Background

Currently there are three types of retirement options that SCFHP provides to employees:

1) CalPERS is a defined benefit plan that employees are automatically enrolled in upon hire. Beginning January 1, 2013, the California Public Employees' Pension Reform Act of 2013 (PEPRA) was enacted that no longer allows an organization or its employees to make contributions beyond the annual limit ($145,666 in 2018). This Act (PEPRA) impacted SCFHP in the following ways:

- Employees in management positions that were hired before PEPRA came into effect (January 1, 2013) continue to have SCFHP contribute to CalPERS up to the annual IRS limit ($275,000). This category of employee is referred to as Classic members.
- Employees in management positions that were hired after PEPRA (January 1, 2013), for whom SCFHP cannot contribute beyond the lower limit, have a substantially lower overall benefit.
- This leaves a significant equity gap in both employer contribution and benefits between the Classic team member and PEPRA-impacted team member.

(Note: SCFHP does not participate in Social Security.)

2) SCFHP offers a Money Purchase Plan governed by section 401(a) of the Internal Revenue code for all team members. Employees must opt in at time of hire to be eligible. Staff contribute 6% of their wages and receive a company match of 3%, Executives contribute 0.067% and receive a company match of 6% up to an annual Max contribution of $10,200. Currently, 74% (166) of the eligible SCFHP workforce currently participates in this benefit.

3) SCFHP offers a voluntary deferred compensation plan governed by section 457(b) of the Internal Revenue code for all team members. Currently, 31% (70) of the eligible SCFHP workforce participates in this benefit.

Discussion

In addition to the equity gap due to PEPRA, SCFHP continues to face recruitment and retention challenges with leadership talent. CalPERS at the original level is no longer available as an incentive to balance out SCFHP's lower than market wages, especially as we compete for talent outside of the Bay Area. To alleviate the current equity gap and make our compensation portfolio more competitive, SCFHP plans to offer a 401(a) PEPRA Supplement for employees hired after January 1, 2013. This will allow employees to continue their contributions (6.25%) and to be matched by the company up to the IRS limits. Additionally, for the PEPRA Executives, the maximum contribution in the 401(a) of $10,200 would be eliminated. Maximum contribution is limited by IRS rules.

Santa Clara
Family Health Plan

Additionally, in the interest of promoting greater staff participation in SCFHP's retirement savings opportunities, and to stay competitive with what is commonly offered by most companies, SCFHP will provide a match on staff contributions to either the 401(a) or 457(b) plans. This will allow employees to change their level of participation throughout their employment, better accommodating their changing personal financial needs. In addition, SCFHP will structure the 457(b) retirement plan to allow employees at their discretion to contribute lump sum pay, such as team incentive or PTO payout. We hope these modifications will motivate many of our younger employees to start utilizing the program to protect their future. Maximum contributions are limited by IRS rules.

The annual fiscal impact for both programs is estimated to be between $100k and $300k contingent on enrollment in the 457(b) plan and turnover in management staff.

Recommendation:
SCFHP is requesting that the Governing Board approve the revisions to the retirement benefit programs and authorize the CEO to execute all applicable documents to activate the changes. Market survey data indicates the requested changes are consistent to the industry and ensures that SCFHP can remain a competitive place of employment to attract and maintain quality leadership.

SANTA CLARA FAMILY HEALTH PLAN (SCFHP)
PROPOSED CHANGES TO 401(a) AND 457(b) PLANS
AS OF 3/15/18

1. Existing Plans

a. CalPERS for all Employees

- Employer currently contributes 8.418% for "Classic" members. (The Employer contribution may change in July of each year based on periodic actuarial valuations.) This contribution continues on the employee's compensation up to an indexed compensation limit (currently $275,000).
- Employer currently contributes 6.533% for "PEPRA" members, hired after 2012. (The Employer contribution may change in July of each year based on periodic actuarial valuations.) Under PEPRA, the new benefit formula for PEPRA hires is based only on the employee's compensation up to an indexed compensation limit (currently $145,666).

b. 457(b) Plan for all Employees (457(b))

- All employees may elect from time to time under plan rules to contribute some of their compensation to plan on a pre-tax basis. There is an annual indexed contribution limit of $18,500 in 2018, which is increased by $6,000 for those who are at least 50. Although allowed by law, the Employer currently makes no matching contribution to this plan – in part, because any employer contribution would be counted against the annual deferral limit.

c. 401(a) Plan for Staff (Current Staff 401(a))

- In addition to CalPERS, the Employer makes a 3% of pay contribution for non-Executive staff, to a defined contribution plan (401(a)); but only if the employee agrees to participation at time of hire and agrees to make a mandatory employee contribution of 6%. This election and participation is irrevocable, so if an employee chooses not to participate upon hire, the employee is prevented from participating in this opportunity in the future.

d. 401(a) Plan for Executives (Current Executive 401(a))

- In addition to CalPERS, the Employer makes a 6% of pay contribution for Executive staff, to a defined contribution plan (401(a)); but only if the employee agrees to participation at time of hire and agrees to make a mandatory employee contribution of 0.067%. This election and participation is irrevocable, so if an Executive chooses not to participate upon hire, the Executive is prevented for participating in this opportunity in

the future. Plan currently caps annual contribution for Executives at $10,200.

2. Reasons for Proposed Changes

a. Want to recognize impact of PEPRA on all PEPRA employees and provide some type of supplemental benefit for them that addresses PEPRA limit on compensation.

b. Want to eliminate the current cap on Employer contributions under the Current Executive 401(a) Plan for PEPRA employees.

c. Want to give all employees who do not participate in 401(a) Plan, an opportunity to make pre-tax employee contributions into the 457(b) Plan and take advantage of an Employer match into the 401(a) plan with the goal to increase employee retirement savings. At the present time, 57 staff are not participating in the 401(a) Plan and are missing out on the 3% Employer contribution.

3. Proposed New Plans and Plan Changes Using Current or New Plan Documents

a. Create a New 401(a) PEPRA Supplemental Plan (for all PEPRA Employees).

- 16 current employees affected.
- This plan will provide for "continued" Employer and employee contributions (ER = 6.533% EE = 6.25%) once the employee's compensation has hit the applicable PEPRA compensation limit, up until the employee's compensation has hit the Classic compensation limit. (The Employer contribution may change in July of each year based on periodic actuarial valuations.)
- Participation will be Mandatory.

b. "Convert" Current Executive 401(a) Into "Discretionary" Plan and Remove Artificial Contribution Limit

- Permit Employer to decide in its discretion to contribute some of Executive team incentive/bonus to the 401(a) Plan, up to IRS limits ($55,000), in lieu of paying such amounts in cash – this decision/determination will be made by SCFHP, not by the employee.
- Continue current rates of Employer and employee contributions to Plan, but eliminate $10,200 cap on Employer contributions for PEPRA employees.

c. Amend Staff 401(a) Plan to Provide New Incentive to Defer

- In addition to current rates of Employer and employee contributions for those past and future employees who elect to participate at time of hire, this plan would be amended to allow those employees who do not elect to participate in the Staff 401(a) to obtain a 50% matching contribution (not to exceed the value of 3% of compensation) for amounts they choose to defer into the 457(b) Plan. This will give employees greater flexibility to obtain some of the benefit they could have received in the 401(a) Plan. The Employer match will be calculated on an annual basis.

d. Revise 457(b) Plan Communications and Forms for All Employees to Permit Deferral of Lump Sum Pay Pursuant to 457 Rules

- This would allow employee pre-tax contributions of lump sum pay (e.g., team incentive or PTO cash-out), at employee's discretion, up to the IRS limit.

Santa Clara County Health Authority
Updates to Pay Schedule
March 22, 2018

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Configuration Data Analyst	Annually	76,639	95,799	114,959
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
Manager, Health Care Analytics	Annually	119,295	152,102	184,908
Manager, Oversight	Annually	101,528	129,448	157,368
Supervisor, Case Management	Annually	86,407	110,169	133,930
Vice President, Health Services	Annually	197,966	257,356	316,746

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
March 22, 2018

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Compliance Program Director	Annually	101,528	129,448	157,368