Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the
Santa Clara County Health Authority
Governing Board

Thursday, June 22, 2017
2:30 PM – 5:00 PM
210 E. Hacienda Avenue
Campbell, CA 95008

VIA TELECONFERENCE AT:
Business
4000 Moorpark Avenue, Suite 200
San Jose, CA 95117

VIA TELECONFERENCE AT:
Residence
2060 Bryant Street
Palo Alto, CA 94301

Agenda (Revised June 19, 2017)

1.	**Roll Call**	Mr. Brownstein	2:30	3 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).	Mr. Brownstein	2:33	2 min
3.	**Adjourn to Closed Session**		2:35	
	a. **<u>Anticipated Litigation</u>** (Government Code Section 54956.9(d)(2)): It is the intention of the SCCHA Governing Board to meet in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation involving a CalPERS administrative claim for damages.			
	b. **<u>Conference with Labor Negotiator</u>** (Government Code Section 54956.9(f)): It is the intention of the SCCHA Governing Board to meet in Closed Session to confer with Legal Counsel for labor relations regarding the status of salary benchmarking for SCCHA staff represented by SEIU Local 521			
4.	**Report from Closed Session**	Mr. Brownstein	2:50	5 min.

5.	**Property Acquisition** Review analysis and resolution ratifying the acquisition of 50 Great Oaks Blvd. and authorizing designated officers to execute documents. **Possible Action:** Approve Resolution for Approval of Acquisition of 50 Great Oaks Blvd., San Jose, CA	Ms. Tomcala/ Mr. Cameron	2:55	5 min
6.	**Approve Consent Calendar and Changes to the Agenda** Items removed from the Consent Calendar will be considered as regular agenda items. **Possible Action:** Approve Consent Calendar	Mr. Brownstein	3:00	5 min

a. Approve minutes of the March 16, 2017 **Regular Board** Meeting

b. Accept minutes of the March 21, 2017 **Bylaws Committee** Meeting

c. Accept minutes of the April 27, 2017 **Executive/Finance Committee** Meeting
- Ratify approval of the February 2017 Financial Statements

d. Accept minutes of the May 25, 2017 **Executive/Finance Committee** Meeting
- Ratify approval of the March 2017 Financial Statements
- Ratify approval of the reallocation of $75k from Conference Room improvements to the Disaster Recovery project

e. Accept minutes of the April 26, 2017 **Compliance Committee** Meeting
- Ratify approval of CMC and Medi-Cal Operational Compliance Reports
- Ratify approval of Misdirected Claims and Provider Dispute Resolution Corrective Action Plans
- Ratify approval of Fraud, Waste and Abuse Report

f. Accept minutes of the May 10, 2017 **Quality Improvement Committee** Meeting and:
- Ratify approval of twelve (12) policies:
  - QI.01 Conflict of Interest
  - QI.02 Clinical Practice Guidelines
  - QI.03 Distribution of Quality Improvement Information
  - QI.04 Peer Review Process
  - QI.05 Potential Quality of Care Issues
  - QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting
  - QI.07 Physical Access Compliance
  - QI.08 Linguistics Culture
  - QI.09 Health Education Program and Delivery System Policy
  - QI.10 IHA and HEBA Assessments Policy
  - QI.11 Member Non-Monetary Incentives
  - QI.12 SBIRT
- Ratify approval of Adult Preventive Health Guidelines
- Ratify approval of QI Work Plan, QI Program Evaluation, and QI Program Description
- Ratify approval of Complex Case Management Outcomes for 2016 and CM Program Evaluation

- Ratify approval of Health Education Program Evaluation and Health Education Work Plan
- Ratify approval of Americans with Disabilities Act Work Plan
- Ratify Adoption of five (5) Optum Complex Case Management Policies:
  - CM-010 Care Plans and Goals
  - CM-007 Data Collection Tools and Assessments
  - CM-009 Identification-Case Opening and Closure Criteria
  - QI-004 Program Content Development Review and Approval Process
  - QI-020 Program Satisfaction-Feedback
- Ratify approval of Optum 2016 Quality Improvement Program Description and Work Plan
- Ratify acceptance of Committee Reports:
  - Credentialing Committee – February 1, 2017and April 5, 2017
  - Pharmacy & Therapeutics Committee – December 15, 2016
  - Utilization Management Committee – January 18, 2017 and March 22, 2017

g. Accept minutes of the May 4, 2017 **Provider Advisory Council** Meeting

h. Accept minutes of the June 13, 2017 **Consumer Affairs Committee** Meeting

7.	**Amendments to the Bylaws** Review and discuss amendments to the Bylaws recommended by the Bylaws Committee. **Possible Action:** Approve amendments to the Bylaws	Ms. Pianca	3:05	5 min
8.	**Election of Secretary** Consider nomination for the office of Secretary. **Possible Action:** Accept resignation of the Secretary **Possible Action:** Elect nominee for the office of Secretary to serve the balance of the term	Mr. Brownstein	3:10	5 min
9.	**CEO Update** Discuss status of current topics and initiatives. **Possible Action:** Accept CEO Update	Ms. Tomcala	3:15	5 min
10.	**Compliance Report** Review and discuss quarterly compliance activities and notifications. **Possible Action:** Accept Compliance Report	Ms. Larmer	3:20	10 min
11.	**Policy FA.13 Employee Recognition Gift Cards** Consider proposed Policy FA.13, which provides parameters for recognizing employee performance with a gift card. **Possible Action:** Approve Policy FA.13 Employee Recognition Gift Cards	Ms. Tomcala	3:30	5 min

12. April 2017 Financial Statements Review recent organizational financial performance. **Possible Action:** Approve April 2017 Financial Statements	Mr. Cameron	3:35	10 min
13. Fiscal Year 2017-2018 Budget Review proposed budget for FY'18. **Possible Action:** Approve FY'18 Budget	Ms. Tomcala/ Mr. Cameron	3:45	25 min
14. Preliminary Fiscal Year 2016-2017 Year in Review Review preliminary performance on FY'17 Plan Objectives **Possible action:** Accept Preliminary FY'17 Plan Objectives	Ms. Tomcala	4:10	10 min
15. Fiscal Year 2017-2018 Plan Objectives Review draft FY'18 Plan Objectives **Possible Action:** Accept FY'18 Plan Objectives	Ms. Tomcala	4:20	10 min
16. Fiscal Year 2017-2018 Team Incentive Compensation Consider proposed team incentive compensation program. **Possible Action:** Approve FY'18 Team Incentive Compensation Program	Ms. Tomcala	4:30	10 min
17. 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
18. Employee Satisfaction Survey Report Review highlights and summary data from the 2017 Employee Satisfaction Survey.	Ms. Tomcala	4:45	10 min
19. Network Detection and Prevention Report Review report on firewall intrusion, detection, and prevention efforts.	Mr. Tamayo	4:55	5 min
20. Adjournment	Mr. Brownstein	5:00	

Notice to the Public—Meeting Procedures

Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.

The Governing Board may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.

In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at 408-874-1842.

To obtain a copy of any supporting document that is available, contact Rita Zambrano at 408-874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 210 E. Hacienda Avenue, Campbell.

This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan
Financial Statements Before and After Building Purchase

	Projected June 2017	
	Before	After
Balance Sheet		
Short Term Investments		
Cash/Investments**	$137,835,653	$123,592,653
Receivables	$528,740,901	$528,740,901
Prepaid Expenses and Other Current Assets	$5,622,002	$5,622,002
Long Term Assets		
PPE	$21,916,470	$36,159,470
Less Depreciation	($10,907,019)	($10,907,019)
Net PPE	$11,009,450	$25,252,450
Deferred Outflow of Resources	$1,570,339	$1,570,339
Total Assets	$684,778,345	$684,778,345
Total Liabilities**	$561,425,601	$561,425,601
Net Equity	$123,352,744	$123,352,744
Liquidity Ratio		
Total Current Assets	$672,198,556	$657,955,556
Total Current Liabilities**	$552,166,432	$552,166,432
Current Ratio	1.22	1.19

$14.2 M

** Excludes MCE Payable

	Lease	Purchase
Income Statement 7/1/2018 - 6/30/2019		
Revenue	1,224,523,551	1,224,523,551
Health Care Costs	1,153,999,084	1,153,999,084
Occupancy Cost	$1,110,588	$575,212
Sub-lease income	$0	$306,641
Depreciation Expense	3,875,041	4,516,282
Other Administrative Costs	46,371,527	46,371,527
Net Surplus	$19,167,312	$19,368,087
Liquidity Ratio		
Total Current Assets	$234,297,266	$221,014,861
Total Current Liabilities	$109,518,255	$109,518,255
Current Ratio *	2.14	2.02

* The current ratio shows SCFHP ability to meet our short term obligations. The current ratio should be greater that 1.0. With the purchase of the building, SCFHP's current ratio would drop slightly at end of Year 1 but is still in a strong range. With expected changes in pass-through assets and liabilities, the current ratio is even stronger at end of Year 2.

LABOR MARKET ANALYSIS

Santa Clara County Health Authority

April 27, 2017

CBRE

CONTENTS

PROJECT REQUIREMENTS

Operational Objective

Santa Clara County Health Authority ("SCCHA") has identified the need to evaluate the Santa Clara County, CA labor market from an employee disruption and commute perspective between its existing location and a proposed new location.

To assist SCCHA in evaluating this labor market, LAG was engaged to asses the employee distribution and potential commute disruption for SCCHA.

Staffing Requirements

Total Employment:

- ✓ 204

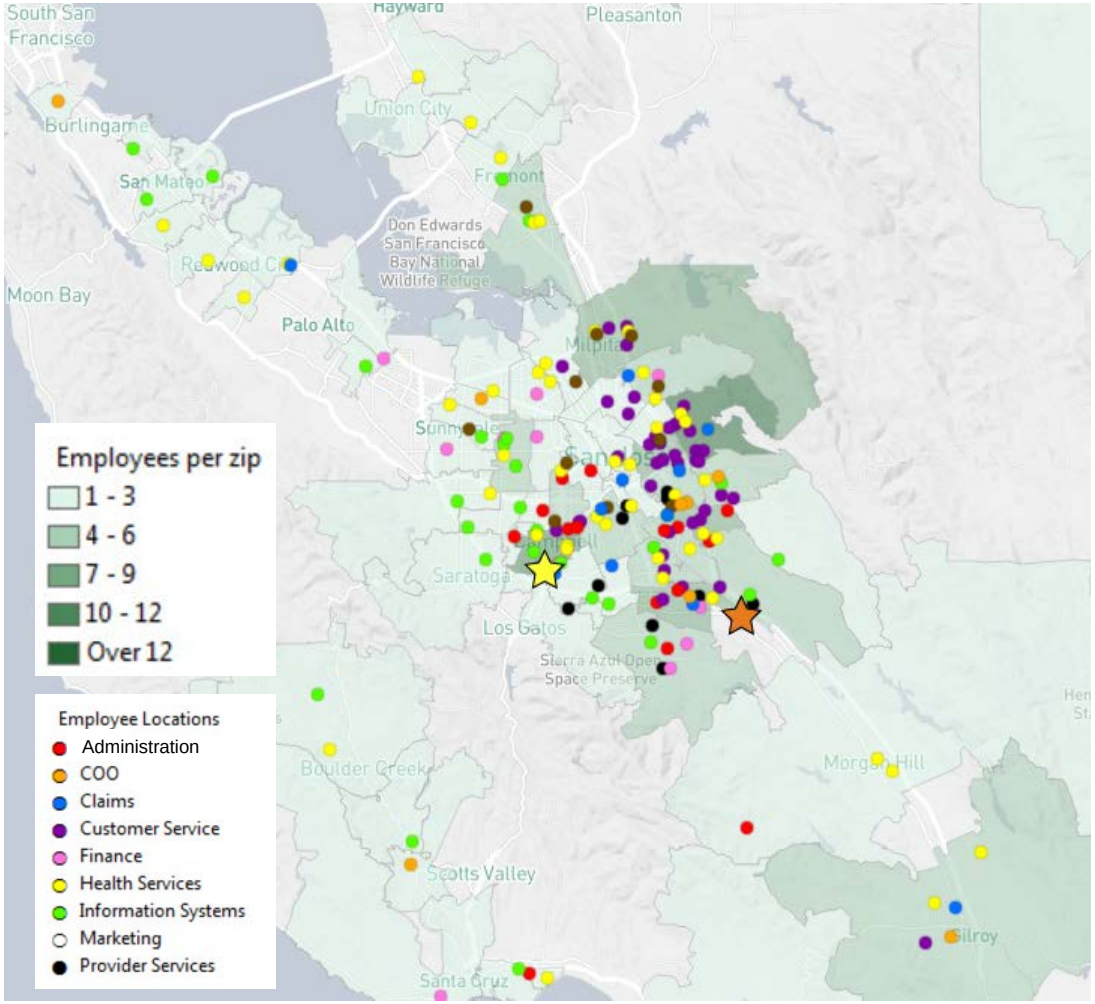
Jobs Categories and Population:

- ✓Claims, 20
- ✓Customer Service, 42
- ✓Administration, 24
- ✓Finance, 13
- ✓Health Services, 52
- ✓Information Systems, 31
- ✓Marketing, 11
- ✓Provider Services, 11

Geographic Parameters

SCCHA has requested a review of two locations within the San Jose, CA market.

EMPLOYEE LOCATION MAP



This map identifies where the employees of SCCHA reside in relation to the existing and proposed corporate headquarter locations.

The Yellow Star represents Client's **existing headquarter location** at 210 E. Hacienda, Campbell, CA

The Orange Star represents the **proposed corporate headquarter building** located at 50 Great Oaks Boulevard, San Jose, CA.

The colored dots indicate where employees reside as well as which department they belong to. Each node provides the commute times and distances for the existing and proposed headquarter locations.

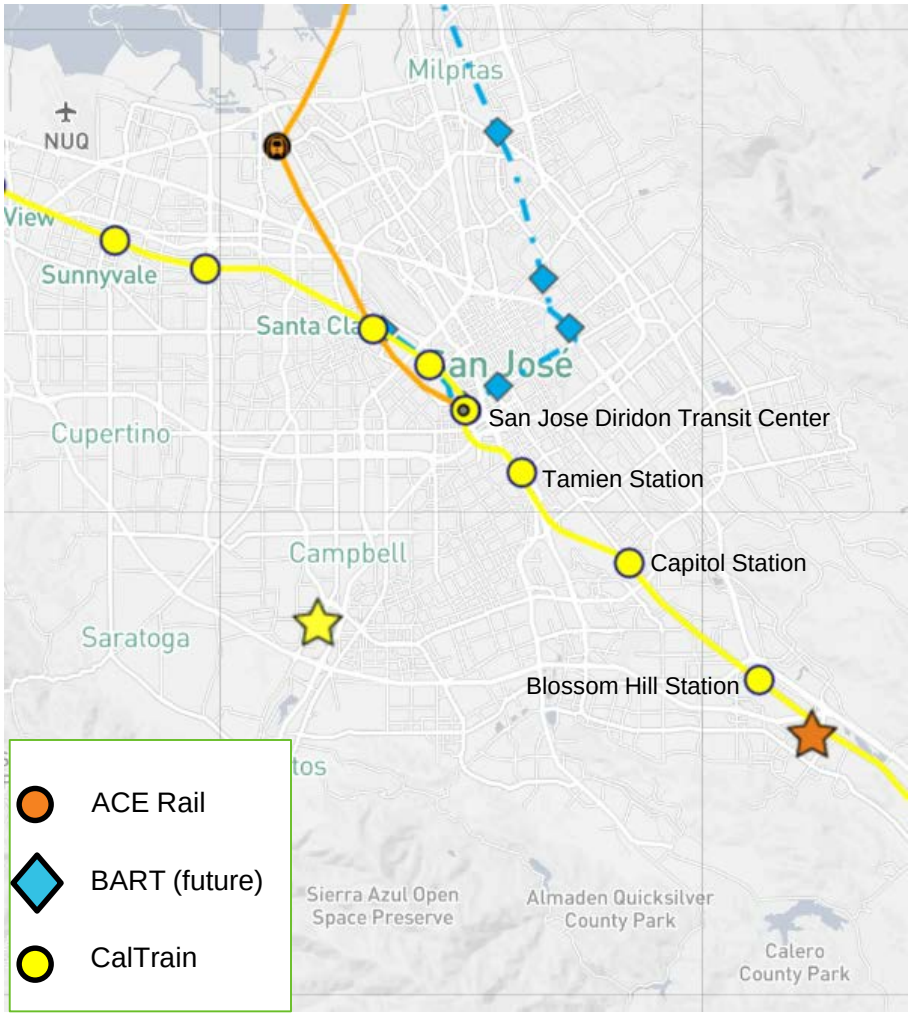
The shaded areas indicate the number of employees per zip code. The darkest green represents the highest density of employees residing in the zip code.

*Commuting time reflects hours of high traffic volume (rush hour). Rush hour is defined as average volume for Monday at 8am and 5pm.

By following the link below, you can access the live interactive maps.
http://mapping.cbre.com/maps/335913/map-app/#filterTab
The user name and password for the dimension account is
335913_MOS
8TAM4Vpv4h

CBRE

TRANSIT MAP



Distance to Transit (mi)	Existing	Proposed
CalTrain Station		
San Jose Diridon Transit Center	8.5	11.2
Tamien	8.3	12.7
Blossom Hill	15.2	2.9
BART (future)		
San Jose Diridon Transit Center	8.5	11.2
ACE Rail		
San Jose Diridon Transit Center	8.5	11.2

The San Jose Diridon Transit Center is the transit hub that serves the South Bay. The station is served by Caltrain, ACE, VTA light rail, and Amtrak. This is in addition to various bus and shuttle services.

The **Blossom Hill station** is the nearest stop to the proposed building, which is **2.9miles away**, compared to the nearest transit station at the existing location, which is 8.3 miles (Tamien Station).

The Valley Transportation Authority has plans to construct a 16-mile extension of the BART line to Santa Clara County, known as VTA's BART Silicon Valley Extension. This project includes four additional stations, including Alum Rock/28th Street, Downtown San Jose, Diridon, and Santa Clara.

Construction of Phase II is anticipated to begin as additional funding is secured in 2019 based on the preliminary schedule.

SUMMARY OF FINDINGS

- Of the existing 204 total employees, 192 commute to the office.
- 30% of the commuters projected to have a shorter distance to drive to the proposed location
- 42% have a shorter drive time to the proposed location
  - Overall, the average commute time increases approximately two minutes, or 9%.
  - The average distance travelled increases from 18.5 miles to 20.8 miles.
- 123 (64%) of the existing commuters are union employees.
  - Of the union employees, 44 (36%) have an improved commute time to the proposed location.
  - Of the remaining 69 unrepresented employees, 14 (20%) have an improved commute time.
- Health Services represents the largest department within the organization accounting for 52 employees; 23% of these employees have an improved commute time with the proposed location.
- Provider Services is the department with the highest percentage of employees benefitting from an improved commute (45%).
- The highest density of employees reside in zip code 95127, with 13 employees.

SUMMARY OF FINDINGS

Average Commute Distance & Times, by Group

	Distance (mi)				Time (min)			
	Existing	Proposed	Difference	%	Existing	Proposed	Difference	%
Office, All (192)	18.5	20.8	2.3	12%	20.7	22.5	1.8	9%
Union Representation								
Union	19.3	20.5	1.2	6%	20.9	21.8	0.9	4%
Unrepresented	17.2	21.4	4.2	24%	20.4	23.6	3.2	16%
Department								
Administration	12.0	12.5	0.5	4%	15.7	15.8	0.1	1%
COO	23.8	24.1	0.3	1%	25.7	25.9	0.2	1%
Claims	12.1	15.6	3.5	29%	13.6	16.6	3.0	22%
Customer Service	13.5	13.2	-0.3	-2%	15.4	15.2	-0.2	-1%
Finance	14.6	19.7	5.1	35%	18.1	21.7	3.6	20%
Health Services	21.5	24.1	2.6	12%	23.2	25.2	2.0	9%
Information Services	27.6	33.1	5.5	20%	29.9	34.3	4.4	15%
Marketing	12.4	16.4	4.0	32%	14.6	18.2	3.6	25%
Provider Services	18.0	17.6	-0.4	-2%	20.3	19.7	-0.6	-3%

SUMMARY OF FINDINGS

Commute Savings/Additions

All Employees	204
LESS: Telecommuters	12
	192

Commute Change	Existing	Proposed
Time (avg, min)	20.7	22.5
Distance (avg, mi)	18.5	20.8

Total Commuters	192	100%
Saving 10+ min	13	7%
Saving 5-10 min	16	8%
Saving 0-5 min	51	27%
Adding 0-5 min	46	24%
Adding 5-10 min	40	21%
Adding 10+ min	26	13%

Total Commuters	192	100%
Less 10mi+	0	0%
Less 5-10mi	26	13%
Less 0-5mi	32	17%
Adding 0-5mi	77	40%
Adding 5-10mi	51	27%
Adding 10+mi	6	3%

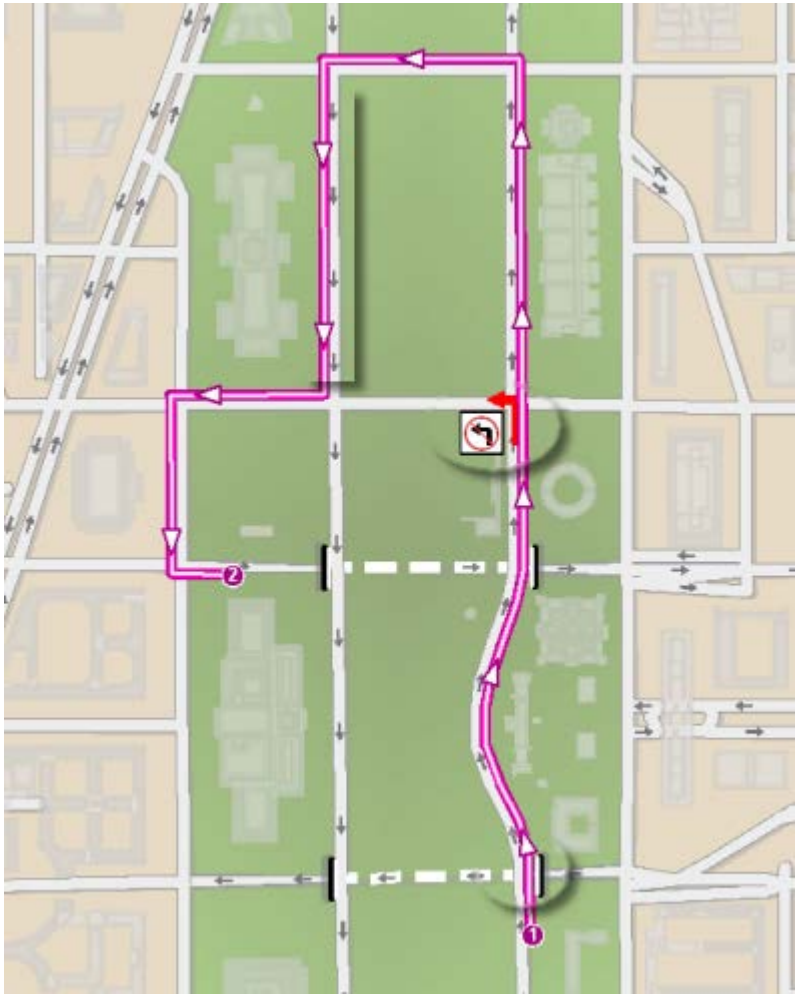
APPENDIX

CBRE

DEPARTMENT SUMMARIES

Department Roll Up	Home Department
Administration	Office of the CEO
Administration	Facilities
Administration	Vendor Relations
Administration	Human Resources
Administration	Compliance
COO	Enrollment & Eligibility
COO	Grievance & Appeals
Provider Service	N/A
Customer Service	N/A
Finance	N/A
Information Systems	N/A
Health Services	Medical Management
Health Services	LTSS Operations
Health Services	Behavioral Health
Health Services	Medical Services
Health Services	Quality Improvement
Health Services	Pharmacy
Marketing	N/A
Claims	N/A

NETWORK DATASET



Network datasets are well suited to model transportation networks. They are created from source features, which can include simple features (lines and points) and turns, and store the connectivity of the source features. When you perform an analysis using the ArcGIS Network Analyst extension, the analysis always happens on a network dataset.

A network dataset models the street network shown in the graphic below. The graphic highlights that one-way streets, turn restrictions, and overpasses/tunnels can be modeled. The analyses that are performed on the network, such as the route from stop 1 to stop 2, respect these and other network dataset properties.

For more information regarding this presentation please contact:

LAURA SIDNEY
Director, Client Strategy
T +1 602 735 5564
Email.laura.sidney@cbre.com

VALENTIN HERNANDEZ
Senior Director
T +1 602 735 5684
Email.valentin.hernandez@cbre.com

BRIAN ALLEN
Research Project Manager
T +1 602 735 1911
Email.brian.allen@cbre.com

CBRE

SANTA CLARA COUNTY HEALTH AUTHORITY
GOVERNING BOARD RESOLUTION
APPROVAL OF ACQUISITION OF 50 GREAT OAKS BLVD., SAN JOSE, CA

WHEREAS, the Governing Board of the Santa Clara County Health Authority (the "Authority"), at a regularly scheduled Board meeting on March 16, 2017, has previously approved that certain Purchase and Sale Agreement dated as of March 20, 2017, which contemplates the acquisition of that certain real property commonly known as 50 Great Oaks Boulevard/6201 San Ignacio, San Jose, California (the "Property") from LBA RIV-Company VII, LLC (the "Seller") to the Authority, which acquisition of Property the Governing Board of the Authority has found to be in the best interests of the Authority;

WHEREAS, in furtherance of such prior approval, the Governing Board of the Authority desires to authorize specifically execution of all documents necessary for the closing of the acquisition of the Property from the Seller to the Authority.

NOW, THEREFORE, BE IT RESOLVED by the Governing Board of the Authority that:

1. The acquisition of the Property from the Seller to the Authority is hereby ratified.

2. The following persons are hereby authorized to execute any and all documents as may be necessary or desirable to accomplish the sale of the Property, including without limitation a Grant Deed, an Assignment and Assumption of Lease, Bill of Sale, Assignment and Assumption of Operating Agreements, Warranties and Intangibles, Information for Real Estate 1099-S Report Filing as Required by the Internal Revenue Service, Form W-9, Preliminary Change of Ownership Report, and Closing Statement: the Chief Executive Officer or Chief Financial Officer of the Authority, each acting singly.

3. Any acts of an authorized officer of the Authority authorized by the foregoing resolutions but taken before the adoption of this resolution are hereby separately ratified, confirmed, approved and adopted as acts in the name of and on behalf of the Authority.

[Certification follows on next page]

Adopted by the Governing Board of the Authority on June 22, 2017 pursuant to a regular meeting.

DATED: June __, 2017

_____
Bob Brownstein
Chairperson of the Authority

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the
Santa Clara County Health Authority
Governing Board

Thursday, March 16, 2017
2:30 PM – 5:00 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes – DRAFT

Board Members Present
Bob Brownstein, Chair
Michele Lew, Vice Chair
Dolores Alvarado
Brian Darrow
Darrell Evora
Kathleen King
Paul Murphy
Brenda Taussig
Wally Wenner, M.D.
Linda Williams

Board Members Absent
Chris Dawes
Liz Kniss
Jolene Smith

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Jeff Robertson, M.D., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Sharon Valdez, VP Human Resources
Beth Paige, Compliance Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

Others Present
Stacey Renteria, SEIU Representative
Janet Sommer, Burke, Williams, & Sorensen LLC (via phone)

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. **Adjourn to Closed Session**

   a. **Anticipated Litigation**
   The SCCHA Governing Board met in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation involving a CalPERS administrative claim for damages.

   b. **Conference with Labor Negotiators**
   The Committee met in Closed Session to confer with its Designated Representatives.

   c. **Real Property Negotiations**
   The Committee met in Closed Session to confer with its Real Property Negotiators concerning the price and terms of payment related to the possible acquisition of real property located at 50 Great Oaks Boulevard, San Jose, California.

4. **Report from Closed Session**

   Mr. Brownstein reported the Board met in Closed Session to discuss Items 3 (a), (b), and (c).

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 December 15, 2017 **Regular Board** Meeting

   b. Accept minutes of the January 27, 2017 **Bylaws Committee** Meeting

   c. Accept minutes of the January 26, 2017 **Executive/Finance Committee** Meeting and:
      - Ratify approval of the November 2016 Financial Statements
      - Ratify authorization of the CEO to negotiate, execute, amend, and terminate a contract with selected Provider and Member Portal vendor for an initial year cost of approximately $500,000 for implementation and maintenance
      - Ratify approval of a CEO signatory limit of $250,000

   d. Accept minutes of the February 23, 2017 **Executive/Finance Committee** Meeting
      - Ratify approval of the December 2016 Financial Statements

   e. Accept minutes of the February 8, 2017 **Quality Improvement Committee** Meeting and:
      - Ratify approval of two policies:
        - CM.10 Early Start Program (Early Intervention Services)
        - QI.02 Clinical Practice Guidelines
      - Ratify approval of four program descriptions:
        - QI Program Description
        - Case Management Program Description
        - Health Education Program Description
        - Cultural and Linguistics Program Description
      - Ratify approval of reports and actions taken by:
        - Credentialing Committee
        - Pharmacy & Therapeutics Committee
        - Utilization Management Committee

f. Accept minutes of the February 2, 2017 **Provider Advisory Council** Meeting

g. Accept minutes of the March 14, 2017 **Consumer Affairs Committee** Meeting

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

6. CEO Update

Christine Tomcala, Chief Executive Officer, provided a year-to-date status update on the FY 2016-17 Plan Objectives. She noted the Plan hired a Chief Compliance Officer and an Outreach Manager. Ms. Tomcala also reported an Employee Satisfaction Survey was underway. The Board requested that the results of the survey be presented at a future meeting.

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

7. Compliance Report

Beth Paige, Compliance Officer, presented the December 2016 – February 2017 Compliance Report and noted DHCS would be onsite April 3-14 for the 2017 Annual Medical Audit. She provided additional detail on DMHC annual Timely Access reporting, and corrective action plans for misdirected claims and provider dispute resolutions (PDRs).

It was noted that the Plan is responsible for conducting initial and monthly exclusion screening for various entities, including Board members.

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

8. January 2017 Financial Statements

Dave Cameron, Chief Financial Officer, presented the January 2017 financial statements. He noted the Plan achieved a net surplus of $2 million for the month and $12.9 for the first seven months of the fiscal year. Financial results for the month and year-to-date both favorably exceed budget. Mr. Cameron reviewed several key enrollment trends, noting that enrollment continues to exceed budget but that new membership has flattened. A reduction of approximately $3 million to prior year incurred-but-not-paid estimates also contributed to favorable year-to-date results. Medical expenses are generally tracking to budget. Administrative expenses are exceeding budget due in part to additional temporary and consulting staff supplementing key Claims and Compliance projects. Mr. Cameron noted that DHCS is in the process of reconciling and paying several old receivables and payables, with over $130 million received for January alone. Actual TNE and Required TNE have both increased during the fiscal year. Capital projects are on-target and are not expected to exceed the annual capital budget. Headcount is currently at approximately 200.

While current financial results are favorable, Mr. Cameron noted several key risks on the horizon, of which many pertain to the CCI program. These include rate recasts, (which have been conservatively estimated in financial statements, but significant swings in rates have been noted by other CCI-participating plans), Medicare risk adjustment, the future of CCI in the May Revised budget, risk corridors, and the elimination of IHSS.

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

DRAFT

9. Funding Pension Liability

Mr. Cameron presented a proposed resolution to fund the CalPERS pension liability with a $5.9 million lump-sum payment before March 31, 2017. He noted that pre-funding now will enable the Plan to avoid future additional contributions of over $7 million. Ms. Tomcala noted the Executive Committee took action in January to recommend pre-funding the CalPERS pension liability

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

10. Employee Pension Benefit Contributions

Mr. Cameron presented a proposed resolution which would functionally allow employees' contributions to the CalPERS pension plan on a pre-tax basis. Mr. Cameron advised that when the Plan was initially formed, the Plan defaulted to after-tax treatment of employee contributions.

> **It was moved, seconded, and** the Resolution to Tax Defer Member Paid Contributions – IRC 414(h)(2) Employer Pickup was **unanimously approved**.

11. Whole Person Care (WPC)

Ms. Tomcala presented a proposal to fund an expansion of WPC and the Community Living Connection Pilot (CLCP) in conjunction with the County Department of Social Services and The Health Trust. The CLCP expansion would combine intensive case management and comprehensive housing services that enable member transitions from facility settings to lower levels of care in the community.

The Plan is working collaboratively with Valley Health and Hospital System, which is completing the application and serving as the liaison with the State.

> **It was moved, seconded and** an investment in the proposed Whole Person Care Expansion of $2 million over 3 ½ years was **unanimously approved**.

12. 20th Anniversary Community Sponsorship

Ms. Tomcala noted that SCFHP's 20th Anniversary offers an opportunity for the Plan to contribute to improving health and wellness of Santa Clara County residents, working in collaboration with community partners. Three proposals are recommended for funding: Indian Health Center (exercise), Gardner Family Health Comprecare (dental care), and Veggielution (nutrition). She noted the exercise and dental care projects may be funded at $5,000 each through the usual sponsorship process.

> **It was moved, seconded and unanimously approved** to fund an outdoor shade structure providing classroom space at Veggielution at a cost of $20,000, in recognition of SCFHP's 20th Anniversary.

13. Firewall Monitoring Report

Jonathan Tamayo, Chief Information Officer, reported on firewall intrusion, detection, and prevention efforts. The network intrusion reports show malicious activities that were prevented from accessing SFHP's network.

It was moved, seconded and unanimously approved to accept the Network Detection and Prevention Report.

14. Publicly Available Salary Schedule Ranges

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

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

15. Annual CEO Compensation Review

Mr. Brownstein reported on the annual performance and compensation review of the CEO, noting that the FY 2015-16 performance review was discussed and a compensation recommendation was made at the February Executive/Finance Committee meeting. Based on the positive evaluation of the CEO, it was recommended that the CEO receive a 4% annual salary increase effective July 1, 2016, and a 9% bonus.

It was moved, seconded, and the recommended Annual Salary Increase and Incentive Bonus for the CEO was **unanimously approved**.

16. Adjournment

The meeting was adjourned at 4:45 pm.

_____
Bob Brownstein, Chair of the Board

DRAFT

Santa Clara
Family Health Plan
The Spirit of Care

Santa Clara County Health Authority
Bylaws Committee
Special Meeting

Tuesday, March 21, 2017
1:00 pm - 2:30 pm
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

Minutes – DRAFT

DRAFT

Members Present
Brian Darrow
Paul Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer

Members Absent
Liz Kniss

Others Present
Elizabeth Pianca, Secretary

1. **Roll Call**

   Brian Darrow, Chair, called the meeting to order at 1:08 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 January 27, 2017 Bylaws Committee Meeting were reviewed.

   It was moved, seconded, and the January 27, 2017 Bylaws Committee minutes were **unanimously approved** as presented.

4. Amendments to the Bylaws

Proposed amendments to the Santa Clara County Health Authority Bylaws were discussed.

> **It was moved, seconded and unanimously approved** to recommend to the Governing Board approval of the proposed Amendments to the Bylaws.

5. Adjournment

The meeting was adjourned.

_____
Elizabeth Pianca, Secretary to the Board

DRAFT

Santa Clara
Family Health Plan
The Spirit of Care

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

Thursday, April 27, 2017
8:30 AM - 10:00 AM
210 E. Hacienda Avenue
Campbell, CA 95008

VIA TELECONFERENCE AT:
Residence
2060 Bryant Street
Palo Alto, CA 94301

Minutes – DRAFT

Members Present
Michele Lew, Chair
Bob Brownstein
Wally Wenner, M.D.
Linda Williams *(via phone)*

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

Members Absent
Liz Kniss

Others Present
Janet Sommers, Burke, Williams, & Sorenson LLP *(via phone)*

1. **Roll Call**

   Michele Lew, Chair, called the meeting to order at 8:33 am. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The minutes of the February 23, 2017 Executive/Finance Committee Meeting were reviewed.

   It was moved, seconded, and the February 23, 2017 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 Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation involving a CalPERS administrative claim for damages.

   b. **Real Property Negotiations**
   The Committee conferred with its Real Property Negotiators concerning the price and terms of payment related to the possible acquisition of real property located at 50 Great Oaks Boulevard, San Jose, California.

Linda Williams left the meeting.

5. **Report from Closed Session**

   Ms. Lew reported the Committee met in Closed Session and authorized the CEO to take action to complete the transaction to purchase 50 Great Oaks Boulevard at a price not to exceed $10.151mm.

6. **February 2017 Financial Statements**

   Dave Cameron presented the February 2017 financial statements. For the month, the Plan reported a net surplus of $2.3 million, which is $1.2 million favorable to budget. For the first eight months of the fiscal year, the Plan reported a net surplus of $15.1 million or $6.7 million favorable to budget. The surplus results from a combination of factors, including higher enrollment (versus both budget and prior year actual) and decreases in prior medical expense (IBNR) estimates which are favorable to the financial statements. The overall medical loss ratio has improved to 94.5% on a year-to-date basis. Administrative expenses were 3% above budget for the month and within 1% over budget on a year-to-date basis due to the continued use of consultants and temps in support of unfilled staff positions.

   Mr. Cameron noted that enrollment, which exceeds budget by 1.9% on a year-to-date basis, has flattened lately. Enrollment at February 28, 2017 was 279,000 members. Ms. Tomcala noted that outreach efforts to increase enrollment in the Cal Medi-Connect program has recently commenced.

   Mr. Cameron observed that the balance sheet continues to include large receivables from, and payables to, DHCS. A significant portion of the CCI program receivables was recently paid and the Plan expects recoupment of the MCE overpayment to commence in July 2017.

   Mr. Cameron noted that the Plan's net assets of $115.4 million represented 325% of the DMHC minimum required tangible net equity (TNE) of $35.5 million.

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

7. **Annual Healthy Kids Report to the County Health and Hospital Committee**

   Christine Tomcala presented the Committee with the Annual Healthy Kids Report that was provided to the County Health and Hospital Committee this year. Membership decreased from 4,328 in April 2016 to 2,752 in March 2017, largely due to Healthy Kids members becoming eligible for full scope Medi-Cal. Ms. Tomcala noted the termination reasons for children leaving the program, as well as funding provided by the City of San Jose which supplements the County of Santa Clara County funding.

8. CEO Update

Ms. Tomcala invited Mr. Cameron to update the Committee on misdirected claims. Mr. Cameron reported that delegated claims were forwarded on a timely basis 96% and 98% of the time in the months of March and April, meeting the compliance requirement of 95%.

Mr. Cameron further reported on the Provider Dispute Resolution (PDR) backlog. The original goal was to eliminate the backlog by April 1st. The Plan requested a 30-day extension and the team is working diligently to be current by April 30th.

Mr. Cameron noted that a general assessment of the financial operations was completed in August 2016 with recommendations for a more detailed review of several key areas. The areas of vendor procurement/payment and segregation of duties are being reviewed by Moss-Adams, the Plan's independent accountant. A report of their recommendations will be reviewed by the Executive Committee at its next meeting.

Ms. Tomcala reported on implementation of the QNXT system for Medi-Cal claims, noting the status is yellow, but it is still on track for a July 1st go-live.

Ms. Tomcala updated the Committee on the Employee Satisfaction Survey, noting the results were positive and they will be shared with the Board at the next meeting.

The Plan continues to move forward with its Duals-Special Needs Plan (D-SNP) application. Although staff are optimistic the CMC program will continue, there would be a significant impact on the Health Plan and its CMC members if it did not.

Ms. Tomcala noted that the Civil Grand Jury will be releasing its report on the Health Plan within a couple weeks. There are three findings, one of which is a commentary on how low reimbursement rates in the broader Medi-Cal program negatively affect the number of providers in the community who accept Medi-Cal.

The Committee was also informed that the Whole Person Care expansion application has been favorably received by the State.

9. Adjournment

The meeting was adjourned at 9:50 am.

_____

Michele Lew, Chair

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

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

Tuesday, June 13, 2017
6:00 – 7:00 pm
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes

Committee Members Present:
Waldemar Wenner, M.D., Chair
Ms. Blanca Ezquerro
Ms. Rachel Hart
Ms. Margaret Kinoshita
Mr. Tran Vu

Staff Present:
Ms. Laura Watkins, Director of Marketing, Outreach Enrollment
Ms. Chelsea Byom, Marketing and Communications Manager
Ms. Sherita Gibson, Marketing Coordinator
Ms. Emily Hennessy, Interim Marketing and Communications Manager
Ms. Angela Sheu-Ma, Health Educator
Ms. Christine Tomcala, Chief Executive Officer
Ms. Chris Turner, Interim Chief Operating Officer

---

1. Call to Order

Dr. Waldemar Wenner, Chair, called the meeting to order at 6:05 p.m. A quorum was established.

2. Roll Call and Introductions

Introductions were made.

3. Public Comments

There were no public comments.

4. Review and Approval of March 14, 2017 Minutes

Ms. Ezquerro **moved** and Ms. Hart **seconded** the motion to approve the minutes of the March 14, 2017 meeting. The **motion passed unanimously**.

5. Health Plan Updates – Christine Tomcala

Ms. Tomcala presented an enrollment update: As of June 1, Medi-Cal enrollment is 265,649; Cal MediConnect is 7,543; and Healthy Kids is 2,732 for a total of approximately 276,000.

Ms. Tomcala announced that SCFHPs is partnering with community organizations in celebration of its 20th anniversary. SCFHP is providing a $20,000 sponsorship to Veggielution, an urban farm located in Emma Prusch Park in East San Jose, to build an outdoor shade structure for educational events for children and youth. In addition, SCFHP is providing a $5,000 sponsorship to Indian Health Center (IHC) to help them purchase new gym equipment, and a $5,000 sponsorship to Gardner Family Health Network, a community clinic in the Alum Rock neighborhood, to expand services at one of their dental clinics.

Ms. Tomcala suggested that SCFHP's Provider Network Management Department could share a map of all the clinic locations with the committee at a future meeting.

Ms. Tomcala announced that SCFHP's board is in the process of approving the acquisition of an office building at 50 Great Oaks Boulevard in San Jose. It is anticipated that the move will occur in about a year.

Mr. Vu asked about the decrease in enrollment of 2,000 in Medi-Cal. Ms. Tomcala noted that members regularly go off and on the plan during relatively short periods of times for a number of reasons. Ms. Watkins stated that it is difficult to determine how much churning is affecting SCFHP; however, Medi-Cal enrollment is forecast to be slightly down overall in the county over the coming year. Ms. Tomcala states SCFHP is expecting a 3% decrease in overall membership next year, which mirrors the county-wide enrollment decrease that county social services is expecting.

Ms. Tomcala briefly stated that the ACA repeal and replace effort currently resides in the Senate and that the likelihood it will pass is uncertain.

6. Health Education

Ms. Sheu-Ma distributed a draft of a cervical cancer screening (Pap test) member incentive flyer, to solicit feedback from the committee. The purpose of field testing is to:

- Gather input from members *before* implementation,
- Meet the contractual requirements from DHCS, and
- Strengthen the community partnership between SCFHP and its members.

The committee reviewed the flyer in English, Spanish and Vietnamese versions and provided feedback. Ms. Sheu-Ma answered questions posed by the committee and said she would incorporate the feedback into the form.

7. Cervical Cancer Screening Frequently Asked Questions

Ms. Sheu-Ma distributed to the committee a draft of the Cervical Cancer Screening Frequently Asked Questions (FAQs). The committee reviewed them, asked questions, and provided feedback.

8. Recent SCFHP Member Communications

Ms. Byom provided an overview of recent SCFHP member communications:

- Website-- board and committee meetings continue to be posted on the site and updated; member materials, such as provider directories and formularies are updated monthly.
- Community resources and events -- Cal Fresh incentive to use EBT cards at Santa Clara County farmers' markets.
- Facebook -- photo of SCFHP being recognized by the Santa Clara County Board Supervisors
- Mail -- newsletters; City of San Jose swim program; and mailings for diabetic eye exams, high blood pressure, and cervical cancer exams

Committee members asked questions about the swim program. Ms. Sheu-Ma stated this swim program is for kids in the summer, at Camden Community Pool, Mayfair, and Rotary Ryland in downtown San Jose. Members may call SCFHP Customer Service and request a swim lesson letter or swim pass.

Ms. Kinoshita asked about content for seniors in the Medi-Cal newsletter. Ms. Watkins noted that most Medi-Cal newsletters do have some content directed specifically at seniors, and that we will continue to be aware of the importance of this when identifying content for future newsletters. Ms. Watkins mentioned that the Cal MediConnect newsletter is written mainly for seniors and people with disabilities, and that all newsletters are available on the SCFHP website.

9. Future Meetings and Agenda Items

The next Consumer Advisory Committee meeting is September 12, 2017. Topics suggested for next meeting:

- Newsletter content ideas -- mention of farmers market information content relevant to the senior population, and general information on allergies
- The new member portal
- Locations of Community Clinics and VMC Clinics

Mr. Vu asked about transportation for members. He requested that staff share the transportation options available to members. Ms. Turner stated that the state just released changes to the transportation benefits. SCFHP will share the updated information as it becomes available.

10. Adjournment

Mr. Vu **moved** and Ms. Kinoshita **seconded** the motion to adjourn the meeting at 7:12 pm. The **motion passed unanimously**.

_____

Waldemar Wenner, MD
Consumer Advisory Committee Chairperson

Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Eight Months Ended February 2017
(Unaudited)

Table of Contents

Fiscal Year 2016-17 Year-To-Date Highlights

- **Net Surplus –** February $2.3m surplus and YTD $15.1m surplus ($6.7m favorable to budget)
- **Enrollment –** February 2017 membership: 278,843 (1.1% favorable to budget) and February YTD: 2,237,802 member months (1.9% favorable to budget and 6.3% higher than February YTD last year)
  - Both Medi-Cal and CMC membership grew slightly. HK membership transition to Medi-Cal is slower than planned.
- **Revenue –** over YTD budget by $41.5m (+5.5%)
  - Increase was largely due to higher than budgeted members year to date, which was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher risk scores of the plan members. Part D Medicare revenue was lower than the budget.
- **Medical Expenses –** over YTD budget by $34`.7m (-4.4%)
  - Increase in expense was due to higher than budgeted member months resulting in higher capitation costs as well as higher hospital, LTC, and provider risk sharing/CCI and CMC recast reserve expenses. Prior year medical expense estimate reduction offset some of this unfavorable variance.
- **Administrative Expenses –** over YTD budget by $0.2 million (-0.8%)
  - Increase in expense was due to positions being filled by consulting/temporary resources and Pharmacy Administration Fees; partially offset by lower Advertising and Postage expenses.
- **Other Income/Expenses –** net expense under budget by $0.2m due to higher than budgeted interest earnings.
- **Balance Sheet**
  - DHCS paid a significant portion of the prior period receivables (rate differentials, MCO, etc.). As a result, SCFHP is in a position to make its first MCO quarterly installment payment. Overall cash position increased due to the receipt of these funds, Medicare RAF funds, partially offset by increase in payables.
  - Receivables for CCI rate recast continued to increase (partially offset by Medi-Cal Expansion rate overpayments).
  - TNE of $115.4m or 325% of most recent Required TNE of $35.5m per DMHC ($8.7m below the SCFHP low-end Equity Target and $177.9m above the low-end Liquidity Target).
  - Capital Expenses increased by $5.4 million largely due to capitalization of Trizetto/QNXT claims system expenses.

Consolidated Performance
February 2017 and Year to Date

	Month	YTD
Revenue	$100 million	$802 million
Medical Costs	$94 million	$758 million
Medical Loss Ratio	94.0%	94.5%
Administrative Costs	$4 million (3.6%)	$28 million (3.5%)
Other Income/ Expense	($116,191)	($527,988)
Net Surplus (Loss)	$2,269,899	$15,136,696

Cash on Hand	$304 million
Net Cash Available to SCFHP	$300 million
Receivables	$558 million
Current Liabilities	$751 million
Tangible Net Equity	$115 million
Pct. Of Min. Requirement	**325%**

Santa Clara Family Health Plan
CFO Finance Report
For the Month and Year to Date Ended February 28, 2017

Summary of Financial Results

For the month of February 2017, SCFHP recorded a net surplus of $2.3 million compared to a budgeted net surplus of $1.1 million resulting in a favorable variance from budget of $1.2 million. For year to date February 2017, SCFHP recorded a net surplus of $15.1 million compared to a budgeted net surplus of $8.4 million resulting in a favorable variance from budget of $6.7 million. The table below summarizes the components of the overall variance from budget.

Summary Operating Results - Actual vs. Budget

For the Current Month & Fiscal Year to Date - Feb 2017

Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$100,302,842	$ 95,440,059	$ 4,862,783	5.1%	Revenue	$ 801,662,222	$ 760,170,311	$ 41,491,911	5.5%
94,292,051	90,756,696	(3,535,355)	-3.9%	Medical Expense	757,796,685	723,090,669	(34,706,017)	-4.8%
6,010,791	4,683,363	1,327,428	28.3%	Gross Margin	43,865,536	37,079,642	6,785,894	18.3%
3,624,701	3,517,518	(107,183)	-3.0%	Administrative Expense	28,200,853	27,973,071	(227,782)	-0.8%
2,386,090	1,165,844	1,220,245	104.7%	Net Operating Income	15,664,683	9,106,572	6,558,112	72.0%
(116,191)	(85,842)	(30,349)	-35.4%	Non-Operating Income/Exp	(527,988)	(686,739)	158,752	23.1%
$ 2,269,899	$ 1,080,002	$ 1,189,897	110.2%	Net Surplus/ (Loss)	$ 15,136,696	$ 8,419,832	$ 6,716,863	79.8%

Member Months

For the month of February 2017, overall member months were higher than budget by 3,007 (+1.1%). For year to date February 2017, overall member months were higher than budget by 41,605 (+1.9%).

In the eight months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 3.2%, membership in Healthy Kids program decreased by 37.3%, and membership in CMC program decreased by 7.4%.

Member months, and changes from prior year, are summarized on Page 10.

Revenue

The Plan recorded net revenue of $100.3 million for the month of February 2017, compared to budgeted revenue of $95.4 million, resulting in a favorable variance from budget of $4.9 million, or 5.1%. For year to date February 2017, the Plan recorded net revenue of $801.7 million, compared to budgeted revenue of $760.2 million, resulting in a favorable variance from budget of $41.5 million, or 5.5%. The favorable variance was largely due to higher than budgeted members year to date. The Plan also received prior year revenue and higher than budgeted Behavioral Health revenue. This positive variance was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Hep C revenue is unfavorable due to lower than budgeted actual rate and Medi-Cal CMC revenue is lower due to lower than budgeted member months. Medicare revenue was favorable due to higher PMPM reflecting the higher risk scores of the plan members. Part D Medicare revenue was lower than the budget.

A statistical and financial summary for all lines of business is included on page 15 of this report.

Medical Expenses

For the month of February 2017, medical expense was $94.3 million compared to budget of $90.8 million, resulting in an unfavorable budget variance of $3.5 million, or 3.8%. For year to date February 2017, medical expense was $757.8 million compared to budget of $723.1 million, resulting in an unfavorable budget variance of $34.7 million, or 4.8%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by a lowering of the prior year medical cost reserves as well as lower than budgeted Pharmacy expenses. Additionally, the Plan has set aside $21.5 million for provider risk sharing and IHSS/recast reserves.

Administrative Expenses

Overall administrative costs were over budget by $0.1 million (-3.0%) for the month of February 2017 and over budget by $0.2 million (-0.8%) for year to date February 2017. Personnel costs were over budget due to open positions being filled by temporary staffing and consulting resources. Pharmacy administration fees were also higher than budget. Some of this unfavorability was offset by lower advertising and postage expenses.

Overall administrative expenses were 3.5% of revenue for year to date February 2017.

Balance Sheet

Current assets totaled $869.9 million compared to current liabilities of $748.2 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0 as of February 28, 2017. Working capital increased by $14.6 million for the eight months year to date ended February 28, 2017.

Cash as of February 28, 2017, increased by $157.5 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by $141.3 million during the same eight months period ended February 28, 2017. The cash position increased largely due to the receipt of prior period receivables, capitation revenue paid at the prospective rates, and an overall increase in the payables.

Liabilities increased by a net amount of $288.9 million during the eight months ended February 2017. Liabilities increased primarily due to the overpayment of Medi-Cal expansion premium revenues by the State and an increase in IHSS/MCO payables year to date. With the receipt of most prior period MCO funds, the Plan also made its first quarterly MCO payment.

Capital Expenses increased by $5.3 million for the eight months ended February 28, 2017. The capital expenses include:

Expense	**YTD Actual**	**Annual Budget**
Trizetto Upgrade	4,665,594	6,800,000
Computers	690,179	2,584,500
Leasehold Improvement & Furniture	51,267	992,700
TOTAL	**5,407,040**	**10,377,200**

Reserves Analysis

Tangible Net Equity (TNE) was $115.4 million at February 28, 2017 or 325% of the most recent quarterly Department of Managed Health Care (DMHC) minimum requirement of $35.5 million. A chart showing TNE trends is shown on page 16 of this report.

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 February 28, 2017, the Plan's TNE was $8.7 million below the low-end Equity Target and $177.9 million above the low-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$115,430,152
Current Required TNE	$35,478,000
Excess TNE	$79,952,152
Required TNE Percentage	325%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$124,173,000
500% of Required TNE (high end)	$177,390,000
TNE Above/(Below) SCFHP Low End Target	**($8,742,848)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$303,617,915
Less: Pass-Through Liabilities (Non State of CA *)	($3,411,467)
Net Cash Available to SCFHP	$300,206,448
SCFHP Target Liquidity: **	
45 days of Total Operating Expenses	($122,330,127)
60 days of Total Operating Expenses	($163,106,835)
Liquidity Above/(Below) SCFHP Low End Target	**$177,876,322**

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Feb 2017			Eight Months Ending Feb 2017				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**FY17 vs. FY16**
Medi-Cal	268,465	266,782	0.6%	2,151,073	2,113,668	1.8%	2,002,435	7.4%
Healthy Kids	2,780	1,476	88.4%	24,632	21,005	17.3%	34,729	(29.1%)
Medicare	7,598	7,578	0.3%	62,097	61,524	0.9%	68,157	(8.9%)
Total	278,843	275,836	1.1%	2,237,802	2,196,197	1.9%	2,105,321	6.3%

Santa Clara Health Authority
Feb 2017

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	26,920	10%	339	12%	7,598	100%	34,857	13%
SCVVHS, Safety Net Clinics, FQHC Clinics	141,491	53%	1,491	54%	-	0%	142,982	51%
Palo Alto Medical Foundation	7,437	3%	68	2%	-	0%	7,505	3%
Physicians Medical Group	48,829	18%	737	27%	-	0%	49,566	18%
Premier Care	16,650	6%	145	5%	-	0%	16,795	6%
Kaiser	27,138	10%	-	0%	-	0%	27,138	10%
Total	**268,465**	**100%**	**2,780**	**100%**	**7,598**	**100%**	**278,843**	**100%**
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	3.2%		-37.3%		-7.4%		2.3%	

Santa Clara Family Health Plan
Enrollment by Aid-Category

		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200	31,372	31,863	31,603	31,396	31,072	30,836
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006	108,627	108,876	107,489	106,719	106,926
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150	10,138	10,199	10,216	10,206	10,371	10,400
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,262	11,125	11,108	11,037	10,963	10,921	10,864	10,814	10,782	10,882	10,998	11,049	11,028	11,023	11,033	11,069
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350	1,297	1,150	1,078	973	921
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572	83,721	84,679	84,327	84,551	83,031	82,715
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38	37	35	35	34	38
	Long Term Care	194	194	205	212	229	247	246	288	293	290	295	295	300	305	305	310	321	317	310	298
	Total Non-Duals	221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928	248,061	247,556	246,095	243,543	243,203
DUAL	Aged	10,003	10,678	11,583	12,426	13,380	14,034	14,071	14,196	14,275	14,249	14,369	14,456	14,474	14,460	14,662	14,731	14,811	14,963	15,390	16,006
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083	6,027	6,024	6,034	6,033	6,353	6,478
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843	1,856	1,896	1,879	1,891	1,727	1,686
	Long Term Care	644	722	814	904	983	1,065	1,061	1,088	1,072	1,058	1,049	1,038	1,042	1,041	1,036	1,022	1,013	1,018	1,101	1,092
	Total Duals	16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427	23,581	23,673	23,737	23,905	24,571	25,262
	Total Medi-Cal	238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509	271,734	271,293	270,000	268,114	268,465
	Healthy Kids	4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962	2,662	2,458	2,581	2,585	2,780
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,526	9,304	8,783	8,526	8,375	8,150	8,036	7,875	7,782	7,699	7,594	7,493	7,280	7,253	7,247	7,330
	CMC - Long Term Care	294	312	325	352	380	395	376	360	353	338	331	328	326	326	315	308	303	293	280	268
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909	7,801	7,583	7,546	7,527	7,598
	Total Enrollment	**250,307**	**254,629**	**258,516**	**262,767**	**267,842**	**272,675**	**269,304**	**269,290**	**272,918**	**270,396**	**271,930**	**272,669**	**276,311**	**280,384**	**280,380**	**282,197**	**281,334**	**280,127**	**278,226**	**278,843**
	iCAT Total	250,306	254,628	258,515	262,766	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384	280,380	282,197	281,334	280,127	278,226	278,843
	Difference	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Santa Clara County Health Authority
Balance Sheet

	FEB 17	JAN 17	DEC 16	JUN 16
Assets				
Current Assets				
Cash and Marketable Securities	$ 303,617,915	$ 272,773,734	$ 254,735,289	$ 146,082,070
Premiums Receivable	558,497,011	607,918,209	595,551,520	417,166,973
Due from Santa Clara Family Health Foundation - net				
Prepaid Expenses and Other Current Assets	7,764,853	6,271,355	5,886,241	6,766,163
Total Current Assets	869,879,780	886,963,298	856,173,050	570,015,205
Long Term Assets				
Equipment	19,124,839	18,979,046	16,687,799	13,717,799
Less: Accumulated Depreciation	(10,040,964)	(9,876,718)	(9,712,824)	(8,775,886)
Total Long Term Assets	9,083,875	9,102,328	6,974,975	4,941,913
Total Assets	$ 878,963,655	$ 896,065,626	$ 863,148,025	$ 574,957,118
Deferred Outflow of Resources	$ 1,570,339	$ 1,570,339	1,570,339	1,570,339
Total Deferred Outflows and Assets	880,533,994	897,635,965	864,718,364	576,527,457
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 5,351,195	$ 9,171,162	$ 3,575,307	$ 4,824,017
Deferred Rent	109,201	113,352	117,503	142,408
Employee Benefits	1,150,530	1,164,820	1,076,426	1,013,759
Retirement Obligation per GASB 45	478,237	418,458	358,678	
Advance Premium - Healthy Kids	40,104	35,254	30,131	65,758
Deferred Revenue - Medicare		31,858,336		
Liability for ACA 1202	2,065,180	2,065,180	2,065,180	5,503,985
Payable to Hospitals (SB90)				55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	21,833,087	(35,535)
Payable to Hospitals (AB 85)	1,381,822	1,612,403	1,443,471	1,717,483
Due to Santa Clara County Valley Health Plan and Kaiser	20,901,222	26,672,461	32,975,625	6,604,472
MCO Tax Payable - State Board of Equalization	46,338,820	62,651,340	56,925,409	10,779,014
Due to DHCS	225,345,089	206,278,883	206,983,756	107,213,315
Liability for In Home Support Services (IHSS)	363,801,996	347,265,141	331,443,147	238,387,141
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	81,933,950	79,037,425	78,645,907	84,321,012
Total Current Liabilities	751,236,336	770,683,205	739,848,151	462,966,494
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	5,618,386	5,543,386	5,468,386	5,018,386
Total Liabilities	762,774,222	782,146,091	751,236,037	473,904,380
Deferred Inflow of Resources	2,329,621	2,329,621	2,329,621	2,329,621
Net Position / Reserves				
Invested in Capital Assets	9,083,875	9,102,328	6,974,975	4,941,913
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	90,904,231	90,885,778	93,013,131	67,383,691
Current YTD Income (Loss)	15,136,696	12,866,797	10,859,250	27,662,502
Net Position / Reserves	115,430,152	113,160,253	111,152,706	100,293,456
Total Liabilities, Deferred Inflows, and Net Assets	$ 880,533,994	$ 897,635,965	$ 864,718,364	$ 576,527,457

Santa Clara County Health Authority
Income Statement for Eight Months Ending Feb 28, 2017

	For the Month of Feb 2017					For Eight Months Ending Feb 28, 2017				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 91,477,704	91.2%	$ 87,191,903	91.4%	$ 4,285,801	$ 729,876,965	91.0%	$ 692,411,162	91.1%	$ 37,465,803
HEALTHY KIDS	$ 289,648	0.3%	$ 130,407	0.1%	$ 159,241	$ 2,390,692	0.3%	$ 1,853,057	0.2%	$ 537,634
MEDICARE	$ 8,535,490	8.5%	$ 8,117,748	8.5%	$ 417,741	$ 69,394,565	8.7%	$ 65,906,091	8.7%	$ 3,488,474
TOTAL REVENUE	$ 100,302,842	100.0%	$ 95,440,059	100.0%	$ 4,862,783	$ 801,662,222	100.0%	$ 760,170,311	100.0%	$ 41,491,911
MEDICAL EXPENSES										
MEDI-CAL	$ 86,797,860	86.5%	$ 83,089,644	87.1%	$ (3,708,215)	$ 688,138,509	85.8%	$ 660,076,760	86.8%	$ (28,061,749)
HEALTHY KIDS	$ 189,003	0.2%	$ 125,456	0.1%	$ (63,547)	$ 1,962,196	0.2%	$ 1,785,826	0.2%	$ (176,370)
MEDICARE	$ 7,305,188	7.3%	$ 7,541,595	7.9%	$ 236,407	$ 67,695,979	8.4%	$ 61,228,082	8.1%	$ (6,467,897)
TOTAL MEDICAL EXPENSES	$ 94,292,051	94.0%	$ 90,756,696	95.1%	$ (3,535,355)	$ 757,796,685	94.5%	$ 723,090,669	95.1%	$ (34,706,017)
MEDICAL OPERATING MARGIN	$ 6,010,791	6.0%	$ 4,683,363	4.9%	$ 1,327,428	$ 43,865,536	5.5%	$ 37,079,642	4.9%	$ 6,785,894
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 1,903,052	1.9%	$ 2,041,889	2.1%	$ 138,837	$ 14,224,284	1.8%	$ 14,922,760	2.0%	$ 698,476
RENTS AND UTILITIES	$ 105,803	0.1%	$ 132,848	0.1%	$ 27,045	$ 830,769	0.1%	$ 945,513	0.1%	$ 114,744
PRINTING AND ADVERTISING	$ 58,213	0.1%	$ 54,108	0.1%	$ (4,105)	$ 491,235	0.1%	$ 602,617	0.1%	$ 111,381
INFORMATION SYSTEMS	$ 183,232	0.2%	$ 149,226	0.2%	$ (34,006)	$ 1,469,891	0.2%	$ 1,503,916	0.2%	$ 34,025
PROF FEES / CONSULTING / TEMP STAFFING	$ 1,023,594	1.0%	$ 719,780	0.8%	$ (303,814)	$ 7,955,397	1.0%	$ 6,431,749	0.8%	$ (1,523,648)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 205,854	0.2%	$ 239,289	0.3%	$ 33,435	$ 1,551,325	0.2%	$ 1,521,707	0.2%	$ (29,619)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 67,074	0.1%	$ 89,180	0.1%	$ 22,105	$ 1,025,289	0.1%	$ 1,296,437	0.2%	$ 271,149
MEETINGS / TRAVEL / DUES	$ 71,824	0.1%	$ 86,919	0.1%	$ 15,095	$ 579,939	0.1%	$ 679,085	0.1%	$ 99,146
OTHER	$ 6,055	0.0%	$ 4,280	0.0%	$ (1,776)	$ 72,724	0.0%	$ 69,287	0.0%	$ (3,437)
TOTAL ADMINISTRATIVE EXPENSES	$ 3,624,701	3.6%	$ 3,517,518	3.7%	$ (107,183)	$ 28,200,853	3.5%	$ 27,973,071	3.7%	$ (227,782)
OPERATING SURPLUS (LOSS)	$ 2,386,090	2.4%	$ 1,165,844	1.2%	$ 1,220,245	$ 15,664,683	2.0%	$ 9,106,572	1.2%	$ 6,558,112
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (50,592)	-0.1%	$ (9,187)	$ (478,237)	-0.1%	$ (404,738)	-0.1%	$ (73,499)
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (600,000)	-0.1%	$ (600,000)	-0.1%	$ -
INTEREST, OTHER INCOME, ALLOWANCE FOR UNCOLLECTIBLES	$ 18,588	0.0%	$ 39,750	0.0%	$ (21,161)	$ 550,250	0.1%	$ 317,999	0.0%	$ 232,251
NET SURPLUS (LOSS) FINAL	$ 2,269,899	2.3%	$ 1,080,002	1.1%	$ 1,189,897	$ 15,136,696	1.9%	$ 8,419,832	1.1%	$ 6,716,863

Santa Clara Family Health Plan
Statement of Cash Flows
For Eight Months Ended Feb 28, 2017

Cash flows from operating activities		
Premiums received	$	811,023,762
Medical expenses paid	$	(617,472,142)
Administrative expenses paid	$	(31,158,984)
Net cash from operating activities	$	162,392,636
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(5,407,040)
Cash flows from investing activities		
Interest income and other income, net	$	550,250
Net (Decrease) increase in cash and cash equivalents	$	157,535,845
Cash and cash equivalents, beginning of year	$	146,082,070
Cash and cash equivalents at Feb 28, 2017	$	303,617,915
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	17,586,446
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	1,265,078
Changes in operating assets and liabilities		
Premiums receivable	$	(141,330,039)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	(998,691)
Deferred outflow of resources	$	-
Accounts payable and accrued liabilities	$	(2,746,281)
State payable	$	150,691,579
Santa Clara Valley Health Plan and Kaiser payable	$	14,296,750
Net Pension Liability	$	600,000
Medical cost reserves and PDR	$	(2,387,061)
Deferred inflow of resources	$	-
Total adjustments	$	144,806,190
Net cash from operating activities	$	162,392,636

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

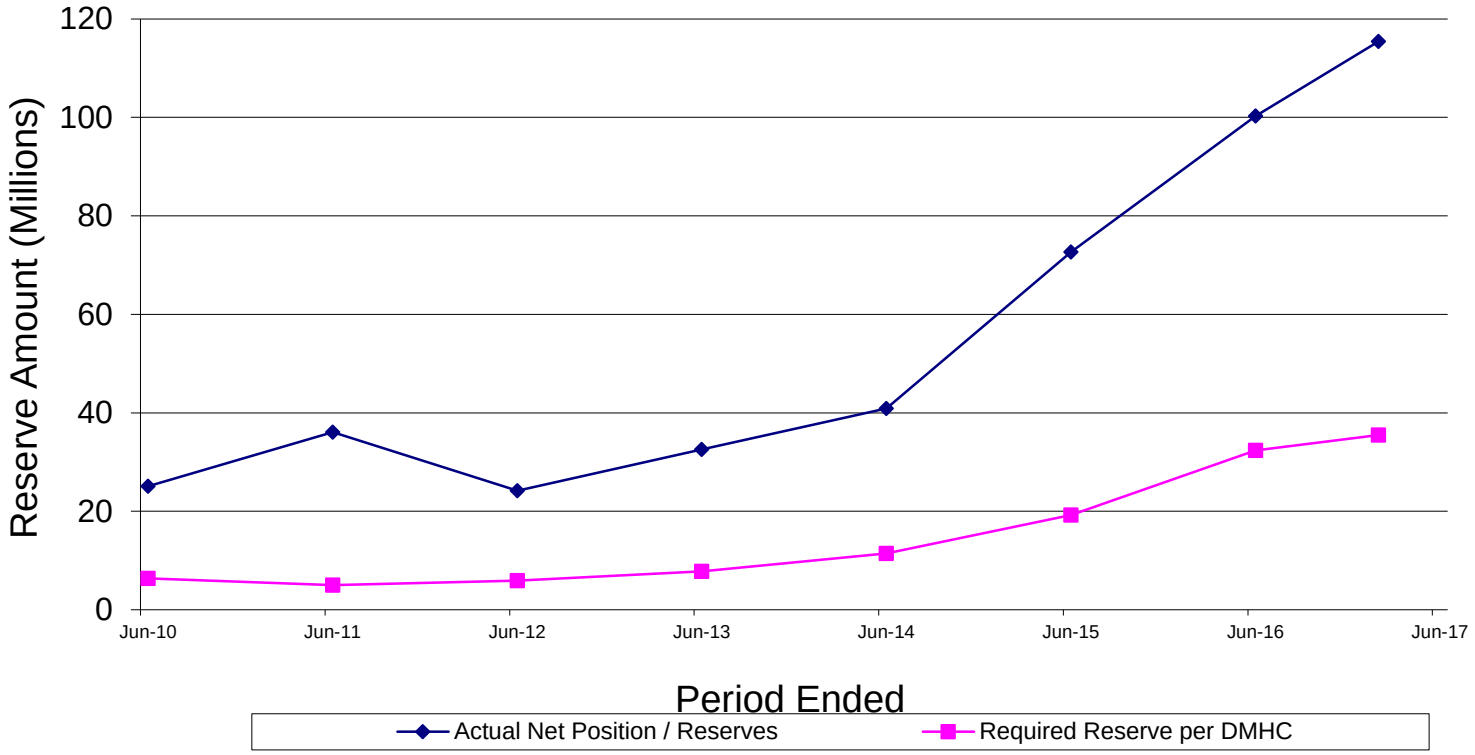
Eight Months Ended Feb 28, 2017

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$711,990,127	$87,281,403	$2,390,692	**$801,662,222**
MEDICAL EXPENSES	667,627,032	88,207,457	1,962,196	**757,796,685**
(MLR)	93.8%	101.1%	82.1%	**94.5%**
GROSS MARGIN	44,363,095	(926,054)	428,495	**43,865,536**
ADMINISTRATIVE EXPENSES	24,845,958	3,070,383	284,512	**28,200,853**
(% MM allocation except CMC)				
OPERATING INCOME/(LOSS)	19,517,137	(3,996,437)	143,984	**15,664,683**
OTHER INCOME/(EXPENSE)	(468,928)	(57,485)	(1,575)	**(527,988)**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$19,048,209	($4,053,922)	$142,409	**$15,136,696**
PMPM (ALLOCATED BASIS)				
REVENUE	$330.99	$1,405.57	$97.06	**$358.24**
MEDICAL EXPENSES	310.37	1,420.48	79.66	**338.63**
GROSS MARGIN	20.62	(14.91)	17.40	**19.60**
ADMINISTRATIVE EXPENSES	11.55	49.44	11.55	**12.60**
OPERATING INCOME/(LOSS)	9.07	(64.36)	5.85	**7.00**
OTHER INCOME / (EXPENSE)	(0.22)	(0.93)	(0.06)	**(0.24)**
NET INCOME / (LOSS)	$8.86	($65.28)	$5.78	**$6.76**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*2,151,073*	*62,097*	*24,632*	***2,237,802***
Member MONTHS by LOB	*96.1%*	*2.8%*	*1.1%*	***100%***
Revenue by LOB	*88.8%*	*10.9%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the CCI data

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

	6/30/2010	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	2/28/2017
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	115,430,152
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	35,478,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	70,956,000
	3.93	7.22	4.10	4.19	3.57	3.77	3.10	3.25



Santa Clara
Family Health Plan
The Spirit of Care

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

Thursday, May 25, 2017
8:30 AM - 10:00 AM
210 E. Hacienda Avenue
Campbell CA 95008

VIA TELECONFERENCE AT:
Residence
1985 Cowper Street
Palo Alto, CA 94301

Minutes – DRAFT

Members Present
Michele Lew, Chair
Bob Brownstein
Wally Wenner, M.D.
Linda Williams *(via telephone)*

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Neal Jarecki, Controller
Rita Zambrano, Executive Assistant

Members Absent
Liz Kniss

Other Attendees
Janet Sommers, Burke, Williams, & Sorenson LLP (via phone)

1. **Roll Call**

   Michele Lew, Chair, called the meeting to order at 8:35am. Roll call was taken and a quorum was not established.

2. **Public Comment**

   There were no public comments.

3. **FY 2018 Budget Planning**

   Mr. Cameron provided an overview of Fiscal Year 2017-18 budget planning. He noted that Medi-Cal enrollment is expected to decline approximately 3% based on in-part on estimates provided by County Social Services. In response to a question, Ms. Tomcala noted that, because of the inclusion of the CMC program in the Governor's FY 2017-18 budget, the Plan's Medicare D-SNP efforts have been suspended and the FY 2018 budget does not

include costs associated with pursuing a D-SNP contract.

Mr. Cameron reviewed the key revenue and expense assumptions. Although the general tone of spending reflects the flattening of membership, some additional headcount is anticipated.

Mr. Cameron noted that costs of the new building will be included in the FY 2018 capital budget, with sublease income approximately offsetting operating costs incurred. Operating and capital budgets will be presented to the Board at its June meeting.

4. External Audit Management Letter

Mr. Cameron reviewed the six management letter comments made by Moss-Adams, the Plan's external auditor, at the conclusion of the 2015-2016 audit. He noted that considerable progress has been made on each item listed and that all items are expected to be completed by the upcoming annual audit.

Wally Wenner, M.D., arrived and a quorum was established.

Announcement Prior to Recessing into Closed session @ 9:00 am

5. Adjourn to Closed Session

a. Anticipated Litigation
The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding one item of potential litigation involving a CalPERS administrative claim for damages.

b. Real Property Negotiations
The Committee conferred with its Real Property Negotiators concerning the possible acquisition of real property located at 50 Great Oaks Boulevard, San Jose, California.

6. Report from Closed Session

Ms. Lew reported the Committee met in Closed Session to discuss Items 5 (a) and (b).

7. Meeting Minutes

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

It was moved, seconded, and the April 27, 2017 meeting minutes were **unanimously approved** as presented.

8. March 2017 Financial Statements

Dave Cameron, Chief Financial Officer, presented the March 2017 financial statements. For the month, the Plan reported a net surplus of $2.8 million, which is $2.0 million favorable to budget. For the first nine months of the fiscal year, the Plan reported a net surplus of $17.9 million or $8.7 million favorable to budget. The surpluses result from a combination of factors including higher member months (versus both budget and prior year actual) and decreases in prior medical expense (IBNR) estimates which are favorable to the financial statements. The overall medical loss ratio has improved to 94.4% on a year-to-date basis. Administrative expenses were at budget for the month and 1% over budget on a year-to-date basis due to the continued use of consultants and temps in support of unfilled staff positions and special projects.

Mr. Cameron noted that enrollment, which exceeds budget by 1.7% on a year-to-date basis, has flattened lately.

Enrollment at March 2017 was 278,000 members, with no significant changes by network.

Mr. Cameron observed that the balance sheet continues to include large receivables from, and payables to, DHCS. A significant portion of the CCI program receivables were recently paid, as was a significant portion of the MCO tax. The Plan expects recoupment of MCE overpayment to commence in July 2017.

Mr. Cameron noted that the Plan's net assets of $118.0 million represented 324% of the DMHC minimum required tangible net equity (TNE) of $36.5 million at March 31, 2017.

In response to a question concerning the risks entailed by having IHSS under the Plan, Mr. Cameron noted that there is risk that the current capitated rates paid by the State may not be sufficient to cover actual IHSS costs. The Plan is paid at 2015 capitation rates per DHCS and currently accrues costs to a break-even point. DHCS has yet to release rates for 2016 and IHSS utilization is increasing (with increases noted in wages, hours worked, and overtime). Mr. Cameron noted that an accrual will be posted by fiscal year-end to address this exposure.

Capital assets of $5.5MM have been acquired year-to-date, much of which is related to the QNXT claims system implementation. The Board approved capital acquisitions of $10.9 million for full fiscal year.

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

9. FY 2017 Capital Budget Allocation Change

Mr. Cameron noted that quotes received for the Disaster Recovery and Business Continuity site procurement project were close to $300,000 versus $225,000 approved in the 2016-2017 Capital Budget. The IT team respectfully requests that the $75,000 designated for the conference room revitalization be reallocated to cover the higher than estimated cost of the Disaster Recovery project.

> **It was moved, seconded, and** the reclassification of $75,000 from the Conference Room to Disaster Recovery project in the capital budget was **unanimously approved**.

10. CEO Update

Ms. Tomcala invited Mr. Cameron to update the Committee on misdirected claims. He indicated the Plan attained a compliance rate of 96% - 98% for the months of March through May, meeting the compliance requirement of 95%.

Mr. Cameron advised the Board that the PDR backlog has been addressed and the Plan is now compliant. The process entailed five months of effort and resources. Work continues to ensure that the Plan sustains current compliance (attained for CMC, nearly-attained for Medi-Cal).

Mr. Cameron advised the Committee that, during recent discussion of the May Revise of the California FY2017-18 budget, DHCS said it would seek to recoup an estimated $360 million from Plans statewide. In August 2016, DHCS noted that some MCE members had Medicare Part A and were therefore ineligible for MCE categorization. Since then, MCE members have been recategorized as Dual (either Full Dual or Partial Dual) at their annual redetermination. A preliminary estimate of $4 million has been calculated for SCFHP. Once member-specific detail is received from DHCS, the estimate will be recalculated and an adjustment posted.

Ms. Tomcala reported on implementation of the QNXT system for Medi-Cal, noting the status is yellow, and still on track for a July 1st go-live.

The Committee was reminded of the upcoming Joint Planning session scheduled for May 30th.

Ms. Tomcala discussed the three Civil Grand Jury findings, as well as the article and letter to the editor in the San Jose Mercury News. The Plan has 90 days to respond to the findings.

Ms. Tomcala reported the Plan is moving forward with the County on the Whole Person Care expansion. Our proposal was favorably received by the State and we are expecting a response from CMS in June.

The Congressional Budget Office (CBO) released its score of AHCA and estimated that 23 million fewer Americans would have insurance by 2026, with an $834 billion cut to Federal Medicaid spending over the period 2017-2026, and 14 million fewer Medicaid enrollees by 2026 (roughly a 17% reduction in enrollment compared to current law).

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

11. Adjournment

The meeting was adjourned at 9:30am.

_____

Michele Lew, Chair

DRAFT

Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Nine Months Ended March 2017
(Unaudited)

Table of Contents

Fiscal Year 2016-17 Year-To-Date Highlights

- **Net Surplus –** March $2.8m surplus and YTD $17.9m surplus ($8.7m favorable to budget)
- **Enrollment –** March 2017 membership: 277,914 (0.5% favorable to budget) and March YTD: 2,515,716 member months (1.7% favorable to budget and 5.8% higher than March YTD last year)
  - Medi-Cal membership dropped slightly continuing the downward trend that started in November 2016. CMC membership grew slightly. HK membership transition to Medi-Cal is slower than planned.
- **Revenue –** over YTD budget by $50.1m (+5.8%)
  - Increase was largely due to higher than budgeted members year to date, which was partially offset by unfavorable variance in Medi-Cal Expansion, Hep C, and Medi-Cal CMC revenue. Medicare revenue was higher due to higher risk scores of the plan members. Part D Medicare revenue was lower than the budget.
- **Medical Expenses –** over YTD budget by $41.3m (-5.1%)
  - Increase in expense was due to higher than budgeted member months resulting in higher capitation costs as well as higher hospital, LTC, and provider risk sharing/CCI and CMC recast reserve expenses. Prior year medical expense estimate reduction offset some of this unfavorable variance.
- **Administrative Expenses –** over YTD budget by $0.3 million (-0.9%)
  - Increase in expense was due to positions being filled by consulting/temporary resources and Pharmacy Administration Fees due to higher utilization; partially offset by lower Advertising and Postage expenses (possibly timing).
- **Other Income/Expenses –** net expense under budget by $0.2m due to higher than budgeted interest earnings.
- **Balance Sheet**
  - DHCS paid a significant portion of the prior period receivables (rate differentials, MCO, etc.). As a result, SCFHP is in a position to continue making MCO quarterly installment payments. Overall cash position increased due to the receipt of these funds, Medicare RAF funds, partially offset by increase in payables.
  - Receivables for CCI rate recast continued to increase (partially offset by Medi-Cal Expansion rate overpayments).
  - TNE of $118.2m or 324% of most recent Required TNE of $36.5m per DMHC ($9.5m below the SCFHP low-end Equity Target and $163.8m above the low-end Liquidity Target).
  - YTD Capital Expenses increased by $5.5 million largely due to capitalization of Trizetto/QNXT claims system expenses.

Consolidated Performance
March 2017 and Year to Date

	Month	YTD
Revenue	$104 million	$906 million
Medical Costs	$98 million	$855 million
Medical Loss Ratio	93.6%	94.4%
Administrative Costs	$4 million (3.7%)	$32 million (3.5%)
Other Income/ Expense	($50,584)	($578,571)
Net Surplus (Loss)	$2,788,539	$17,925,235

Cash on Hand	$289 million
Net Cash Available to SCFHP	$286 million
Receivables	$583 million
Current Liabilities	$766 million
Tangible Net Equity	$118 million
Pct. Of Min. Requirement	**324%**

Santa Clara Family Health Plan
CFO Finance Report
For the Month and Year to Date Ended March 31, 2017

Summary of Financial Results

For the month of March 2017, SCFHP recorded a net surplus of $2.8 million compared to a budgeted net surplus of $0.8 million resulting in a favorable variance from budget of $2.0 million. For year to date March 2017, SCFHP recorded a net surplus of $17.9 million compared to a budgeted net surplus of $9.2 million resulting in a favorable variance from budget of $8.7 million. The table below summarizes the components of the overall variance from budget.

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

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$104,292,910	$ 95,730,190	$ 8,562,720	8.9%	Revenue	$ 905,955,131	$ 855,900,501	$ 50,054,631	5.8%
97,585,230	91,028,744	(6,556,486)	-7.2%	Medical Expense	855,381,915	814,119,412	(41,262,503)	-5.1%
6,707,680	4,701,446	2,006,233	42.7%	Gross Margin	50,573,216	41,781,088	8,792,128	21.0%
3,868,557	3,821,776	(46,781)	-1.2%	Administrative Expense	32,069,410	31,794,846	(274,563)	-0.9%
2,839,123	879,671	1,959,452	222.7%	Net Operating Income	18,503,806	9,986,242	8,517,564	85.3%
(50,584)	(85,842)	35,259	41.1%	Non-Operating Income/Exp	(578,571)	(772,582)	194,010	25.1%
$ 2,788,539	$ 793,828	$ 1,994,711	251.3%	Net Surplus/ (Loss)	$ 17,925,235	$ 9,213,661	$ 8,711,574	94.6%

Member Months

For the month of March 2017, overall member months were higher than budget by 1,283 (+0.5%). For year to date March 2017, overall member months were higher than budget by 42,887 (+1.7%).

In the nine months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 2.9%, membership in Healthy Kids program decreased by 37.9%, and membership in CMC program decreased by 7.1%.

Member months, and changes from prior year, are summarized on Page 10.

Revenue

The Plan recorded net revenue of $104.3 million for the month of March 2017, compared to budgeted revenue of $95.7 million, resulting in a favorable variance from budget of $8.6 million, or 8.9%. For year to date March 2017, the Plan recorded net revenue of $906.0 million, compared to budgeted revenue of $855.9 million, resulting in a favorable variance from budget of $50.1 million, or 5.8%. The favorable variance was largely due to higher than budgeted members year to date. The Plan also received prior year revenue and higher than budgeted Behavioral Health, Maternity, and Abortion revenue. This positive variance was partially offset by unfavorable variance in Medi-Cal Expansion, Hep C, and Medi-Cal CMC revenue. Medi-Cal Expansion revenue is unfavorable due to both lower than budgeted member months and PMPM. Hep C revenue is unfavorable due to lower than budgeted actual rate and Medi-Cal CMC revenue is lower due to lower than budgeted member months. Medicare revenue was favorable due to higher PMPM reflecting the higher risk scores of the plan members. Part D Medicare revenue was lower than the budget.

A statistical and financial summary for all lines of business is included on page 15 of this report.

Medical Expenses

For the month of March 2017, medical expense was $97.6 million compared to budget of $91.0 million, resulting in an unfavorable budget variance of $6.6 million, or 7.2%. For year to date March 2017, medical expense was $855.4 million compared to budget of $814.1 million, resulting in an unfavorable budget variance of $41.3 million, or -5.1%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by a lowering of the prior year medical cost reserves as well as lower than budgeted Pharmacy expenses. Additionally, the Plan has set aside $21.5 million for IHSS/recast reserves and provider risk sharing.

Administrative Expenses

Overall administrative costs were over budget by $47 thousand (-1.2%) for the month of March 2017 and over budget by $0.3 million (-0.9%) for year to date March 2017. Personnel costs were over budget due to open positions being filled by temporary staffing and consulting resources. Pharmacy administration fees were also higher than budget. Some of this unfavorability was offset by lower advertising and postage expenses.

Overall administrative expenses were 3.5% of revenue for year to date March 2017.

Balance Sheet

Current assets totaled $881.8 million compared to current liabilities of $766.1 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0 as of March 31, 2017. Working capital increased by $8.7 million for the nine months year to date ended March 31, 2017.

Cash as of March 31, 2017, increased by $143.0 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by $165.6 million during the same nine months period ended March 31, 2017. The cash position increased largely due to the receipt of prior period receivables, capitation revenue paid at the prospective rates, and an overall increase in the payables.

Liabilities increased by a net amount of $297.9 million during the nine months ended March 2017. Liabilities increased primarily due to the overpayment of Medi-Cal expansion premium revenues by the State and an increase in IHSS/MCO payables year to date.

Capital Expenses increased by $5.5 million for the nine months ended March 31, 2017. The capital expenses include:

Expense		**YTD Actual**		**Annual Budget**
Trizetto Upgrade	$	4,449,113	$	6,800,000
Computers	$	835,977	$	3,131,000
Leasehold Improvement & Furniture	$	192,624	$	996,200
TOTAL	$	5,477,714	$	10,927,200

Reserves Analysis

Tangible Net Equity (TNE) was $118.2 million at March 31, 2017 or 324% of the most recent quarterly Department of Managed Health Care (DMHC) minimum requirement of $36.5 million. A chart showing TNE trends is shown on page 16 of this report.

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 March 31, 2017, the Plan's TNE was $9.6 million below the low-end Equity Target and $163.8 million above the low-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$118,218,691
Current Required TNE	$36,507,000
Excess TNE	$81,711,691
Required TNE Percentage	324%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$127,774,500
500% of Required TNE (high end)	$182,535,000
TNE Above/(Below) SCFHP Low End Target	**($9,555,809)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$289,101,317
Less: Pass-Through Liabilities (Non State of CA *)	($3,412,423)
Net Cash Available to SCFHP	$285,688,895
SCFHP Target Liquidity: **	
45 days of Total Operating Expenses	($121,909,416)
60 days of Total Operating Expenses	($162,545,888)
Liquidity Above/(Below) SCFHP Low End Target	**$163,779,479**

* Supplemental Information: Pass-Throughs from State of CA

Receivables Due to SCFHP	582,189,374
Payables Due from SCFHP	(657,053,227)
Net Receivable/(Payable)	($74,863,853)

** Excludes IHSS

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Mar 2017			Nine Months Ending Mar 2017				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**FY17 vs. FY16**
Medi-Cal	267,540	267,578	(0.0%)	2,418,613	2,381,246	1.6%	2,262,465	6.9%
Healthy Kids	2,752	1,426	93.0%	27,384	22,431	22.1%	38,887	(29.6%)
Medicare	7,622	7,628	(0.1%)	69,719	69,152	0.8%	76,885	(9.3%)
Total	277,914	276,631	0.5%	2,515,716	2,472,829	1.7%	2,378,237	5.8%

Santa Clara Health Authority
Mar 2017

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	27,200	10%	342	12%	7,622	100%	35,164	13%
SCVVHS, Safety Net Clinics, FQHC Clinics	140,606	53%	1,477	54%	-	0%	142,083	51%
Palo Alto Medical Foundation	7,455	3%	75	3%	-	0%	7,530	3%
Physicians Medical Group	48,472	18%	715	26%	-	0%	49,187	18%
Premier Care	16,605	6%	143	5%	-	0%	16,748	6%
Kaiser	27,202	10%	-	0%	-	0%	27,202	10%
Total	**267,540**	**100%**	**2,752**	**100%**	**7,622**	**100%**	**277,914**	**100%**
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	2.9%		-37.9%		-7.1%		1.9%	

Santa Clara County Health Authority
Balance Sheet

	MAR 17	FEB 17	JAN 17	JUN 16
Assets				
Current Assets				
Cash and Marketable Securities	$ 289,101,317	$ 303,617,915	$ 272,773,734	$ 146,082,070
Premiums Receivable	582,790,351	558,497,011	607,918,209	417,166,973
Prepaid Expenses and Other Current Assets	9,917,891	7,764,853	6,271,355	6,766,163
Total Current Assets	881,809,559	869,879,780	886,963,298	570,015,205
Long Term Assets				
Equipment	19,196,267	19,124,839	18,979,046	13,717,799
Less: Accumulated Depreciation	(10,218,119)	(10,040,964)	(9,876,718)	(8,775,886)
Total Long Term Assets	8,978,148	9,083,875	9,102,328	4,941,913
Total Assets	$ 890,787,708	$ 878,963,655	$ 896,065,626	$ 574,957,118
Deferred Outflow of Resources	$ 1,570,339	$ 1,570,339	1,570,339	1,570,339
Total Deferred Outflows and Assets	892,358,047	880,533,994	897,635,965	576,527,457
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 5,073,718	$ 5,351,195	$ 9,171,162	$ 4,824,017
Deferred Rent	105,050	109,201	113,352	142,408
Employee Benefits	1,198,230	1,150,530	1,164,820	1,013,759
Retirement Obligation per GASB 45	538,017	478,237	418,458	
Advance Premium - Healthy Kids	47,050	40,104	35,254	65,758
Liability for ACA 1202	2,065,180	2,065,180	2,065,180	5,503,985
Payable to Hospitals (SB90)				55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,382,777	1,381,822	1,612,403	1,717,483
Due to Santa Clara County Valley Health Plan and Kaiser	8,642,584	20,901,222	26,672,461	6,604,472
MCO Tax Payable - State Board of Equalization	53,486,885	46,338,820	62,651,340	10,779,014
Due to DHCS	220,020,766	225,345,089	206,278,883	107,213,315
Liability for In Home Support Services (IHSS)	383,545,576	363,801,996	347,265,141	238,387,141
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	79,216,042	81,933,950	79,037,425	84,321,012
Total Current Liabilities	766,097,708	751,236,336	770,683,205	462,966,494
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	(207,473)	5,618,386	5,543,386	5,018,386
Total Liabilities	771,809,735	762,774,222	782,146,091	473,904,380
Deferred Inflow of Resources	2,329,621	2,329,621	2,329,621	2,329,621
Net Position / Reserves				
Invested in Capital Assets	8,978,148	9,083,875	9,102,328	4,941,913
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	91,009,958	90,904,231	90,885,778	67,383,691
Current YTD Income (Loss)	17,925,235	15,136,696	12,866,797	27,662,502
Net Position / Reserves	118,218,691	115,430,152	113,160,253	100,293,456
Total Liabilities, Deferred Inflows, and Net Assets	$ 892,358,047	$ 880,533,994	$ 897,635,965	$ 576,527,457

Santa Clara County Health Authority
Income Statement for Nine Months Ending Mar 31, 2017

	For the Month of Mar 2017					For Nine Months Ending Mar 31, 2017				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 95,542,177	91.6%	$ 87,432,489	91.3%	$ 8,109,688	$ 825,419,142	91.1%	$ 779,843,652	91.1%	$ 45,575,490
HEALTHY KIDS	$ 284,359	0.3%	$ 126,391	0.1%	$ 157,968	$ 2,675,050	0.3%	$ 1,979,448	0.2%	$ 695,602
MEDICARE	$ 8,466,374	8.1%	$ 8,171,310	8.5%	$ 295,064	$ 77,860,939	8.6%	$ 74,077,401	8.7%	$ 3,783,538
TOTAL REVENUE	$ 104,292,910	100.0%	$ 95,730,190	100.0%	$ 8,562,720	$ 905,955,131	100.0%	$ 855,900,501	100.0%	$ 50,054,631
MEDICAL EXPENSES										
MEDI-CAL	$ 89,972,808	86.3%	$ 83,316,203	87.0%	$ (6,656,605)	$ 778,111,318	85.9%	$ 743,392,963	86.9%	$ (34,718,355)
HEALTHY KIDS	$ 218,222	0.2%	$ 121,206	0.1%	$ (97,017)	$ 2,180,418	0.2%	$ 1,907,032	0.2%	$ (273,386)
MEDICARE	$ 7,394,200	7.1%	$ 7,591,335	7.9%	$ 197,135	$ 75,090,179	8.3%	$ 68,819,418	8.0%	$ (6,270,762)
TOTAL MEDICAL EXPENSES	$ 97,585,230	93.6%	$ 91,028,744	95.1%	$ (6,556,486)	$ 855,381,915	94.4%	$ 814,119,412	95.1%	$ (41,262,503)
MEDICAL OPERATING MARGIN	$ 6,707,680	6.4%	$ 4,701,446	4.9%	$ 2,006,233	$ 50,573,216	5.6%	$ 41,781,088	4.9%	$ 8,792,128
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 1,999,808	1.9%	$ 2,288,881	2.4%	$ 289,074	$ 16,224,092	1.8%	$ 17,211,641	2.0%	$ 987,549
RENTS AND UTILITIES	$ 123,227	0.1%	$ 133,541	0.1%	$ 10,313	$ 953,997	0.1%	$ 1,079,054	0.1%	$ 125,057
PRINTING AND ADVERTISING	$ 20,408	0.0%	$ 54,108	0.1%	$ 33,700	$ 511,644	0.1%	$ 656,725	0.1%	$ 145,081
INFORMATION SYSTEMS	$ 168,822	0.2%	$ 193,276	0.2%	$ 24,454	$ 1,638,712	0.2%	$ 1,697,192	0.2%	$ 58,480
PROF FEES / CONSULTING / TEMP STAFFING	$ 1,176,825	1.1%	$ 726,780	0.8%	$ (450,045)	$ 9,132,222	1.0%	$ 7,158,529	0.8%	$ (1,973,693)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 219,780	0.2%	$ 239,478	0.3%	$ 19,698	$ 1,771,105	0.2%	$ 1,761,184	0.2%	$ (9,920)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 60,713	0.1%	$ 89,180	0.1%	$ 28,466	$ 1,086,002	0.1%	$ 1,385,617	0.2%	$ 299,615
MEETINGS / TRAVEL / DUES	$ 91,729	0.1%	$ 91,252	0.1%	$ (476)	$ 671,668	0.1%	$ 770,337	0.1%	$ 98,670
OTHER	$ 7,245	0.0%	$ 5,280	0.0%	$ (1,965)	$ 79,969	0.0%	$ 74,567	0.0%	$ (5,402)
TOTAL ADMINISTRATIVE EXPENSES	$ 3,868,557	3.7%	$ 3,821,776	4.0%	$ (46,781)	$ 32,069,410	3.5%	$ 31,794,846	3.7%	$ (274,563)
OPERATING SURPLUS (LOSS)	$ 2,839,123	2.7%	$ 879,671	0.9%	$ 1,959,452	$ 18,503,806	2.0%	$ 9,986,242	1.2%	$ 8,517,564
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (50,592)	-0.1%	$ (9,187)	$ (538,017)	-0.1%	$ (455,330)	-0.1%	$ (82,687)
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (675,000)	-0.1%	$ (675,000)	-0.1%	$ -
INTEREST, OTHER INCOME, ALLOWANCE FOR UNCOLLECTIBLES	$ 84,196	0.1%	$ 39,750	0.0%	$ 44,446	$ 634,446	0.1%	$ 357,749	0.0%	$ 276,697
NET SURPLUS (LOSS) FINAL	$ 2,788,539	2.7%	$ 793,828	0.8%	$ 1,994,711	$ 17,925,235	2.0%	$ 9,213,661	1.1%	$ 8,711,574

Santa Clara Family Health Plan
Statement of Cash Flows
For Nine Months Ended Mar 31, 2017

Cash flows from operating activities		
Premiums received	$	895,847,074
Medical expenses paid	$	(713,290,337)
Administrative expenses paid	$	(34,693,466)
Net cash from operating activities	$	147,863,270
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(5,478,468)
Cash flows from investing activities		
Interest income and other income, net	$	634,446
Net (Decrease) increase in cash and cash equivalents	$	143,019,247
Cash and cash equivalents, beginning of year	$	146,082,070
Cash and cash equivalents at Mar 31, 2017	$	289,101,317
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	17,290,789
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	1,442,233
Changes in operating assets and liabilities		
Premiums receivable	$	(165,623,379)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	(3,151,728)
Deferred outflow of resources	$	-
Accounts payable and accrued liabilities	$	5,524,314
State payable	$	155,515,321
Santa Clara Valley Health Plan and Kaiser payable	$	2,038,112
Net Pension Liability	$	(5,225,859)
Medical cost reserves and PDR	$	(5,104,970)
Deferred inflow of resources	$	-
Total adjustments	$	130,572,481
Net cash from operating activities	$	147,863,270

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

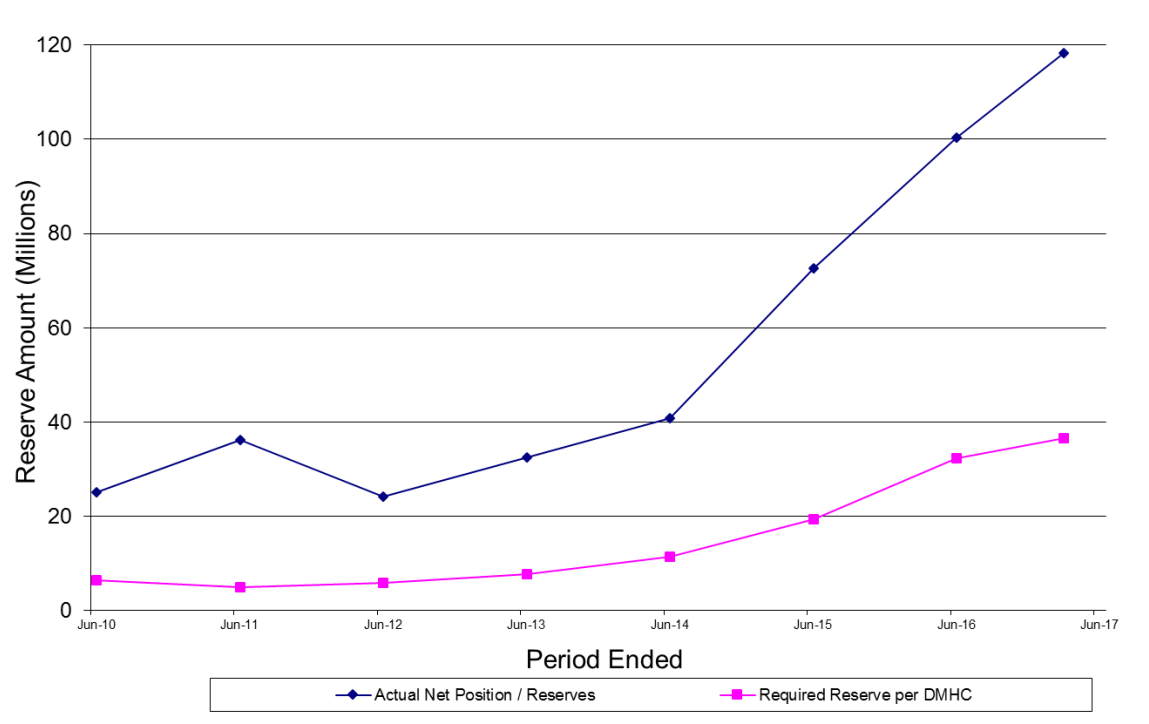
Nine Months Ended Mar 31, 2017

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$805,367,739	$97,912,342	$2,675,050	**$905,955,131**
MEDICAL EXPENSES	753,463,857	99,737,639	2,180,418	**855,381,915**
(MLR)	93.6%	101.9%	81.5%	**94.4%**
GROSS MARGIN	51,903,882	(1,825,297)	494,632	**50,573,216**
ADMINISTRATIVE EXPENSES	28,283,236	3,465,945	320,228	**32,069,410**
(% MM allocation except CMC)				
OPERATING INCOME/(LOSS)	23,620,645	(5,291,243)	174,404	**18,503,806**
OTHER INCOME/(EXPENSE)	(514,333)	(62,530)	(1,708)	**(578,571)**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$23,106,312	($5,353,773)	$172,695	**$17,925,235**
PMPM (ALLOCATED BASIS)				
REVENUE	$332.99	$1,404.39	$97.69	**$360.12**
MEDICAL EXPENSES	311.53	1,430.57	79.62	**340.02**
GROSS MARGIN	21.46	(26.18)	18.06	**20.10**
ADMINISTRATIVE EXPENSES	11.69	49.71	11.69	**12.75**
OPERATING INCOME/(LOSS)	9.77	(75.89)	6.37	**7.36**
OTHER INCOME / (EXPENSE)	(0.21)	(0.90)	(0.06)	**(0.23)**
NET INCOME / (LOSS)	$9.55	($76.79)	$6.31	**$7.13**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*2,418,613*	*69,719*	*27,384*	***2,515,716***
Member MONTHS by LOB	*96.1%*	*2.8%*	*1.1%*	***100%***
Revenue by LOB	*88.9%*	*10.8%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the CCI data

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

	6/30/2010	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	3/31/2017
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	118,218,691
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	36,507,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	73,014,000
	3.93	7.22	4.10	4.19	3.57	3.77	3.10	3.24



Santa Clara Family Health Plan
Capital Budget
as of 3/31/17

Description	YTD Actual	FY17 Budget	Variance Fav/(Unfav)
Systems	**$4,912,502**	**$9,000,000**	**$4,087,498**
Claims System Conversion	$4,449,113	$6,800,000	$2,350,887
Optum, EDIFECS, Advanced Health	$125,650	$1,000,000	$874,350
Essette (Case Management System)	$220,000	$550,000	$330,000
Web Portal (Health-X)	$92,000	$500,000	$408,000
IVR Upgrade (Inbound and Outbound)	$25,739	$75,000	$49,261
Projects yet to commence	$0	$75,000	$75,000
Licensing	**$15,642**	**$330,000**	**$314,358**
MS Licensing (Office 365, Server, SQL)	$15,642	$175,000	$159,358
Projects yet to commence	$0	$155,000	$155,000
Software	**$15,300**	**$181,000**	**$165,700**
Symantec AntiVirus	$15,300	$15,000	($300)
Projects yet to commence	$0	$166,000	$166,000
Hardware	**$341,646**	**$420,000**	**$78,354**
VM Ware & Workstation Upgrades (combined)	$253,619	$250,000	($3,619)
Pure Storage Expansion	$88,027	$125,000	$36,973
Projects yet to commence	$0	$45,000	$45,000
Building	**$192,624**	**$996,200**	**$803,576**
Second Floor Reconfigurations Net 17 cubicle addition	$112,671	$215,000	$102,329
Second Floor Reconfigurations Net 10 cubicle addition	$39,350	$87,000	$47,650
First Floor Three Cubicle Installation - IT Room	$13,100	$8,200	($4,900)
First Floor Q2 Card Reader Install	$4,085	$4,500	$415
Digital display screens - 1 large and 1 small	$7,800	$3,500	($4,300)
Training Room Electrical and Data monuments installation	$3,200	$30,000	$26,800
Disaster Recovery and Business Continuity Site Procurement (Coresite Denver) (M50, BackupArray)	$12,418	$225,000	$212,582
Conference Room Hardware / Revitalization	$0	$75,000	$75,000
Projects yet to commence	$0	$348,000	$348,000
Total Capital Expenditures	**$5,477,714**	**$10,927,200**	**$5,449,486**

Santa Clara
Family Health Plan

Regular Meeting of the
Santa Clara County Health Authority
Compliance Committee

Wednesday, April 26, 2017
3:00 PM – 4:00 PM
210 E. Hacienda Avenue
Campbell CA 95008

VIA TELECONFERENCE AT:
Residence
4127 SW Holden Street
Seattle, WA 98136

Minutes

Members Present
Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer*
Chris Turner, Interim Chief Operations Officer*
Jeff Robertson, Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Sharon Valdez, VP, Human Resources
*via telephone

Staff Present
Beth Paige, Director, Compliance
Peggy Periandri, Director, Compliance Audits
Jordan Yamashita, Compliance Manager

Members Absent
Dave Cameron, Chief Financial Officer

1. **Roll Call**

   Ms. Paige called the meeting to order at 3:06 pm. Roll call was taken and a quorum established.

2. **Introduction**

   Ms. Tomcala introduced Robin Larmer, Chief Compliance and Regulatory Affairs Officer.

DRAFT

3. Public Comment

There were no public comments.

4. Committee Charter

Ms. Paige presented the Compliance Committee Charter, which was approved by the Governing Board in December 2016.

5. Compliance Report

a. Quarterly Compliance Report

Ms. Paige presented the Quarterly Compliance Report highlighting the activities of the Compliance Department. Ms. Paige also noted that 100% of the required Form 700 Disclosure forms had been filed with the County Board of Supervisors.

b. CMC and Medi-Cal Compliance Monitoring Report

Ms. Turner presented the CMC and Medi-Cal Operational Compliance Report.

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

6. Regulatory Corrective Action Plans

a. Misdirected Claims

Ms. Paige presented the regulatory Corrective Action Plan (CAP) to review and monitor misdirected claims. The compliance rate for April 2017 is 98%.

b. Provider Dispute Resolution

Ms. Paige presented the CAP to monitor the Provider Dispute Resolution backlog. Letters to the impacted beneficiaries will be sent beginning the week of May 1, 2017.

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

7. 2017 DHCS Audit

Ms. Paige presented an overview of the preliminary findings of the DHCS auditors, reported during the audit closing session on April 14, 2017.

DRAFT

8. Medicare Data Validation Audit Update

Ms. Paige presented an overview of the Virtual Onsite Call for the Medicare Data Validation Audit that occurred on April 19, 2017 and the status of audit activities.

9. CMS Medicare-Medicaid Plans (MMP) Denial Letter Monitoring

Ms. Paige reported on a recent CMS initiative to evaluate the completeness, timeliness, and appropriateness of MMP CMC denial letters.

10. Fraud, Waste, and Abuse Report

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

a. One credible case of FWA was reported to both DHCS and CMS.

b. Overview of the DHCS audit findings related to the FWA program.

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

11. Adjournment

The meeting was adjourned at 4:02 pm.

DRAFT

Santa Clara Family Health Plan
Operational Compliance Report
Calendar Year Q1 2017

Santa Clara Family Health Plan
The Spirit of Care

Cal MediConnect		
	Goal	Q1 Results
Enrollment		
Enrollment Materials		
% of New member packets mailed within 10 days of effective Date	100%	Met
% of New Member ID cards mailed within 10 days of effective date	100%	Met
Out of Area Members		
% Compliance with OOA Member Process	100%	Met
Customer Service		
Combined Call Stats		
Member		
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met
Member Abandonment Rate	≤5%	Not Met
Member Service Level	80% in ≤30 Seconds	Not Met
Health Services		
Pre-Service Organization Determinations		
Standard Part C		
% of Timely Decisions made within 14 days	95%	Met
Expedited Part C		
% of Timely Decisions made within 72 Hours	95%	Met
Concurrent Organization Determinations		
% of Timely Decisions made within 24 Hours	95%	Not Met
Post Service Organization Determinations		
% of Timely Decisions made within 30 days	95%	Met
Quality & Case Management		
HRAs/ICPs		
% of HRAs completed in 45 days for High Risk Members	100%	Report Pending
% of HRAs completed in 90 days for Low Risk Members	100%	Report Pending
% of ICPs completed within 30 days for High Risk Members	100%	Report Pending
% of ICPs completed within 30 working days for Low Risk Members	100%	Report Pending
Quality of Care/Service		
% of PQI Extended cases that received an extension letter within 30 Days	100%	Report Pending
% of Resolution Letters sent within 30/44 days	100%	Report Pending
Claims		
Non-Contracted Providers		
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Not Met
Contracted Providers		
% of Claims to Contracted Providers processed within 45 days	90%	Met
% of Claims to Contracted Providers processed within 90 days	99%	Not Met
% of Claims to Contracted Providers processed beyond 90 days	≤1%	Not Met

Medi-Cal		
	Goal	Q1 2017
Enrollment		
Enrollment Materials		
% of New member packets mailed within 10 days of effective Date	100%	Met
% of New Member ID cards mailed within 10 days of effective date	100%	Met
Customer Service		
Call Stats		
Member Queue		
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met
Member Abandonment Rate	≤5%	Not Met
Member Service Level	80% in ≤30 Seconds	Not Met
Health Services		
Medical Authorizations		
Routine Authorizations		
% of Timely Decisions made within 5 Business Days of request	95%	Met
Expedited Authorizations		
% of Timely Decisions made within 72 Hours of request	95%	Not Met
Concurrent Review		
% of Timely Decisions made within 24 Hours of request	95%	Report Pending
Restrospective Review		
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	Not Met
Quality & Case Management		
Initial Health Assessment		
% of High Risk SPD Members who completed HRA in 45 days	100%	Report Pending
% of HRAs completed in 90 days for Low Risk SPD Members	100%	Report Pending
% of HRAs completed in 45 days for High Risk MLTSS Members	100%	Report Pending
% of HRAs completed in 90 days for Low Risk MLTSS Members	100%	Report Pending
Facility Site Reviews		
% of FSRs completed timely	100%	Met
Claims		
Non-Contracted Providers		
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Report Pending
Contracted Providers		
% of Claims to Contracted Providers processed within 45 working days	90%	Report Pending
Provider Claim Dispute Requests (Contracted & Non-Contracted)		
% of Contracted Provider Disputes Processed within 45 days	100%	Report Pending

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

Cal MediConnect (continued)		
	Goal	Q1 Results
Pharmacy/Part D		
Standard Part D Authorization Requests		
% of Standard Prior Authorizations completed within 72 Hours	100%	Met
Expedited Part D Authorization Requests		
% of Expedited Prior Authorizations completed within 24 Hours	100%	Not Met
Other Pharmacy Requirements		
Formulary posted on website by 1st of the month	100%	Met
Step Therapy posted on website by 1st of the month	100%	Met
PA criteria posted on website by 1st of the month	100%	Met
Grievance & Appeals		
Grievances, Part C		
Standard Grievances Part C		
% of Standard Grievances that received Acknowledgement Letters within 5 days	100%	Report Pending
% of Standard Grievances resolved within 30/44 days	100%	Report Pending
Expedited Grievances Part C		
% of Expedited Grievances resolved within 24 hours	100%	Report Pending
Grievances, Part D		
Standard Grievance Part D		
% of Acknowledgement Letters sent within 5 days	100%	Report Pending
% of Grievances processed within 30 days	100%	Report Pending
Expedited Grievance Part D		
% of Expedited Grievances processed within 72 hours	100%	Report Pending
Reconsiderations, Part C		
Standard Post-Service Part C		
% of Standard Post-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Report Pending
% of Standard Post-Service Reconsiderations resolved within 30/44 days	100%	Report Pending
Standard Pre-Service Part C		
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Report Pending
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	Report Pending
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	Report Pending
Expedited Pre-Service Part C		
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100%	Report Pending
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	Report Pending
Redeterminations, Part D		
Standard Part D		
% of Standard Redeterminations resolved within 7 calendar days	100%	Report Pending

Medi-Cal (continued)		
	Goal	Q1 2017
Pharmacy		
Standard Authorization Request		
% of Standard Prior Authorizations completed within 1-Business Day	95%	Met
ExpeditedAuthorization Request		
% of Expedited Prior Authorizations completed within 1-Business Day	95%	Met
Grievance & Appeals		
Grievances		
Standard Grievances		
% of Grievances resolved within 30 days	100%	Not Met
Expedited Grievances		
% of Expedited Grievances resolved within 3 Calendar days	100%	Report Pending
% of Expedited Grievances that received Oral Notification with 3 Calendar days	100%	Report Pending
% of Expedited Grievances that received Resolution Letters within 3 Calendar days	100%	Report Pending
Appeals		
Standard Appeals		
% of Standard Appeals Completed within 30 Days	100%	Not Met
% of Letters sent Timely	100%	Report Pending
Expedited Appeals		
% of Expedited Appeals Resolved within 72 Hours	100%	Not Met
% of Letters sent Timely	<15%	Report Pending
Non-Contracted Provider Standard Appeals		
% of Non-K Standard Provider Appeals Processed within 45 days	100%	Report Pending
State Fair Hearings		
% of State Fair Hearing Decisions Overturn Plan Decision	<15%	Report Pending

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

Cal MediConnect (continued)		
	Goal	Q1 Results
Expedited Part D		
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	100%	Report Pending
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	100%	Report Pending
Complaint Tracking Module (CTM) Complaints		
% Resolved Timely	100%	Met
Provider Relations		
Provider Directories updated monthly by the first day of the month	100%	Met
Provider Network Adequacy	100%	Met
Monthly Excluded Provider Screening Completed	100%	Met
Marketing		
% of Marketing Materials Submitted for Approval	100%	Met
% of Events Submitted for Approval	100%	Met
Finance		
% of Encounters successfully submitted to CMS	100%	Not Met
% of Encounters submitted to CMS within 180 days of date of Service	80%	Met
% of RAPS records accepted by CMS	100%	Met

Medi-Cal (continued)		
	Goal	Q1 2017
Provider Network Management		
# of New Providers Rec'd Orientation within 10 days	100%	Met
Monthly Excluded Provider Screening Completed	100%	Met
Timely Access Surveys	100%	Met
DHCS/DMHC Quarterly Network Assessment	100%	Met
IT		
% Encounter Files Successfully Submitted to DHCS by end of month	100%	Met
% Monthly Eligibility Files successfully submitted to Delegates Timely	100%	Met
% Provider File submitted to DHCS by last Friday of Month	100%	Met

Company Wide Compliance		
	Goal	Q1 2017
Compliance Training		
% New Employee Trainings Completed Timely	100% completed within 3 business days	Met
% of Annual Employee Training Completed Timely	100% completed by year end	Annual Measure
Board of Directors Training		
% of Annual Board Training Completed Timely	100% completed by year end	Annual Measure
Internal Audits		
% of Internal Audits Completed	100% completed by year end	Annual Measure
Delegation Oversight		
% of scheduled Audits Completed	100%	Met
Human Resources		
Excluded Individual Screening Completed Monthly	100%	Met
Reporting		
% of CMC Routine Reports Submitted Timely	100%	Met
% of Medi-Cal Routine Reports Submitted Timely	100%	Met
Filings		
% of Key Personnel Filings Submitted Timely	100%	None Required During Reporting Period

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

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, May 10, 2017

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

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	N
Andres Aguirre, MPH	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	Y
Jennifer Clements	Director of Provider Operations	N
Darryl Breakbill	Grievance and Appeals Operations Manager	N
Sandra Carlson, RN	Director of Health Services	Y
Angela Sheu-Ma	Health Educator	Y
Lori Andersen	Director of LTSS	Y
Sherry Holm	Director of Behavioral Health	Y
Caroline Alexander	Administrative Assistant	N

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman called the meeting to order at 6:05 p.m. Quorum was established. Ms.Tomcala introduced new committee members Jeffrey Arnold, MD, and a member of the SCFHP Governing Board Mr. Darrell Evora to the committee.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Review and Approval of February 08, 2017 minutes	The minutes of the February 08, 2017 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the February 08, 2017 meeting were approved as presented.		
Public Comment	No public comment.			
CEO Update	Ms. Tomcala reported that a bill regarding the Affordable Care Act passed in the House and now will go on to the Senate. There will be administrative and legislative change, as well as more state control. Membership is currently at 276,000. The April 2017 DHCS audit went well. Some findings are anticipated. There were 34 findings last year and anticipate half as many this year. Auditors acknowledged the good progress in operations done by the health plan. SCFHP is currently working on implementing new claims system for MediCal product line (QNXT). July 1st is the expected cutover date for MediCal into QNXT. SCFHP submitted DSNP with CMS on the chance the state budget no longer supports Cal MediConnect (CMC) product line. CMC was supported in initial Governor budget, revise to be released in May. If CMC is supported in the budget of the state, the plan will no longer move forward with DSNP.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Action Items				
A. Review of Quality Improvement Committee Charter	Mr. Aguirre presented the Quality Improvement Committee Charter for annual review. There are no changes, it is presented for annual review.	No action required. Informational only.		
B. Review of Quality Improvement Policies	Twelve policies were presented to the committee: QI.01 Conflict of Interest QI.02 Clinical Practice Guidelines QI.03 Distribution of Quality Improvement Information QI.04 Peer Review Process QI.05 Potential Quality of Care Issues QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting QI.07 Physical Access Compliance QI.08 Linguistics Culture QI.09 Health Education Program and Delivery System Policy QI.10 IHA and HEBA Assessments Policy QI.11 Member Non-Monetary Incentives QI.12 SBIRT	All policies were approved as presented.		
C. Adult Preventive Health Guidelines	Dr. Boris presented the Adult Preventive Health Guidelines. Of note is that Breast Cancer Screening (Mammography) guideline remained as every 1 to 2 years for women 40 years of age and older.	Guidelines approved as presented.		
D. Review of QI Work Plan, QI Program Evaluation, and QI Program Description	Mr. Aguirre presented the QI Work Plan, QI Program Evaluation and QI Program Description. In QI Program Description, added some language around providers that comprise the Quality Improvement Committee on page 23 in order to meet NCQA regulations: "The QIC 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 QIC 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 QI staff may also attend the QIC as appropriate." QI Program Evaluation 2016, has more material than previous years. Picked high priority measures. On schedule and data is looking great. Pages 9 to 11 are CMC, Page 12 describes Quality Improvement Projects. QIP's are mandated by the state. Will	Bring HEDIS 2017 results to next meeting Approved as presented.	Andres Aguirre	

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	select new projects around 4th Quarter. Bring to committee as agenda item. Page 13 LTSS project, admissions from hospital to SNF. Pages 14 and 15 are patient safety measures and potential quality of care issues. QI Work plan new additions are on the last two pages of work plan: Initial Health Assessments, NCQA Accreditation, ADA Workplan, Quality of Care and Model of Care.			
E. Review of Complex Case Management Outcomes for 2016 and CM Program Evaluation	Ms. Carlson presented the Complex Case Management Outcomes and CM Program Evaluation as well as Disease Management Outcomes for 2016. SCFHP's 2016 Comprehensive Case Management program was approved when initially presented to the QIC on August 10th, 2016. At that time, SCFHP recognized that their existing Case Management software program (Altruista) was not designed to document all required regulatory reporting elements related to case management and care coordination interventions. Additionally at that same time, SCFHP was experiencing reduced staffing within their case management team. Since 8/10/2016, SCFHP has filled vacant positions for their Director of Health Services and Manager of Case Management. Three additional Nurse Case managers and one administrative Personal Care Coordinator (PCC) have also been added to this team. Beginning November 15th, 2016 SCFHP contracted with Optum (Alere) to provide additional resources and supports to increase Cal MediConnect HRA outreach and improve regulatory compliance for Individual Care Plan completion. Additionally, Optum has an NCQA accredited Complex Case management and Disease management program which is part of the Scope of Work between Optum and SCFHP. Optum has a team of (27) Registered Nurses who are licensed in the state of California to conduct Case management and Disease management services. As of 12/31/2016, the volume of CMC members with HRA's completed by Optum: 1,531 As of 12/31/2016, the volume of CMC members are enrolled in Optum NCQA programs is as follows: • Coronary Artery Disease: 435 • Depression: 435 • Diabetes: 914 • Complex Case management: 32	Bring data to next Quality Improvement Committee meeting Approved as presented.	Sandra Carlson	08/09/2017

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	In December 2016, SCFHP secured a contract for the purchase and implementation of a new Case Management software program, "Essette". Development and configuration began in January 2017 with a scheduled operational launch date of June 1st, 2017. At that time, SCFHP intends to reconsider plans for outsourcing HRA and Case Management functions to external vendors.			
F. Review of Health Education Program Evaluation and Health Education Work plan	Ms. Sheu-Ma presented the Health Education Program Evaluation and Work plan. Updates given at JOC's regarding classes available and languages offered in. Member incentives, focusing to communicate with state so they are aware of programs conducting. Group Needs Assessment conducted. Submitting annual work plan to the state instead of annual updates on Group Needs Assessment. Work plan a lot of carryover from 2016, deeper dive into processes. Alcohol and Drug Use self-management tools, as well as tools to identify depressive disorders on member portal. Continuation of member incentive programs ongoing.	Approved as presented.		
G. Review of Americans with Disabilities Act Work plan	Mr. Aguirre presented the Americans with Disabilities Act Work plan. Patient Safety metrics reported are: • Number of Critical incidents reported in an MLTSS setting. • Number of Potential Quality of Care Issues identified at IHSS Access metrics reported are: • Number of LTSS sites reviewed • Number of CBAS sites reviewed • Number of referrals to CBAS • Number of referrals to IHSS • Number of High Volume Specialists • Number of Ancillary sites reviewed Preventive Care: • HEDIS: Care of Older Adults-Functional Status Assessment • Medication Reconciliation Post-Discharge Health Education: • Number of referrals for CMC members	Approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
H. Review and Adoption of Optum Complex Case Management Policies	Five Optum Complex Case Management Policies were presented for approval and adoption per NCQA requirements. CM-010 Care Plans and Goals CM-007 Data Collection Tools and Assessments CM-009 Identification-Case Opening and Closure Criteria QI-004 Program Content Development Review and Approval Process QI-020 Program Satisfaction-Feedback	Approved and adopted as presented.		
I. Review and Approval of Optum 2016 Quality Improvement Program Description and Work Plan	Ms. Carlson presented the Optum 2016 Quality Improvement Program Description and Work Plan to the committee for adoption per NCQA requirements.	Approved and adopted as presented.		
Discussion Items				
A. Access and Availability	Mr. Aguirre presented the Access and Availability report. The following access standards are monitored by the health plan: • Time and distance requirements • Appointment availability • Minimum number of providers for each specialty type The Access and Availability Workgroup works on identifying and preventing potential barriers to care related to access issues using the following tools: • Grievances related to access issues • Survey data from CAHPS and timely access surveys • Referral and claims data • Quest Analytic Reports 50 Specialties were analyzed and Met All Requirements. There was 100% compliance for both measures for physician and facility measures.	Report results from the following surveys at next QIC: -DMHC Appointment Availability -DMHC After Hours -DMHC Provider Satisfaction -DMHC Member Satisfaction -Consumer Assessment of Healthcare Providers & Systems (CAHPS)	Jennifer Clements	08/09/2017
B. Appeals and Grievances	Mr. Aguirre and Dr. Boris presented the Grievance and Appeals report for the 1st Quarter of 2017. For Medi-Cal: Number of Medical Appeals increased from 23 in January to 32 in March. Pharmacy Appeals increased from 12 in January to 14 in March. State Fair Hearings decreased from 6 in January to 3 in March. Access to Care Grievances decreased from 35 in January to 18 in March. Quality of Service/Customer Service Grievances			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	increased from 9 in January to 22 in March. 52% of Medi-Cal Medical Appeals were upheld and 40% were overturned. 39% of Pharmacy Appeals were upheld and 51% were overturned. For Cal MediConnect: Number of Part C Appeals Reconsiderations increased from 8 in January to 9 in March. Part D Redeterminations increased from 10 in January to 12 in March. Access to Care Grievances decreased from 24 in January to 16 in March. Quality of Service/Customer Service Grievances increased from 2 in January to 8 in March. Part C Determinations Breakdown was as follows: 27% Overturned, 11% in process, 31% Upheld; 31% Withdrawn and 0% dismissed. Part D Redeterminations Breakdown was as follows: 25% Overturned, 40% Upheld, 26% Withdrawn, 6% dismissed, 3% in process.			
C. Disease Management Outcomes for 2016	*Refer to Action Item E.			
D. CY 2017 Annual Review of SCFHP CMC Population Demographics & Specific Health Conditions	Dr. Boris presented an overview of the Cal MediConnect population. The top chronic conditions unique to County of Santa Clara, as well as Santa Clara Family Health Plan CMC members include: hypertension, high cholesterol, and diabetes. CMC Specific Languages from 2015 CY include: • English • Spanish • Vietnamese • Chinese CMC Specific Diagnoses from 2015 CY include: • Hypertension, Essential NOS • DM, Uncomplicated, Type II • Essential (primary) hypertension • Hyperlipidemia NEC/NOS • Type 2 diabetes mellitus without complications • Atrial fibrillation • Hypertension, Benign essential • DM, Uncomplicated, Type II Uncontrolled • Chest pain, NOS • Depressive Disorder, NEC			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Committee Reports A. Credentialing Committee	Dr. Lin presented the February 01 and April 05, 2017 Credentialing Committee Reports. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.	Credentialing Committee reports were approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the 4th Quarter 2016 Pharmacy and Therapeutics Committee minutes. Plan removed OTC cough and cold medications from formulary. It was moved, seconded to approve Pharmaceutical and Therapeutics Committee minutes as presented.	4th Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the January 18 and March 22, 2017 Utilization Management Committee minutes. Cal MediConnect timeliness goal is 95%. It was moved, seconded to approve Utilization Management Committee meeting minutes as presented.	January 18 and March 22, 2017 Utilization Management Committee minutes were approved as presented.		
D. Dashboard	Mr. Aguirre presented the 1st Quarter Dashboard report, including data through April 2017. Nine facility site reviews performed. 76 Potential Quality Issues total were identified, to include April 2017. 59 Level 1 PQI's: No quality issue determined. 13 Level 2 PQI's: Opportunity for improvement. 4 Level 3 PQI's. No Level 4 PQI's were identified. Initial Health Assessment Rate for 1st Quarter was 40%, and for April 2017 was 37%. Quality Improvement Activities included Member Incentives for the following: • Cervical Cancer Screening • Retinal Eye Exam • Hypertension Return rates were low for member incentives. Suggestion made by committee member Dr. Dawood that member incentive forms be sent directly to provider offices so providers can assist with filling out at member visits.			
E. Consumer Advisory Report	Ms. Andersen presented the 1st Quarter Consumer Advisory Board (CAB) report to the committee. Issues of Cal MediConnect (CMC) program management and enrollee care	Present report to committee quarterly	Lori Andersen	

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	identified by CMC members during monthly Consumer Advisory Board meetings. Santa Clara Family Health Plan is required to share this member input with the Quality Improvement Committee quarterly. Summary of issues included the following: • Phone • SCFHP After-Hours Nurse Line • Customer Service/Case Management Support for Member • Pharmacy Co-Pay Additional Input on CMC Program Management and Enrollee Care included: • Satisfied Working with their case managers and getting the help they need • Appreciation for case manager "check-in" call, particularly in her own language • Excellent service received from nursing staff and doctors at a Specialty Clinic • Excellent service from SCFHP and Pharmacy for prescriptions not typically covered • Suggestion made to provide members with a written summary of how transportation benefit can be arranged including what's different, if after hours			
Adjournment	Meeting adjourned by Dr. Ria Paul at 7:35 p.m.			
Next Meeting	Wednesday, August 09, 2017- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD
Quality Improvement Committee Chairperson

Santa Clara
Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, May 10, 2017
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Ms. Tomcala/Dr. Paul	6:00	5 min.
	a. Introduction of new committee members: Darrell Evora and Jeffrey Arnold, MD			
2.	**Meeting Minutes**	Dr. Paul	6:05	5 min.
	Review minutes of the February 08, 2017 Quality Improvement Committee meeting. **Possible Action:** Approve 02/08/2017 minutes			
3.	**Public Comment**	Dr. Paul	6:10	5 min.
	Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.			
4.	**CEO Update**	Ms. Tomcala	6:15	10 min.
	Discuss status of current topics and initiatives.			
5.	**Action Items**	Mr. Aguirre	6:25	25 min.

a. Review Quality Improvement Committee Charter

b. Review of Quality Improvement Policies

i. QI.01 Conflict of Interest
ii. QI.02 Clinical Practice Guidelines
iii. QI.03 Distribution of Quality Improvement Information
iv. QI.04 Peer Review Process
v. QI.05 Potential Quality of Care Issues
vi. QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting
vii. QI.07 Physical Access Compliance
viii. QI.08 Linguistics Culture
ix. QI.09 Health Education Program and Delivery System Policy
x. QI.10 IHA and HEBA Assessments Policy

xi. QI.11 Member Non-Monetary Incentives
xii. QI.12 SBIRT
Possible Action: Approve Quality Improvement policies.

c. Adult Preventive Health Guidelines — Dr. Boris
Possible Action: Approve Adult Preventive Health Guidelines

d. Review of QI Work Plan, QI Program Evaluation, and QI Program Description — Mr. Aguirre
Possible Action: Approve QI Work Plan, QI Program Evaluation and QI Program Description

e. Review of Complex Case Management Outcomes for 2016 and CM Program Evaluation — Ms. Carlson
Possible Action: Approve Case Management Program Evaluation

f. Review of Health Education Program Evaluation and Health Education Work Plan — Ms. Sheu-Ma
Possible Action: Approve Health Education Program Evaluation and Health Education Work Plan

g. Review of Americans with Disabilities Act Workplan — Mr. Aguirre
Possible Action: Approve Americans with Disabilities Act Workplan

h. Review and Adoption of Optum Complex Case Management Policies — Ms. Carlson
i. Care Plans and Goals CM-010
ii. Data Collection Tools and Assessments CM-007
iii. Identification-Case Opening and Closure Criteria CM-009
iv. Program Content Development Review and Approval Process QI-004
v. Program Satisfaction-Feedback QI-020
Possible Action: Approve and Adopt Optum Complex Case Management Policies

i. Review and Approval of Optum 2016 Quality Improvement Program Description and Work Plan — Ms. Carlson
Possible Action: Approve Optum 2016 Quality Improvement Program Description and Work Plan

6. Discussion Items — 6:50 — 15 min.

a. Access and Availability — Mr. Aguirre

b. Appeals and Grievances — Mr. Aguirre

c. Disease Management Outcomes for 2016 — Ms. Carlson

d. CY 2017 Annual Review of SCFHP CMC Population Demographics & Specific Health Conditions — Dr. Boris

7. Committee Reports

a. Credentialing Committee — Dr. Lin — 7:05 — 5 min.
Review February 01, 2017 and April 05, 2017 reports of the Credentialing Committee.
Possible Action: Accept February 01 and April 05, 2017 Credentialing Committee Reports as presented

b. Pharmacy and Therapeutics Committee — Dr. Lin — 7:10 — 5 min.
Review minutes of the December 15, 2016 Committee Meeting.
Possible Action: Accept December 15, 2016 Pharmacy and Therapeutics Committee minutes as presented

c. Utilization Management Committee — Dr. Lin — 7:15 — 5 min.
Review minutes of the January 18, 2017 and March 22, 2017 Committee Meetings.
Possible Action: Accept January 18 and March 22, 2017 Utilization Management Committee minutes as presented

d. Dashboard — Mr. Aguirre — 7:20 — 10 min.
Possible Action: No action required.

e.	**Consumer Advisory Board** **Possible Action:** No action required.	Ms. Andersen	7:30	10 min.
8.	**Adjournment**	Dr. Paul	7:40	

Notice to the Public—Meeting Procedures

Persons wishing to address the Quality Improvement Committee 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 Quality Improvement Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.

In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Caroline Alexander 48 hours prior to the meeting at 408-874-1835.

To obtain a copy of any supporting document that is available, contact Caroline Alexander at 408-874-1835. 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 www.scfhp.com.

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, February 08, 2017

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

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Andres Aguirre, MPH	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	N
Jennifer Clements	Director of Provider Operations	Y
Darryl Breakbill	Grievance and Appeals Operations Manager	Y
Sandra Carlson, RN	Director of Health Services	Y
Carel Peterson, RN	Manager of Case Management	Y
Caroline Alexander	Administrative Assistant	N

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman was absent so Jeff Robertson, MD, CMO called the meeting to order at 6:05 p.m. Quorum was established.			
Review and Approval of November 09, 2016 minutes	The minutes of the November 09, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the November 09, 2016 meeting were approved as presented.		
Public Comment	No public comment.			
CEO Update	Christine Tomcala reported membership is currently at 278,843 members, down 2500 members in Medi-Cal. Plan has been notified by DHCS/DMHC audit to take place first two weeks of April. Installing QNXT as core claims system for Medi-Cal,			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	already in place for Cal MediConnect. One single core operating system, approximate implementation June 2017. Discussion of ACA replace/repeal. Less dollars and more state control. Association is advocating for us. Governor's budget, because CCI but keep Cal MediConnect and move IHSS back to counties. Moving forward with D-SNP application in case Cal MediConnect goes away, due February 15th, 2 year Cal MediConnect.			
Action Items A. Review of Quality Improvement Policies	Two policies were presented to the committee: CM.10 Early Start Program (Early Intervention Services) QI.02 Clinical Practice Guidelines	All policies were approved as presented.		
B. Review of QI Program Description	Dr. Liu presented the QI Program Description for review and approval.	QI Program Description approved as presented.		
C. Review of Case Management Program Description	Ms. Petersen and Ms. Carlson presented the Case Management Program Description for review and approval. There are 4 levels of Case Management: • Level 3 Complex Case Management • Level 2 Complex Case Management • Level 1 Moderate Case Management • Population Monitoring-Basic Case Management New software program for Case Management.	Case Management Program Description approved as presented.		
D. Health Education Program Description	Mr. Aguirre presented the Health Education Program Description for review and approval. Increasing Health Education monitoring, utilization. More involvement with Consumer Advisory Committee (CAC). Add community classes as needed.	Health Education Program Description approved as presented.		
E. Cultural and Linguistics Program Description	Mr. Aguirre presented the Cultural and Linguistics Program Description for review and approval. Interpreter services and translation are available through the Language Line. The Cultural and Linguistics Program 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.	Cultural and Linguistics Program Description approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Discussion Items A. Access and Availability	Ms. Clements presented the Access and Availability report. Will routinely monitor Access and Availability: • Surveys of appointment availability, partnered with ICE • Access and Availability Workgroup from different departments in house to identify additional issues not in the survey	Report data and findings at next QIC	Jennifer Clements	May 10, 2017
B. Appeals and Grievances	Mr. Breakbill presented the Grievance and Appeals report for the 3rd and 4th Quarter of 2016. Total number of grievances for Medi-Cal decreased from 562 in 3rd Quarter to 469 in 4th Quarter. Total number of appeals for Cal Medi-Connect decreased from August 2016 to January 2017. Total number of grievances increased from August 2016 to January 2017. Cal MediConnect Part D Trends from July 2016 through January 2017: Ambien, Vistaril, and Lidocaine patches were the top 3 number of appeals for Part D. Part C Trends were as follows: MRI/PET/SPECT Scans: 10 appeals DME: 6 appeals Out of Network Provider Requests: 4 appeals			
Committee Reports A. Credentialing Committee	Dr. Lin presented the December 07, 2016 Credentialing Committee Report. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.	Credentialing Committee report was approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the 3rd Quarter 2016 Pharmacy and Therapeutics Committee minutes. Epipen generic is now available. Zepatier is formulary and Harvoni for Hep C.	3rd Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
C. Utilization Management Committee	Dr. Lin presented the 4th Quarter 2016 Utilization Management Committee minutes. Summarized updates to the Medi-Cal Prior Authorization Grid. Inpatient admission will require prior authorization. Hemodialysis no longer requires prior authorization unless out of area. Non contracted providers require prior authorization. Oncology no longer requires prior authorization.	4th Quarter 2016 Utilization Management Committee minutes were approved as presented.		
D. Dashboard	Dr. Liu presented the 4th Quarter Dashboard report, including data through the end of 4th Quarter 2016. HEDIS measures related to auto assignment. HEDIS measures related to quality withhold. Nine facility site reviews performed. 29 Potential Quality Issues reported. 23 Level 1: No quality issue determined. 6 Level 2: Opportunity for improvement. Initial Health Assessment Rate for 4th Quarter was 39%.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Jeff Robertson at 7:20 p.m.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Next Meeting	Wednesday, May 10, 2017- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____
Ria Paul, MD
Quality Improvement Committee Chairperson

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Conflict of Interest**	**Policy No.:**	QI.01
Replaces Policy Title (if applicable):	Conflict of Interest	**Replaces Policy No. (if applicable):**	QI-03
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

The purpose of this policy is to avoid a conflict of interest from occurring as related to Quality Improvement Committee (QIC) activities.

II. Policy

Practitioners and SCFHP staff serving as voting members on any QI Program related Committee or the Quality Improvement Committee (QIC), are not allowed to participate in discussions and determinations regarding any case where the committee member was involved in the care received by a member under review by the committee. Additionally, committee members may not review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issue.

All employees and committee participants sign a Conflict of Interest Statement on an annual basis. Fiscal and clinical interests are separated, as SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care, and there are no financial incentives for UM decision-makers that could encourage decisions that would result in under-utilization.

III. Responsibilities

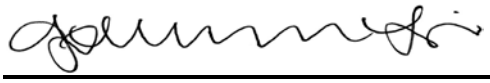
The Quality Improvement Department provides and maintains a Conflict of Interest statement to all Plan Committees that report up to the QIC annually. The Utilization Management Committee, Pharmacy and Therapeutics Committee, Credentialing and Peer Review Committee and Appeals Sub-Committee all sign the agreement and are obligated to report any potential conflict of interest related to committee activities their committee chairperson.

IV. References

Dept. of Plan Surveys; CalMediConnect; Quality Management System (TAG). (2015, October 27). Retrieved April 12, 2016, from Department of Managed Healthcare; CA: https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey.aspx#.Vw1T1e_n-Uk

Quality Improvement 1115 Waiver(TAG). (2015, February 11). Retrieved April 12, 2016, from California Department of Managed Healthcare: https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/MedicalTechnicalAssistanceGuides/1115_qi_02_11_15.pdf

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
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	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	QI.02
Replaces Policy Title (if applicable):	Development of Clinical Practice Guidelines	**Replaces Policy No. (if applicable):**	QM008_001
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To ensure a consistent process for development and revisions of Clinical Practice Guidelines.

II. Policy

Santa Clara Family Health Plan (SCFHP) adopts and disseminates Clinical Practice and Preventive Care Guidelines relevant to its members for the provision of preventive, acute and chronic medical services and behavioral health care services. These guidelines are adopted to help practitioners make appropriate decisions for specific clinical circumstances, preventive health and behavioral healthcare services.

A. These guidelines are based on up to date evidence 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.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Quality Improvement Committee (QIC).

D. The guidelines are available for viewing on the provider web page of the health plan website, in the Provider Manual and upon request.

E. In addition to the clinical practice guidelines, SCFHP adopts preventive health guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Health Guidelines through analysis demonstrating a valid methodology to collect data.
    a. The QI Department analyzes pertinent HEDIS scores and claims data. The analysis includes quantitative and qualitative analysis or performance.
    b. Member satisfaction and grievances are tracked and reported to the QIC at least annually and acted upon as recommended by the QIC.

III. Responsibilities

Health Services Department, Quality Improvement Department and plan providers develop and adhere to Clinical and Preventive Practice Guidelines which are reviewed / revised at least annually. Evaluation of the guidelines occurs every 2 years.

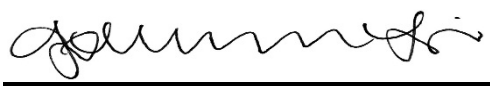
IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 2/2/2017	Title 2/2/2017
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	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
v**2**	**Revised**	**Quality Improvement**	**Approve 2/8/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Distribution of Quality Improvement Information**	**Policy No.:**	QI.03
Replaces Policy Title (if applicable):	Dissemination of Approved Information Following Quality Improvement Committee	**Replaces Policy No. (if applicable):**	QM007_01
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

Santa Clara Family Health Plan (The Plan) requires staff to follow a standard process for distributing Quality Improvement (QI) information to providers and members.

II. Policy

a. At least annually, the Plan communicates Quality Improvement (QI) program information to practitioners, providers and members. Information about QI program processes, goals, and outcomes are shared, as they relate to member care and services, in language that is easy to understand.
b. The Plan may distribute information through regular mail, e-mail, fax, the Web or mobile devices. If posted on the Web, practitioners, providers and members will be notified of the posting and given the opportunity to request the information by mail.

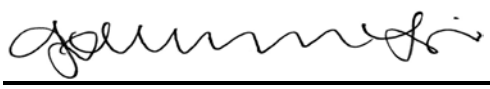
III. Responsibilities

QI forwards information for approval to appropriate departments (HS, Marketing, CEO/COO, DHCS) prior to distribution. Distribution takes place through the approved and appropriate departments after approval.

IV. References

NCQA, 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/18/2016	05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Peer Review Process**	**Policy No.:**	QI.04
Replaces Policy Title (if applicable):	Peer Review Process	**Replaces Policy No. (if applicable):**	QM009_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide a fair, comprehensive peer review process for participating Santa Clara Family Health Plan (SCFHP) providers.

II. Policy

Santa Clara Family Health Plan (SCFHP) Quality Improvement Program provides methods to continuously monitor and evaluate the quality of care and services delivered by the contracted network of practitioners and providers.

The Chief Medical Officer (CMO), overseeing the QI Program activities, is responsible for oversight of peer review activities. Peer Review is coordinated through the Quality Improvement (QI) Department and communicated to the Credentialing Department.

III. Responsibilities

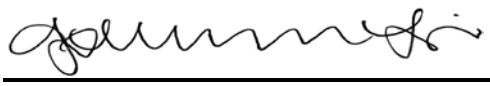
QI continuously monitors, evaluates and develops plans to improve upon PQIs. QI, Health Services, Customer Service, IT, Grievances & Appeals and credentialing monitor for PQIs. The QI Department tracks and trends valuable data which can identify PQIs. All PQIs have the potential for peer review.

IV. References

CA Health and Safety Code section 1370; 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(C) through (E)California Business and Professions Code Section 805

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Potential Quality of Care Issue (PQI)**	**Policy No.:**	QI.05
Replaces Policy Title (if applicable):	Potential Quality of Care Issues	**Replaces Policy No. (if applicable):**	QM002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's policy to identify, address and respond to Potential Quality of Care Issues (PQI).

II. Policy

Santa Clara Family Health Plan (SCFHP) monitors, evaluates, and takes actions to support the quality of care and services delivered to members. The plan identifies and addresses PQI's in order to address potential safety concerns and improve member outcomes.

Potential Quality of Care issues are considered for all providers and provider types such as individual practitioners, groups and facilities. All service types, such as preventive care, primary care, specialty care, emergency care, transportation and ancillary services are considered and are subject to disciplinary action. Availability of care, including case management for the SPD population, continuity of care and coordination of care are also considered. The Plan monitors and analyzes data to determine if services meet professionally recognized standards of practice. Any grievance or PQI referral that involves clinical care or services or potential adverse outcome to a member is referred to a Medical Director.

III. Responsibilities

PQIs may initially be identified by multiple departments within the plan: Health Services, Customer Service, Appeals and Grievances, Credentialing, Provider Services, Compliance, IT, QI, or Claims. All areas are responsible for reporting PQIs to the QI department.

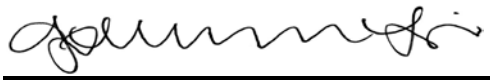
IV. References

California Code and Regulations:

1. 28 CCR 1300.68(a)(e)
2. 28 CCR 1300.70(b)(2)(I)(2)
3. 28 CCR 1300.70(a)(1)
4. 28 CCR 1300.70(b)(2)(C) through (E)

California Health and Safety Code section 1367.1

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

Santa Clara
Family Health Plan

Policy Title:	**Quality Improvement Study Design/Performance Improvement Program Reporting**	**Policy No.:**	QI.06
Replaces Policy Title (if applicable):	Quality Improvement Study Design/Performance Improvement Program Reporting	**Replaces Policy No. (if applicable):**	QM005_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To develop a standard design and/or format for Quality Improvement (QI) Studies and Performance Improvement Program Reporting.

II. Policy

Santa Clara Family Health Plan (SCFHP) continuously monitors and develops ways to improve quality of care for plan members. This is achieved through a variety of measures including, quality of clinical care, safety in clinical care, quality of service, members' experience, trends in potential quality of care issues, chronic care improvement projects, and quality improvement activities.

SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document Q106_01 Quality Improvement Study Design/Performance Improvement Program Reporting.

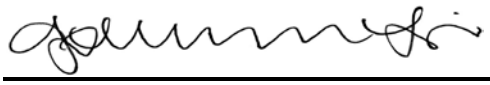
III. Responsibilities

Health Services, Customer Service, Claims, A & G and IT provide data to QI for quality monitoring and reporting. QI then develops a work plan and further monitors and reports on progress and further actions.

IV. References

The Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual Chapter 5, Quality Assessment
The National Committee for Quality Assurance (NCQA), 2016.
NCQA HEDIS Specifications, 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
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	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the process Santa Clara Family Health Plan (SCFHP) follows to monitor that ADA requirements are assessed and compliance is maintained at practice sites for Primary Care Practices, high volume specialists, Community-Bases Adult Services (CBAS) and ancillary practices.

II. Policy

Santa Clara Family Health Plan (SCFHP) conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, Community-Based Adult Services (CBAS) and ancillary practice site listed in the Plan's provider directory.

To drive corrective actions when needed, and monitor the results of the physical assessment review which are made available to SCFHP members following the Department of Healthcare Services (DHCS) requirements.

III. Responsibilities

SCFHP Quality Improvement Department (QI) performs site reviews and reports to the Quality Improvement Committee. Complaints regarding related office accessibility issues are reported by QI to PR/Credentialing as appropriate. Customer Service/IT reports track/trend provider access complaints.

IV. References

Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section

DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

PL 12-006 - Revised Facility Site Review Tool

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
DHCS/SCFHP Contract:
Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM

4. Quality Improvement Committee

8. Quality Improvement Annual Report

10. Site Review

Exhibit A, Attachment 7 - PROVIDER RELATIONS

5. Provider Training

Exhibit A, Attachment 9 - ACCESS AND AVAILABILITY

11. Access for Disabled Members

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title November 9, 2016	Title November 9, 2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve:11/9/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Cultural and Linguistically Competent Services**	**Policy No.:**	QI.08
Replaces Policy Title (if applicable):	Cultural and Linguistic Services Program Policy	**Replaces Policy No. (if applicable):**	CU 002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's (SCFHP) process for accessing and monitoring that services provided to members are culturally and linguistically appropriate to meet member needs.

II. Policy

It is the policy of SCFHP to promote Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population served. SCFHP is committed to providing all services, both clinical and non-clinical, in a culturally competent manner that are accessible to all members, including those with non-English speaking/limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural, ethnic backgrounds, disabilities and regardless of race, gender, sexual orientation or gender identity. SCFHP maintains a Cultural and Linguistics Program that is reviewed and approved by the Quality Improvement Committee on an annual basis. SCFHP completes the Group Needs Assessment every three years to assess member cultural and linguistic needs.

SCFHP assesses monitors and evaluates services for Cultural and Linguistic appropriateness. SCFHP involves member input through the Consumer Advisory Committee.

See associated procedures QI.08.01, QI.08.02, QI.08.03, QI.08.04, and QI.08.05 for detailed process for meeting these objectives.

III. Responsibilities

i. DHCS updates threshold language data at least once every three years, to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal managed care counties. Quality Improvement complies with the update requirements within three months of the publication of the update.

ii. Quality Improvement and Provider Network Management ensure Health Plan Staff and Providers are adequately trained, have access to resources, and provide culturally competent services to all Plan members.

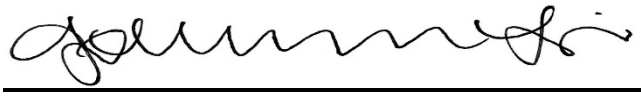
iii. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages which is reviewed and updated as needed based on member assessment needs but no later than every three years based on the results of the Group Needs Assessment survey.

iv. Quality Improvement notifies SCFHP staff and departments of changes to member threshold languages via the Quality Improvement Committee and internal memos or department training sessions.

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA 2016
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract; Title 22 CCR Section 53876, Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5) and section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL -99 03
APL 99005
CFR 42 § 440.262

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
January 31, 2017	January 31, 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	**Original**			

POLICY

Santa Clara
Family Health Plan

Policy Title:	Health Education Program and Delivery System	**Policy No.:**	QI.09
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

The purpose of this policy is to:

A. Describe the Health Education Department and its functions.
B. Define the standards and quality of health education classes and materials.

II. Policy

The Health Education Department of Santa Clara Family Health Plan (SCFHP) seeks to educate and empower health plan members to:

A. Appropriately use the managed care system, preventive and primary health care services
B. Improve their well-being and reduce their risk of disease and injury through adoption of healthy behaviors
C. Understand and adhere to self-care and treatment regimens in the management of chronic and acute conditions.

It is the policy of SCFHP that the Health Education Department will coordinate member educational material and care guidance with the Health Services Department to make certain that recommendations and guidelines to members are aligned with Clinical Practice Guidelines and Utilization Management medical necessity criteria

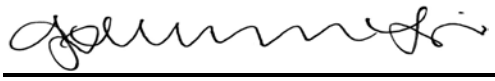
III. Responsibilities

The Health Education Department within the Quality Improvement department of Santa Clara Family Health Plan is responsible for ensuring the policy is enforced with the assistance of the Marketing and Provider services department, and whichever department support is needed to ensure this policy is followed.

IV. References

DHCS Contract Exhibit A, Attachment 10 Section 8.A,
NCQA 2016 Health Plan Accreditation Requirements MEM 8. and MEM 2

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, Pharm D	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approved; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA)	**Policy No.:**	QI.10
Replaces Policy Title (if applicable):	Initial Health Assessments (IHA's) and Behavioral Assessment (HEBA)	**Replaces Policy No. (if applicable):**	HE004_05
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

1. The purpose of this policy is to describe the required completion of the Initial Health Assessments (IHA's) and the Individual Health Education Behavior Assessment (IHEBA) by contracted providers.
2. To define the process that Santa Clara Family Health Plan (SCFHP) will oversee the completion of the SHAs, IHAs and IHEBAs

II. Policy

1. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of the SHA to all Medi-Cal members as part of the Initial Health Assessment (IHA) and to periodically re-administer the SHA according to contract requirements in a timely manner
2. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for an IHA and an IHEBA is to be performed within 120 days of a member's enrollment in SCFHP and that the subsequent IHEBA is re-administered at appropriate age intervals.

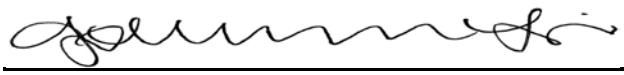
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance of the policy and to collaborate with the Health Education and Provider Services department to train/educate providers on SHA requirements.

IV. References

MMCD Policy Letter 13-001, DHCS Contract Exhibit A Attachment 10, Provisions 3, 4, 5 A and B, and 6.
MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
Staying Healthy Assessment Questionnaires and Counseling and Resource Guide
American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
Web site for SHA Questionnaires and Resources
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Member Non-Monetary Incentives**	**Policy No.:**	QI.11
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

The purpose of this policy is to establish guidelines for the administration of rewarding members who demonstrate effort and success in adopting health-promoting behaviors.

II. Policy

SCFHP may utilize non-monetary incentives to reward members who demonstrate effort and success in adopting health-promoting behaviors or changing health risk behaviors.

A. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
B. SCFHP will submit annual updates to justify the continuation of an ongoing MI program and an end of program evaluation to describe whether or not the MI program was successful.
C. For Focus Group Incentives (FGIs), SCFHP submits an evaluation that incudes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives (Sis), SCFHP will submit a copy of the survey, along with an evaluation that includes findings and recommendations.
D. No member incentives are offered to CMC members (Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72).

III. Responsibilities

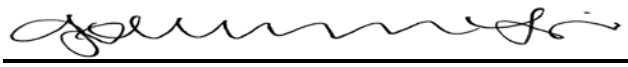
It is the responsibility of the Quality Improvement (QI) department and all departments within the QI department and departments administering incentives, focus groups, and surveys to ensure SCFHP is in compliance with relevant regulations.

IV. References

MMCD APL 16-005, February 25, 2016; AB 915 (Chapter 500., Statutes of 2007): Welfare and Institutions (W&I) Code 14407.1

Title 28. CCR. Section 1300.46, Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol**	**Policy No.:**	QI.12
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☐ CMC

I. Purpose

The purpose of this policy is to describe the required administration of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for Medi-Cal members ages 18 and older who misuse alcohol.

II. Policy

A. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of SBIRT when indicated during administration of the Staying Healthy Assessment or at any time the PCP identifies a potential alcohol misuse problem.

B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for identification, referral, and coordination of care for members requiring alcohol abuse treatment services.

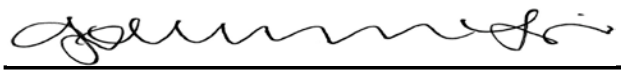
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance with the policy and collaborate with the assistance of the Health Education and Provider Services department to train/educate providers on SBIRT.

IV. References

1. DHCS All Plan Letter 14-004: Screening Brief Intervention, and Referral to Treatment for Misuse of Alcohol
2. DHCS Contract Exhibit A, Attachment 11, Provisions 1A.
3. United States Preventive Task Force (USPSTF) alcohol screening recommendation http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care
4. Website for SHA Questionnaires http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/15/2017	Title 05/15/2017
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	**Original**	**Quality Improvement**	**Approve: 11/9/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	

Santa Clara Family Health Plan

Quality Improvement Program

2017

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 1975and 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. The Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP from 2007 – 2009 to serve as a Special Needs Plan (SNP) in Santa Clara County. In 2014, CMS and the State of California contracted with SCFHP for the Managed Long Term Services and Supports (MLTSS) programs. In 2015, CMS contracted with SCFHP for the Dual Demonstration Project.

SCFHP is dedicated to improving the health and well-being of the residents of our region. SCFHP continues to realize its vision of serving new enrollees, consistent with our mission and core values.

II. Mission Statement

The Mission of Santa Clara Family Health Plan (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 publicly funded, local health plan, we have a unique responsibility to work toward improving the health status of the community in which we are based. SCFHP continually promotes community health 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 Board of Directors assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function. The Board passed a resolution defining the QI Program Description as an organization-wide commitment. This resolution 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 Board of Directors (BOD) has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Board of Directors.

V. Goals

Quality improvement 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 Medi-Cal network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of complaints and 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 it's mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Compliance with regulatory agencies and for CMC the accreditation standards (NCQA)
N. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
O. 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
P. 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. Functions

The QI Program Description supports 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 our members receive.

The QI Program Description supports the QI Department functions, which include:

A. Implement a multidimensional and multi-disciplinary QI work plan that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
B. Monitor, evaluate and act on clinical outcomes for members
C. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    1. Drive improvement of quality of care received
    2. 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)
G. Coordinate and drive improvements with HEDIS compliance and access to preventive care and management of chronic conditions to HEDIS standards
H. Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program
I. Support collaboration and quality processes and effectiveness of continuous quality improvement activities across the organization
J. Conduct effective oversight of delegated providers

All SCFHP members have timely access to health care that is delivered by qualified practitioners and delivery systems, which meets or exceeds standards determined by the Plan, the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

VII. Objectives

The objectives of the QI Program Description include to:

A. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
B. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
C. 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
D. 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
E. 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:
    1. Establishing performance standards
    2. Monitoring performance through regular reporting
    3. Evaluating performance annually
F. 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:
    1. Medical record review
    2. Rates of referral to specialists
    3. Hospital discharge summaries in office charts
    4. Communication between referring and referred-to physicians
    5. Analysis of member complaints regarding difficulty obtaining referrals
    6. Identification and follow-up of non-utilizing members
    7. Practice Pattern Profiles of physicians
    8. Rates of referrals per 1000 members
    9. Performance measurement of practice guidelines
G. 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 complaints and grievances collected through the Member Services Department.
H. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    1. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    2. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
I. 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)
J. 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

K. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
L. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VIII. 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:
    1. Access to Preventive Care (HEDIS)
    2. Behavioral Health Services
    3. Continuity and Coordination of Care
    4. Emergency Services
    5. Grievances
    6. Inpatient Services
    7. Maintenance of Chronic Care Conditions (HEDIS)
    8. Member Experience and Satisfaction
    9. Minor Consent/Sensitive Services
    10. Perinatal Care
    11. Potential Quality of Care Issues
    12. Preventive Services for children and adults
    13. Primary Care
    14. Provider Satisfaction
    15. Quality of Care Reviews
    16. Specialty Care

D. Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:
    1. UM Metrics
    2. Prior authorization
    3. Concurrent review
    4. Retrospective review
    5. Referral process
    6. Medical Necessity Appeals
    7. Case Management
    8. Complex Case Management
    9. Disease Management
    10. California Children's Services (CCS)

IX. QI Work Plan

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

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.

X. QI Methodology

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 Medicare such as Quality Improvement Activities (QIAs)
E. Chronic Care Improvement Project (CCIP)

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 (in house)
D. Provisions of chronic and 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: Board of Directors, 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

QI Project Quality Indicators

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.

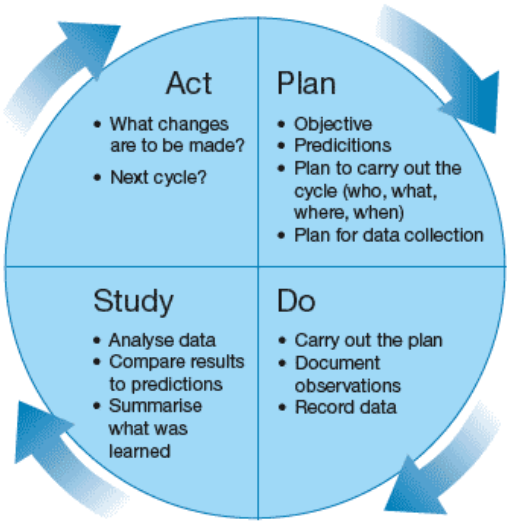
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

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

XI. QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Sentinel Event monitoring. A sentinel 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.

Sentinel events can include:

A. Potential Quality Issues (PQI)
B. Potential Quality of Care Concern
C. Unexpected death during hospitalization
D. Complications of care (outcomes), inpatient and outpatient
E. 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
F. 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. Health Risk Assessment data

An example of identification of risk and quality potential or actual issues include:

A. Ambulatory setting
    1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such an electric exam tables
    2. Annual blood-borne pathogen and hazardous material training
    3. Preventative maintenance contracts to promote that equipment is kept in good working order
    4. Fire, disaster, and evacuation plan, testing, and annual training
B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    1. Falls and other prevention programs
    2. Identification and corrective action implemented to address post-operative complications
    3. Sentinel events identification and appropriate investigation and remedial action

<u>Protocol for Using Quality Monitors Screens</u>

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 Utilization 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.

In-Home Supportive Services (IHSS) Quality Monitoring

SCFHP will participate in the stakeholder workgroup established by the Department of Health Services, the State Department of Social Services, and the California Department of Aging to develop the universal assessment process, including a universal assessment tool, for home-and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, the county, IHSS, Multipurpose Senior Services Program (MSSP), and CBAS providers, and legislative staff. The universal assessment process will be used for all home-and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

In developing the universal assessment process, a universal assessment tool will be developed that will facilitate the development of plans of care based on the individual needs of the recipient. The workgroup shall consider issues including, but not limited to, how the results of new assessments would be used for the oversight and quality monitoring of home- and community-based services providers.

SCFHP will work closely with the local IHSS Agency to develop an appropriate monitoring and oversight plan to adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

Quality Improvement Activities – Long Term Care Facilities

Monitoring of the quality of care provided to SCFHP members, including those residing in LTC facilities, includes, but is not limited to, the following:

- Member complaint and/or grievance trends.
- Provider complaint and/or grievance trends.
- Case review of potential quality of care issue referrals triggered by quality monitors (sentinel events), or utilization management activities.
- Member satisfaction surveys.
- Focused review of topics, including those specifically related to special needs populations such as members residing in LTC facilities.

Topics for review are identified through the monitoring process. Proposed study indicators shall be reviewed by the QI Committee and approved prior to commencing the study. Initiation of quality improvement projects will be directed to the identified needs of members residing in LTC facilities. Focused quality improvement audits, as necessary, for members residing in LTC facilities are performed by the Concurrent Review Case Managers, or Quality Analysts, during on-site facility visits.

Results of quality improvement activities are presented to the Quality Department for review, analysis and summarizing. LTC facilities are notified if there is a need to execute corrective action plans (CAPs). Follow-up reviews will be conducted at LTC facilities when CAPs are executed. SCFHP assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for SCFHP members in LTC facilities, including the local Regional Center, Licensing and Certification, Medi-Cal Operations Division and the Ombudsman's Office. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

XII. 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 Board of Directors 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 Medicare. 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 Quality Improvement Committee 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 UM 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.

1. Primary care services
2. Behavioral health care services
3. Inpatient hospitalization services
4. Home health services
5. 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. Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XIII. QI Organizational Structure

The 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
    1. Drive improvement of quality of care received
    2. Minimize rework and costs
    3. Minimize the time involved in delivering patient care and service
    4. Empower staff to be more effective
    5. 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 serves as the Chairperson for the Quality Improvement Committee and is responsible to report to the Board of Directors 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 General Staff meetings, senior management 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 management program, the utilization management program, and the grievance system. The Medical Director, reporting to the CMO, is 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. 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 registered nurse 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 management 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 senior 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 QI Committee 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 Manager

The Quality 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 Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality management 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 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 Manager facilitates the Plan's QIC 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 Manager and oversees the investigations of member grievances, supports HEDIS reviews, investigates and prepares cases for potential quality of care (QOC) reviews and 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). The QI Nurse is also a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Evaluations (IHEs), and assists with other QI activities at the direction of the Quality Manager.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of quality improvement projects. Director of Quality his position is responsible for developing and maintaining processes that enhance the operationalization of QI 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.

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.

QI Health Educator

The Health Educator is 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 QI Health Educator works under the general direction of the Quality Improvement Manager and works in cooperation with other departments.

Coordinator, QI

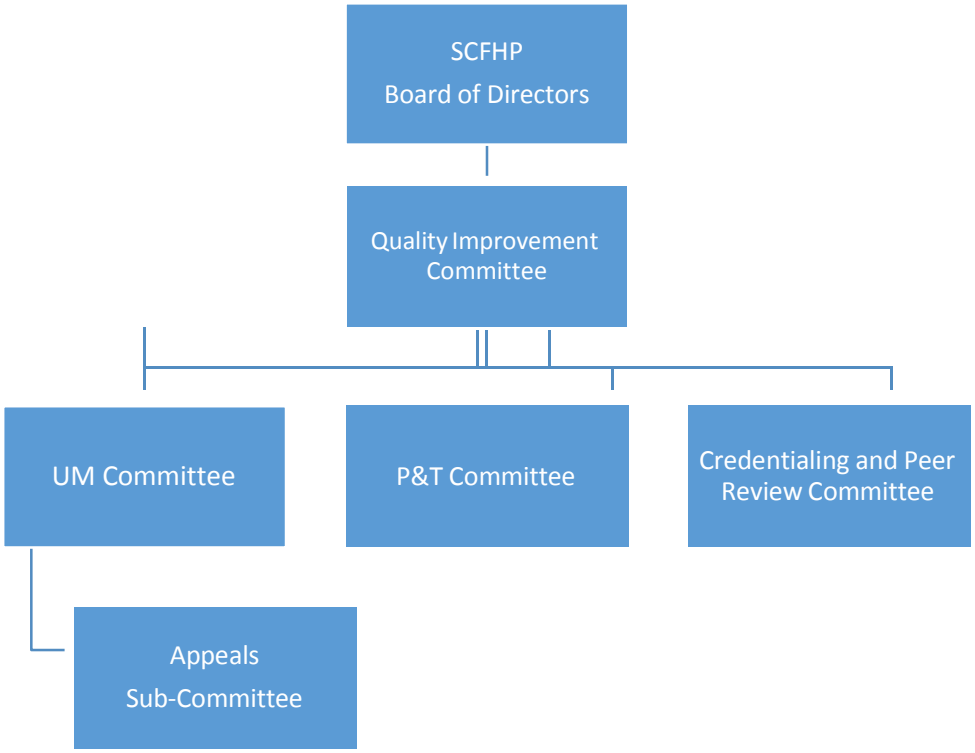
Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management preferred. QI Coordinators report to the Quality Manager and their scope of work may include medical record 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. Committee Structure
Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors.

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.

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



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

Board of Directors

The Board of Directors is responsible to review, act upon and approve the overall QI Program, Work Plan, and annual evaluation. The Board of Directors receives at least quarterly progress and status reports from the QI Committee describing interventions and actions taken, progress in meeting objectives, and improvements achieved. 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 QI C 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.

XIV. Committee Structure

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program. The QIC assists the CMO and administration in overseeing, maintaining, and supporting the QI Program and Work Plan activities. The QIC 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 QIC 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 QI staff may also attend the QIC as appropriate

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.

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.

Utilization Management Committee

The Utilization Management Committee 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 UM Committee 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 UM Committee (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 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 is coordinated through the QI Department and communicated with the Credentialing process. 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 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
    1. Quality Improvement Committee
    2. Pharmacy and Therapeutics Committee
    3. Utilization Management Committee
    4. Credentialing and Peer Review Committee
    5. Additional committees as requested by the Plan

XVI. Pharmacy Services

Pharmacy Services are overseen by the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is two-fold, utilizing the Pharmacy Benefit Manager (PBM) national P&T Committee for the Medicare line of business and a Plan Based P&T Committee for the Medi-Cal line of business as well as to oversee QI monitoring of medication management outcomes, and approve applicable programs and policies and procedures. The P&T Committee oversees the development, maintenance, and improvement of SCFHP's formularies. The P&T Committee recommends policy on all matters related to the use of drugs to promote the clinically appropriate use of pharmaceuticals based on sound clinical evidence. The P&T Committee reports organizationally to SCFHP's Quality Improvement Committee. SCFHP has adopted its PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements.

SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state. SCFHP maintains a closed drug formulary for the Medi-Cal (Medicaid) line of business.

The Plan has adopted the PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements. SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state.

Current versions of SCFHP's formularies are posted on the Plan's web site and are accessible to both members and practitioners. SCFHP pharmaceutical management procedures are included within the formulary as well as in the *Member Guide* (Combined Evidence of Coverage and Disclosure Form) and Provider Manual. Members, prescribers, and pharmacies may receive a printed copy of the formulary upon request.

SCFHP develops its own medical exception review criteria and/or adopts its PBM's criteria. The P&T Committee reviews and approves each set of criteria (both Plan developed and PBM-developed criteria) prior to use and performs an annual review of all criteria. When applying the criteria in a review of a request, SCFHP's criteria are applied when they exist. When Plan-developed criteria do not exist, the appropriate clinical references will be applied.

Member safety is integrated into all components of the Plan's QI Program, and is especially applicable to Pharmacy Services who conducts monitoring and evaluation and takes interventions when application while reviewing processes

SCFHP's pharmaceutical quality improvement process includes measures and reporting systems to address the identification and reduction of medication errors and adverse drug interactions. The PBM's utilization review (DUR) edits provide on-line messaging to dispensing pharmacists. The PBM identifies drug-drug interactions based on three severity levels supported by nationally recognized references (e.g., First Data Bank, NDDF Plus, and National Drug Data File). Eight (8) on-line DUR edits are used and send a message to the dispensing pharmacist when "triggered":

A. Drug Interaction
B. Drug dosage
C. Ingredient duplication
D. Age precaution
E. Pregnancy precaution
F. Gender conflict
G. Therapeutic duplication
H. Late refill

The PBM identifies and notifies SFHP of members and prescribers affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons. SCFHP uses these reports to notify affected physicians and members within 30 calendar days of the FDA notification. An expedited process is followed for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. When the FDA recalls a drug, the product is immediately removed from SCFHP's formularies and active prior authorizations are terminated.

SCFHP conducts retrospective drug utilization of pharmacy claims and other records, through computerized drug claims processing and information retrieval systems to identify patterns of inappropriate or medically unnecessary care among members or associated with specific drugs or groups of drugs.

SCFHP monitors and implements processes to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:

A. Compliance programs designated to improve adherence/persistency with appropriate medication regimens
B. Monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies
C. Quantity versus time edits
D. Early refill edits

XVII. 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 Clinical Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Clinical 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.

XVIII. Utilization Management

Utilization Management activities and related UM activities including Case Management, Disease Management, and Model of Care programs and processes as addressed in the Utilization Management Program Description.

The outcomes of UM activities are measured and reported to the UM Committee and are defined in the UM Work Plan.

Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:

11. UM Metrics
12. Prior authorization
13. Concurrent review
14. Retrospective review
15. Referral process
16. Medical Necessity Appeals
17. Case Management

18. Complex Case Management
19. Disease Management
20. California Children's Services (CCS)
21. Early and Periodic Screening, Diagnosis and Treatment (ESPDT)

Monitoring Utilization Patterns

To monitor and analyze that appropriate care and service to members, SCFHP's Utilization Management Committee performs an annual assessment of utilization data to identify potential under- and over-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data, pharmacy, dental and vision encounter reporting to identify patterns of potential or actual inappropriate utilization of services. The QI Department works closely with the UM Department, Chief Medical Officer Director of Health Care Services and Plan Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the QI and UM Departments will implement approved actions to improve appropriate utilization of services.

The California DHCS also requires submission of selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, SCFHP adheres to DHCS notification to the Plan of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

XIX. Care of Members with Complex Needs

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. Standardized mechanisms for member identification through use of data
B. Documented process to assess the needs of member population
C. Multiple avenues for referral to case management and disease management programs
D. Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
E. Ability of member to opt out
F. Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education
G. Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

H. Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
I. Coordinating services for members for appropriate levels of care and resources
J. Documenting all findings
K. Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
L. Ongoing assessment of outcomes

The Interdisciplinary Care Teams (ICT) includes three (3) levels of ICTs that reflect the health risk status of members. Each are offered an ICT. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into high, moderate and low risk levels.

The low risk members are managed by the basic ICT at the PCP level. Moderate members may be managed by the primary ICT at the Medical Group level, if delegated. High risk members are managed by the Complex ICT at the Plan level or through a delegation agreement by an NCQA Certified organization.

For high risk members, the ICT includes the member if feasible, Medical Director, PCP/specialist as necessary, Case Management Team, Behavioral Health Specialist, and Social Worker. A treating Specialist may be invited to an ICT meeting if the need is identified. The teams are designed to see that members' needs are identified and managed by an appropriately composed team. Additional disciplines, such as the Clinical Pharmacist, Dietician, and/or Long Term Care Manager, may be included in the ICT based on the member's specific needs.

Interdisciplinary Care Teams process includes:

A. Basic ICT for Low Risk Members:

1. Basic CM by PCP in collaboration with the case manager
    a. Initial Health Assessment (IHA)
    b. Initial Health Behavioral Assessment (IHEBA)
    c. Identification of appropriate providers and facilities(such as medical, rehabilitation and support services)
    d. Direct communication between provider, member and family
    e. Member and family education
    f. Coordination of carved out/linked services
    g. Referral to appropriate community resources/agencies

B. Primary ICT for Moderate Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment of Health History
4. Development of ICP
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
5. Identification of appropriate providers and facilities (such and medical, rehabilitation and support services) to meet member care needs
6. Direct communication between provider, member/family or caregiver and case manager/care coordinator
7. Member, family and/or caregiver education including healthy lifestyle changes as appropriate
8. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex ICT for High Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment and Health History
4. Basic CM Services
5. Development of Care Plan (ICP)
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
6. Management of acute/chronic illness(s)
7. Management of emotional/social support issues
    a. By multidisciplinary team
8. Intense coordination of resources
    a. Goal for member to regain optimal health or improved functioning
    b. Focused community based coordination of medical, BH and LTSS benefits and resources including IHSS, MSSP and CBAS.

D. Team Composition (As appropriate for identified needs): Member, Caregiver, or Authorized Representative, Medical Group Medical Director, Plan Clinical/Medical Group Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist
    1. Roles and responsibilities of this team
    2. Consultative for the PCP and Medical Group teams
    3. Encourages member engagement and participation in the IDT process
    4. Coordinating the management of members with complex transition needs and development of ICP
    5. Providing support for implementation of the ICP by the Medical Group
    6. Tracks and trends the activities of the IDTs
    7. Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
    8. Oversight of the activities of all transition activities at all levels of the delivery system
        a. Meets as often as needed until member's condition is stabilized.

XX. 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.

Objectives for serving a culturally and linguistically diverse membership include:

A. Analysis of significant health care disparities in clinical areas
B. Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
C. Consider outcomes of member grievances and complaints
D. Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language specific risks
E. Identify and reduce a specific health care disparity with culture and race
F. Provide information, training and tools to staff and practitioners to support culturally competent communication

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
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 Spanish staff
D. Cultural competency trainings such as:
    1. Cultural Competency Workshops
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

XXI. 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 M.D.s, D.O.s, 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 HDOs (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.

XXII. 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 02-02. 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 02-02 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.

XXIII. 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 and Promotion
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 assure 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
    1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    2. Annual blood-borne pathogen and hazardous material training
    3. Preventative maintenance contracts to promote that equipment is kept in good working order
    4. Fire, disaster, and evacuation plan, testing, and annual training
B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    1. Falls and other prevention programs
    2. Identification and corrective action implemented to address post-operative complications
    3. Sentinel events identification and appropriate investigation and remedial action
    4. Administration of Flu/Pneumonia vaccine
C. Administrative offices
    1. Fire, disaster, and evacuation plan, testing, and annual training

XXIV. 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 and Systems (CAHPS) member satisfaction survey, monitoring member complaints and direct feedback from the Member Policy Committee. The Membership Services Department is responsible for coordinating the 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. Provider Services

Member Grievances and Provider Complaints

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.

XXV. 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
    1. 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.

XXVI. 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
   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
   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:
    1. Initial Health Risk Assessment
    2. Initial Health Education
    3. 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 and Promotion
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.

XXVII. 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.

XXVIII. 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.

XXIX. 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 Board of Directors, 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

XXX. 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 Board of Directors.

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

1. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward

influencing network wide safe clinical practices
4. 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:

1. The adequacy of QI Program resources
2. The QI Committee structure
3. Amount of Practitioner participation in the QI Program, policy setting, and review process
4. Leadership involvement in the QI Program and review process
5. 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.

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	**QI Program**	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4 .7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2016 QI Evaluation and 2017 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Quality of Care	**QI Program Evaluation**	QI Program Annual Evaluation	CMC 2.16.3.3.4	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**UM Program**	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annual	September-17		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1		Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hrs 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity		97%	Provider Services Director	Quarterly	April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews New applicants processed within 180 calendar days of receipt of application		100%	Credentialing Manager	Quarterly	Feb 2017 April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews Recredentialing is processed within 36 months		100%	Credentialing Manager	Quarterly	Feb 2017 April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practioners	CMC 2.11.2.1		Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.		90%	Provider Services Director	Annual	August-17		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practioners	CMC 2.11.2.1		Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution		90%	Provider Services Director	Annual	August-17		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Medi-Cal and CMC	**Utilization Management**	CM Program Annual Evaluation			CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis		Annual Evaluation	CM Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**HEDIS Reporting**	Report HEDIS successfully by 6/15/2017	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 15, 2017 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/5/2017 - Have no Medi-Cal HEDIS measures below the NCQA Medicaid 25th percentile (MPL)	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV - complete at least one Verisk warehouse build with CMC data including drawing samples	- Submission of the IDSS to NCQA by 6/15/2017 - CMC Test warehouse	Annual Submission	HEDIS Project Manager	Annual	June-17	-	Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Statewide Collaborative Performance Improvement Projects**	Increase retinal eye exam screening for members with diabetic retinopathy	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	Five percent increase in diabetic retinal eye exam rates over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2017	37% for Network 50 by the end of the PIP Five percent increase over baseline rate of 32%	QI Project Manager	Quarterly	August-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal**	Controlling blood pressure for members with hypertension	Medi-Cal Exhibit A Attachment 4.9.C.a	4.2 percent increase in CBC rate over the 18 month life of the project	Use Member Incentive to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2017	50% for Network 10 by the end of the PIP. 4.2 percent increase over baseline rate of 45.8%	QI Project Manager	Annual	August-17		Approved by QIC: Adopted by Board:
Quality of Service	**Internal Performance Improvement Projects CMC**	The general topic for the PIP must be on improving care coordination with a focus on the integration of the long-term services and supports (LTSS) programs. The MMP may focus on one or more of the four (community based adult services, in-home supportive services, multipurpose senior services program, and nursing facilities) LTSS programs.	CMC 2.16.4.3.1.2.1	Decrease rate of potentially avoidable hospital readmission rates within 30 days of hospital discharge	- SNF's will submit hospital interfacility transfer/discharge forms when submitting prior authorizations and long term care authorizations - Members flagged for risk of re-admission by UR nurse will be monitored by weekly calls to the SNF to review plan of care	Annual Submission	By June 30th, 2017, decrease rate of potentially avoidable hospital readmissions within 30 days of hospital discharge of CMC members from all SNFs to hospitals from 22.8% to 17.8%.	QI Manager or designee	Annual	January-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Internal Performance Improvement Projects CMC**	HEDIS Measure: Reducing readmissions within 30 days of discharge (PCR)	CMC 2.16.4.3.1.2.1	Successfully submit PIP for the CMC line of business	- HEDIS test run of CMC data for barrier analysis - Collaborate within the Medical Management department to start an initial PDSA cycle	submit a first PIP resubmission to CMS for approval	- Three percent reduction in readmission rates from baseline - 9/17/14 - 10/16/15 PCRB 16.41%	QI Project Manager	Annual	October-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2016 External Accountability Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS - Reminder letters on birthday month - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 25th percentile (55.92%) - 50.36% HEDIS 2016	QI Manager or designee	Quarterly	October-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Childhood Immunization Status (CIS) – Combination 3	DHCS 2016 External Accountability Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 3	- Develop and implement interventions based on a barrier analysis for CIS Combo 3 - Televox reminder calls for non compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 3 rate over the Medicaid 50th Percentile (71.06%) - 72.02% HEDIS 2016	QI Manager or designee	Quarterly	Ongoing - Monthly		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	**Project: Diabetes**	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2016 External Accountability Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 90th percentile (91.73%) - 88.81% HEDIS 2015	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Cardiovascular Conditions**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2016 External Accountability Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (54.80%) -36.01% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Access & Availability of Care**	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - do a meta analysis of the interventions done by other Medi-Cal health plans in the region to find the most effective type of prenatal program - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (82.25%) - 79.56% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Utilization**	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (82.97%) - 74.45% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Service	**Project: 120 Initial Health Assessment**	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations - fully implement IHA work plan by 12/31/17	- Medicaid rate 100%	QI Manager or designee	Quarterly	December-17		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	NCQA Accreditation of the CMC line of business	CMC	Obtain accreditation status by CY 2018	- obtain provisional accreditation by Q3 2017	-provisional accreditation for CMC line of business	Achieve provisional accreditation	Medical Services Project Manager	Annual	October-17		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**ADA Workplan**	Development of a Work Plan and Evaluation each year and subsequent tracking of implementation	CMC	Successfully implement the ADA	ADA Work Plan will be evaluated for effectiveness on an annual basis	Fully Implement ADA work plan by 12/31/2017	Successful Implementation	QI Review Nurse	Quarterly	December-17		

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Facility Site Review**	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow/up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis		QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Quality of Care**	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQI's originating from Grievance and Appeals within 30 days Complete all PQI's from other sources in 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQI's - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	100%	QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:
CMC	**Model of Care**	- Fully implement and measure the effectiveness of the Model of Care		-establish an ongoing monitoring process of the MOC -implment interventions to improve MOC outcomes	-implement MOC work group - develop MOC work plan	-MOC work plan	100%	QI Project Manager	Ongoing	Ongoing - Quarterly		Approved by QIC: Adopted by Board:

2017 Quality Improvement Work Plan

Jeff Robertson, MD
Chief Medical Officer
Santa Clara Family Health Plan

Date

Santa Clara Family Health Plan

The Spirit of Care

2016 QUALITY IMPROVEMENT PROGRAM EVALUATION

☑ Annual Evaluation

Executive Summary:

A. CLINICAL IMPROVEMENT ACTIVITIES
NCQA 2016 Quality HEDIS Measures: (2015 Measurement Year)

HEDIS Hybrid Measure Key:

- Childhood Immunization Status – CIS (MC & HK)
- Well Child Visits in First 15 Months – W15 (HK)
- Well Child Visits 3,4,5,6 – W34 (MC & HK)
- Cervical Cancer Screening – CCS (MC)
- Timely Prenatal and Postpartum Care – PPC (MC)
- Comprehensive Diabetes Care – CDC (MC & CMC)
- Weight Assessment and Counseling –WCC (MC)
- Immunization for Adolescents – IMA (MC & HK)
- Controlling High Blood Pressure – CBP (MC & CMC)
- Adolescent Well Care Visits – AWC (HK)
- Adult BMI Assessment – ABA (CMC)
- Colorectal Cancer Screening – COL (CMC)
- Medication Reconciliation Post-Discharge – MRP (CMC)
- Care of Older Adults – COA (CMC)

HEDIS Administrative Measure Key:

- Chlamydia Screening – CHL (HK)
- All Cause Readmission – ACR (MC) / PCR (CMC)
- Ambulatory Care – AMB (MC)
- Cervical Cancer Screening – CCS (MC)
- Use of Imaging Studies for Low Back Pain –LBP (MC)
- Appropriate Treatment for Children w/ Upper Respiratory Infection – URI (HK)
- Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis – AAB (MC)
- Appropriate Testing for Children w/ Pharyngitis – CWP (HK)
- Use of Appropriate Medication for People w/ Asthma – ASM (HK)
- Children's & Adolescent's Access to PCPs – CAP (MC & HK)
- Annual Monitoring for Patients on Persistent Medication – MPM (MC)
- Annual Dental Visit – ADV (HK)
- Medication Management for People with Asthma – MMA (MC)
- Follow-Up After Hospitalization for Mental Illness – FUH (CMC)

A.1 Goal:

- Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL) ALL Medi-Cal HEDIS Measures.
- Develop and implement interventions for MMCD Auto-Assignment Measures and for CMS Quality Withhold Measures.
- Increase administrative (claims and encounter) data submissions across Networks.

A.2. Interventions:

- Collect and report Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) rates for ALL Product Lines within specified timeframe
- Tested distribution of non-compliant lists for CCS and CDC – HbA1c Testing in Q4 to targeted PCP offices
- Developed member incentives to support CDC – Retinal Eye Exam, Controlling High Blood Pressure, and Cervical Cancer Improvement Projects
- Facility Site Review Nurse performed on site visits to provider offices regarding accurate coding, preventive well visit schedules, and BMI documentation.
- Facility Site Review Nurse educated providers to follow AAP / SCFHP recommended annual Well-Care Visits and immunization schedule and AGOG recommended Cervical Cancer Screenings
- HEDIS results and analysis presented to:
  - SCFHP Board of Directors & SCFHP Quality Improvement Committee,
- Quality Improvement Activities:

- Continued immunization reminder postcards to parents with children at 17 months of age to receive recommended immunizations.
- Education in Quarterly Member Newsletters, for immunizations, well child visits, diabetic care, prenatal and postpartum care and dental care.

A.3. Results:

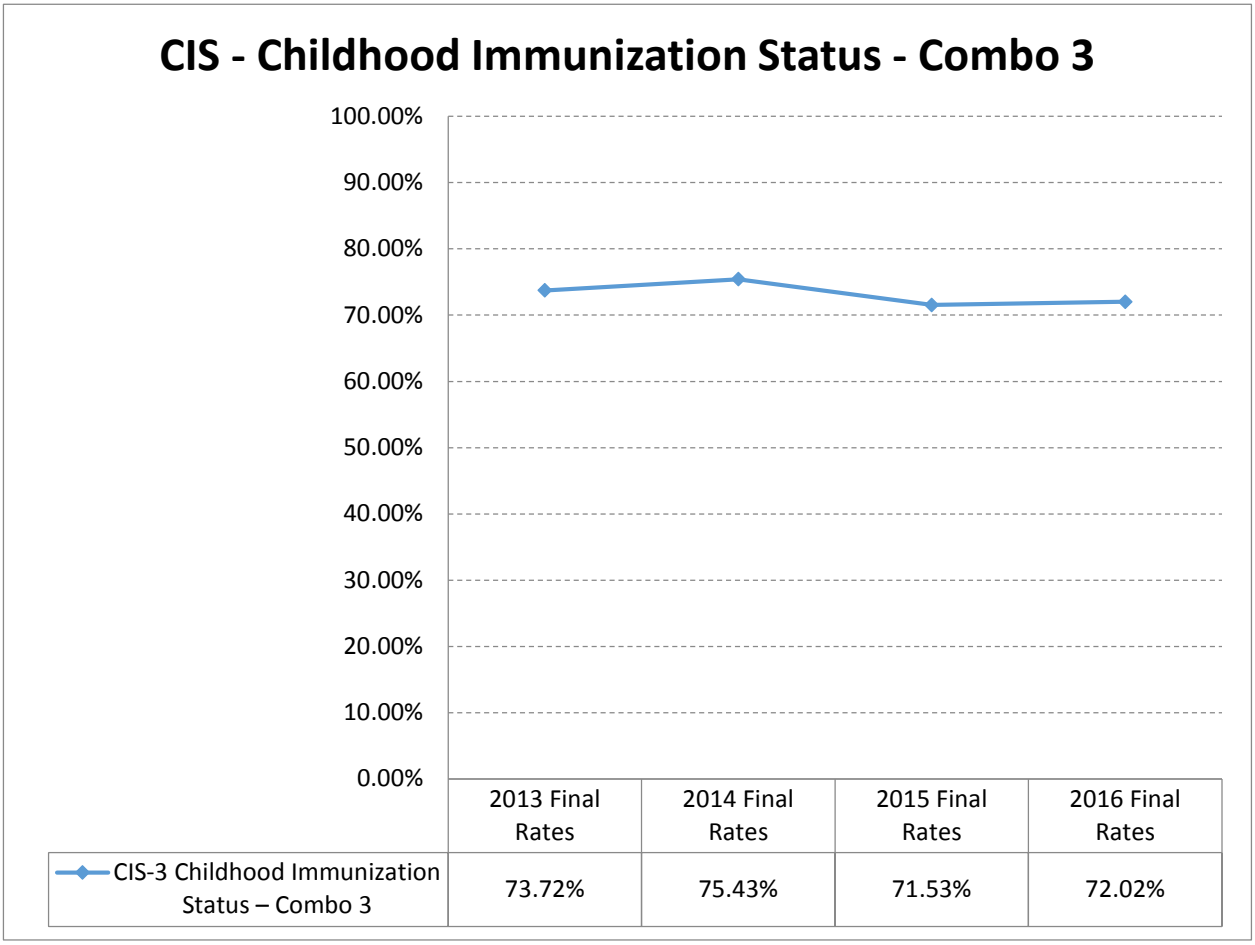
- Exceeded MMCD Minimum Performance Level (MPL) for all measures except Controlling High Blood Pressure, Comprehensive Diabetes Care – Blood Pressure Control and Cervical Cancer Screening.
- Three Medi-Cal measures exceeded the HPL, Comprehensive Diabetes Care—HbA1c Control (<8%), Medication Management for People with Asthma Medication Compliance 50% Total, Medication Management for People with Asthma Medication Compliance 42% Total.
- Medi-Cal measures that have improved significantly (>5%) from the prior year; Comprehensive Diabetes Care – HbA1c Poor Control, Medication Management for People with Asthma Medication Compliance 50% Total, Medication Management for People with Asthma Medication Compliance 42% Total.
- Medi-Cal measures that decreased significantly (>5%); Cervical Cancer Screening, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity, Use of Imaging Studies for Low Back Pain, Controlling High Blood Pressure, Comprehensive Diabetes Care – Blood Pressure Control, Annual Monitoring of Patients on Persistent Medications – Digoxin.
- 2016 was the first year reporting CMC HEDIS measures. The late start to HEDIS medical record retrieval that impacted the Medi-Cal blood pressure rates also negatively impacted the CMC blood pressure rates, resulting in the CBP measure being non-reportable. There are no MPL's for the CMC line of business.

A.4. Analysis of Findings/Barriers/Progress

- Due to Administrative Data Volume being flat, continued chart abstraction and Pinpoint chart chase logic is necessary to improve key measures.
- A Provider/Network dashboard for each measure is necessary to define further provider interventions.
- HEDIS Member outreach and incentives is important to increase key measures.
- Providers / Networks continue to require assistance for data issue improvements:
  - Provider Address discrepancies
  - Coding issues
  - Timely data submission

Immunization Measures Findings

CIS – Childhood Immunization Status (Combo 3) (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CIS-3 Childhood Immunization Status – Combo 3	73.72%	75.43%	71.53%	72.02%

Analysis and Findings/Barriers/Progress

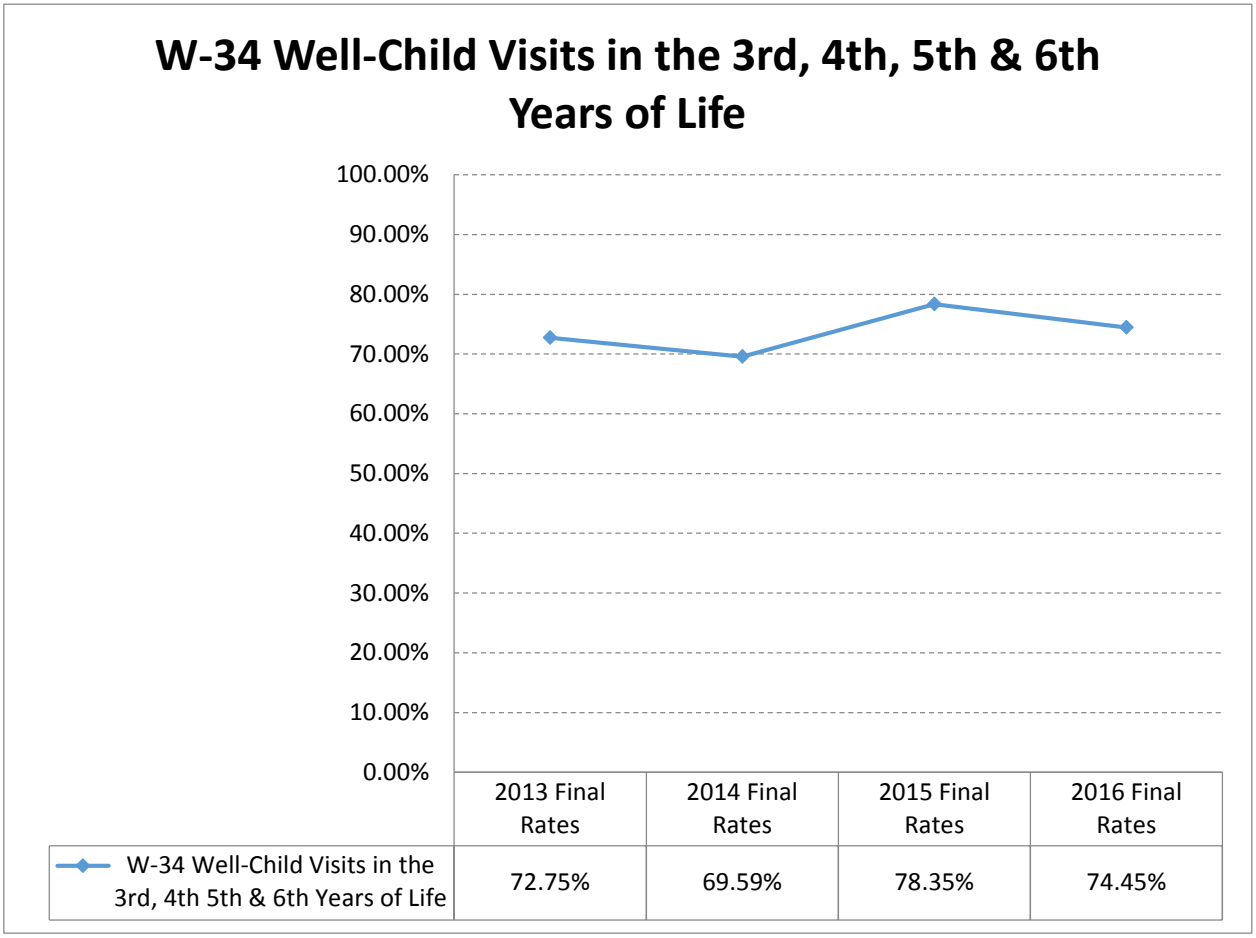
- Above the MPL of 66.19% and remains below the HPL of 81.25%.
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2.

Follow up/Actions:

- Focus ideas on new interventions in 2016 (HEDIS 2017) for providers on immunization schedule.
- Focus ideas on new interventions in 2016 for member outreach and incentives.
- Continue to utilize CAIR for missing immunization status in claims and/or PCP medical record.
- Mine CAIR for additional numerator events that were not matched from the HEDIS extract.

Well Child Visits Key Findings

W34 – Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	72.75%	69.59%	78.35%	74.45%

Analysis and Findings/Barriers/Progress

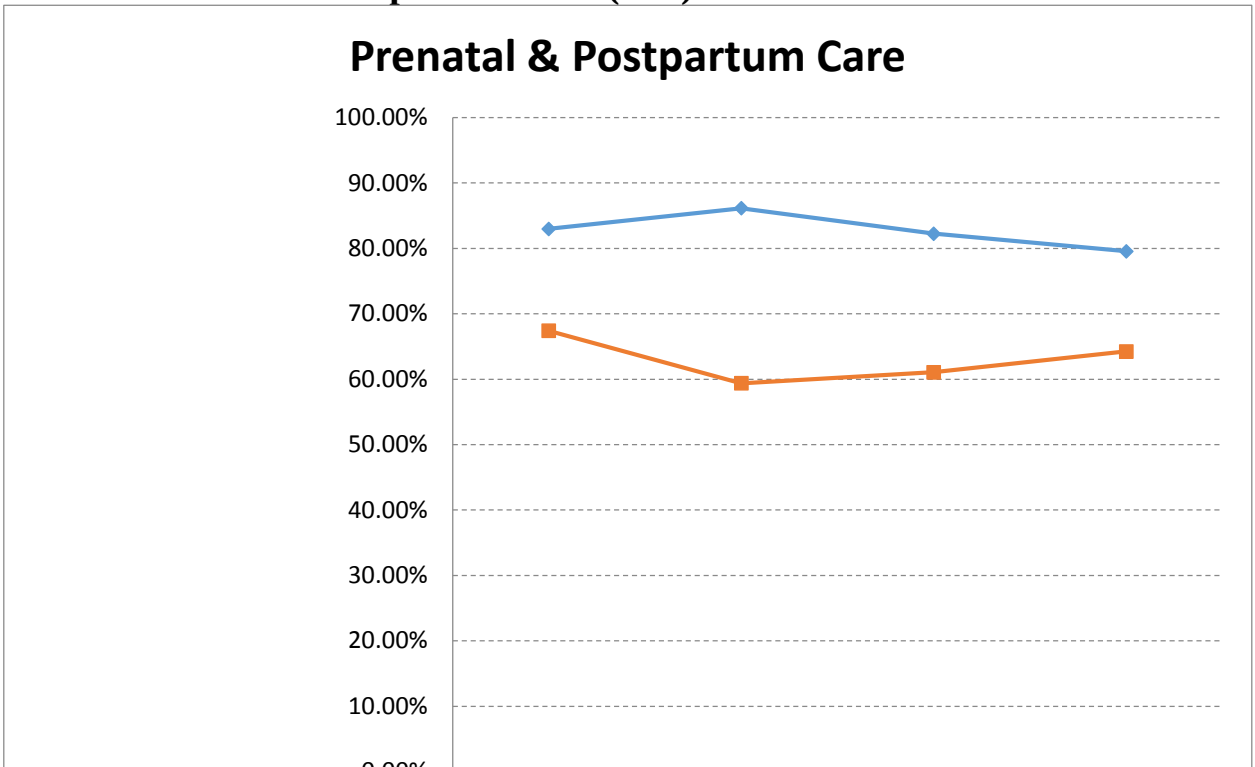
- Above the MPL of 65.54% and remains below the HPL of 83.75%.
- 2016 rate dropped by 4% from HEDIS 2015.

Follow up/Actions:

- Focus ideas on new interventions in 2016 for member outreach with incentives.
- Focus ideas on new interventions in 2016 for Providers on well child visit schedule.
- Pinpoint chart chases for this measure for 2016 data.

Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
PPC-Pre Timeliness of Prenatal Care	82.97%	86.13%	82.24%	79.56%
PPC-Pst Postpartum Care	67.40%	59.37%	61.07%	64.23%

Analysis and Findings/Barriers/Progress

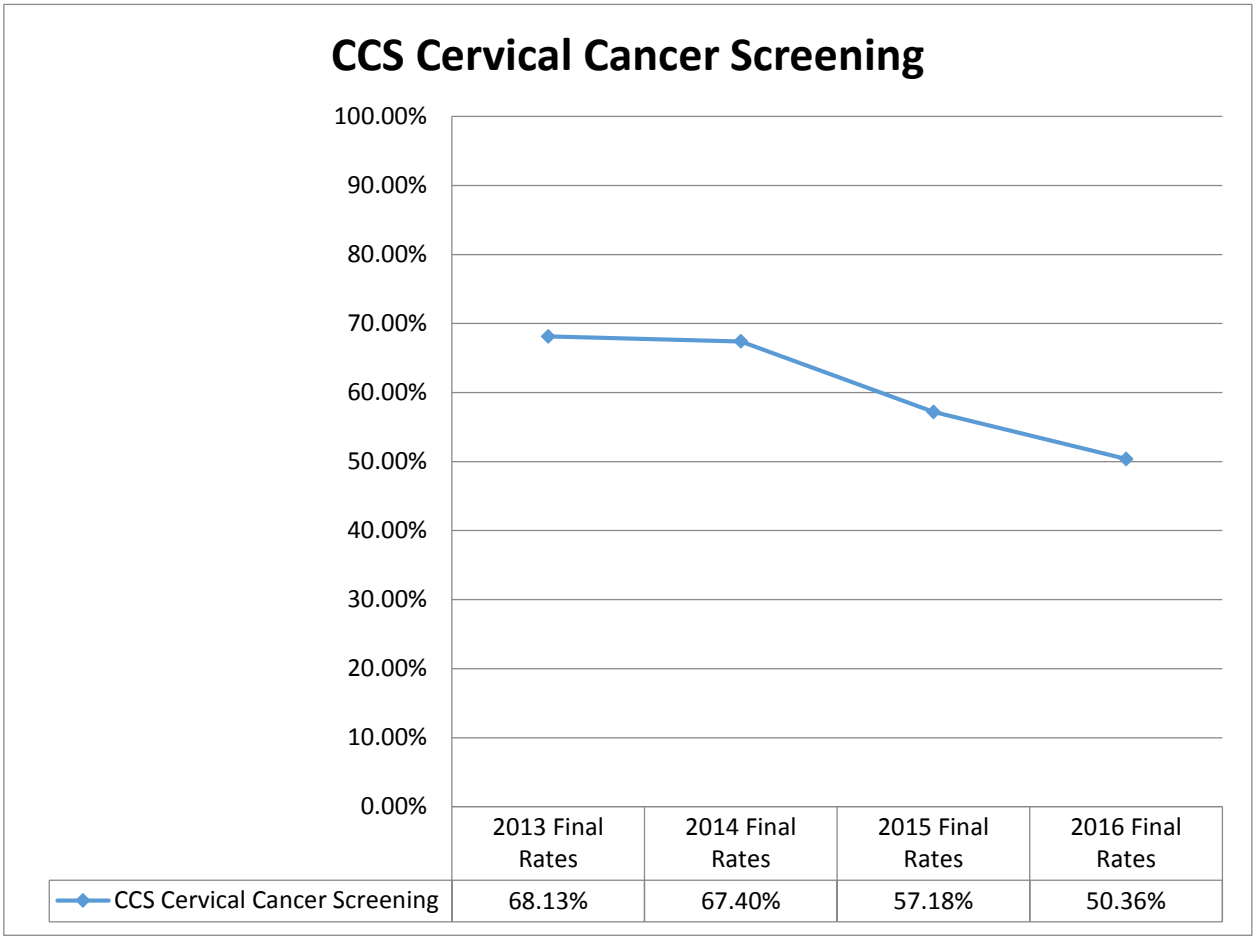
- Above the MPL's and remains below the HPL's of both indicators.
- For Postpartum visits, rate increased by 3%.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2016 data.

Adult Measures: Cervical Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CCS Cervical Cancer Screening	68.13%	67.40%	57.18%	50.36%

Analysis and Findings/Barriers/Progress

- Measure is below MPL of 54.33% but below HPL of 73.08%.
- Decrease in rate is attributed to members not going to see their primary care physicians for screenings.
- As a result of the final compliance rate being below the MPL, the plan had to institute a Improvement Plan.

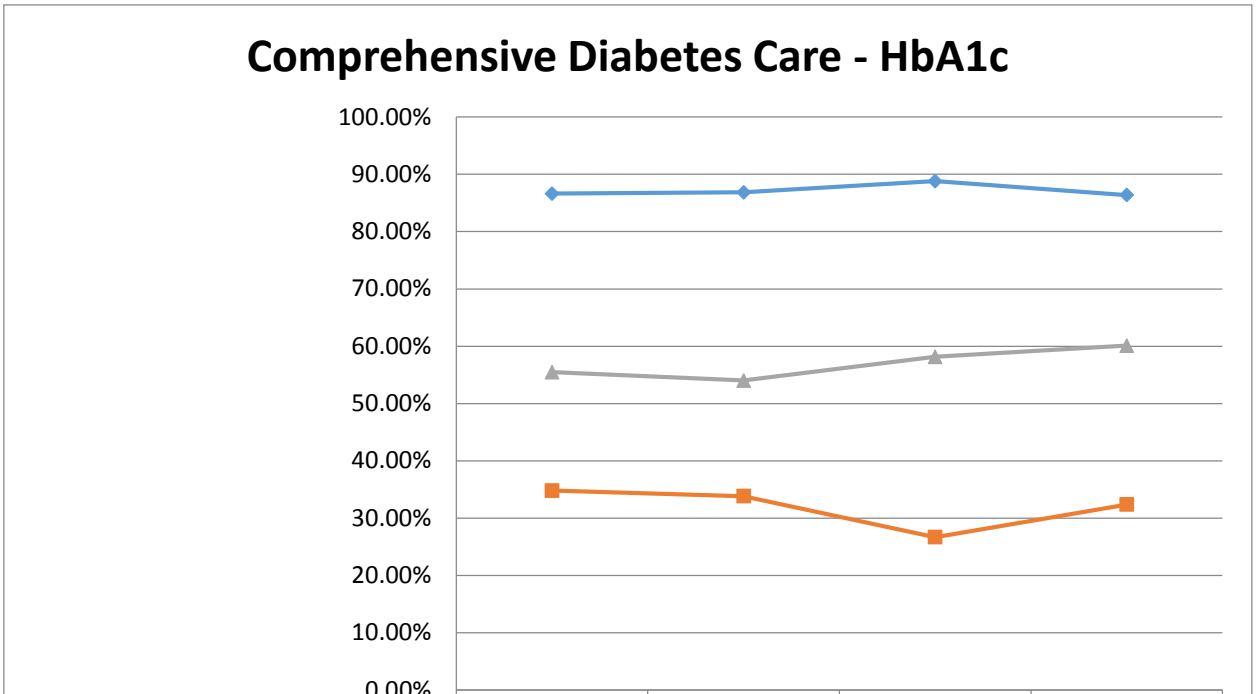
Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders.
- Pinpoint chart chases for this measure for 2016 data.
- The plan implemented a member incentive of a $15 Target gift card.

The plan partnered with a clinic to do a rapid cycle improvement where there was data exchanged every two weeks during the intervention period.

Chronic Care/Disease Management Measures: Comprehensive Diabetes Care (CDC)

CDC – Comprehensive Diabetes Care (MC) HbA1c



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CDC-HT HbA1c Testing	86.62%	86.86%	88.81%	86.37%
CDC-H9 HbA1c Poor Control (>9.0%)	34.79%	33.82%	26.68%	32.36%
CDC-H8 HbA1c Control (<8.0%)	55.47%	54.01%	58.15%	60.10%

Analysis and Findings/Barriers/Progress

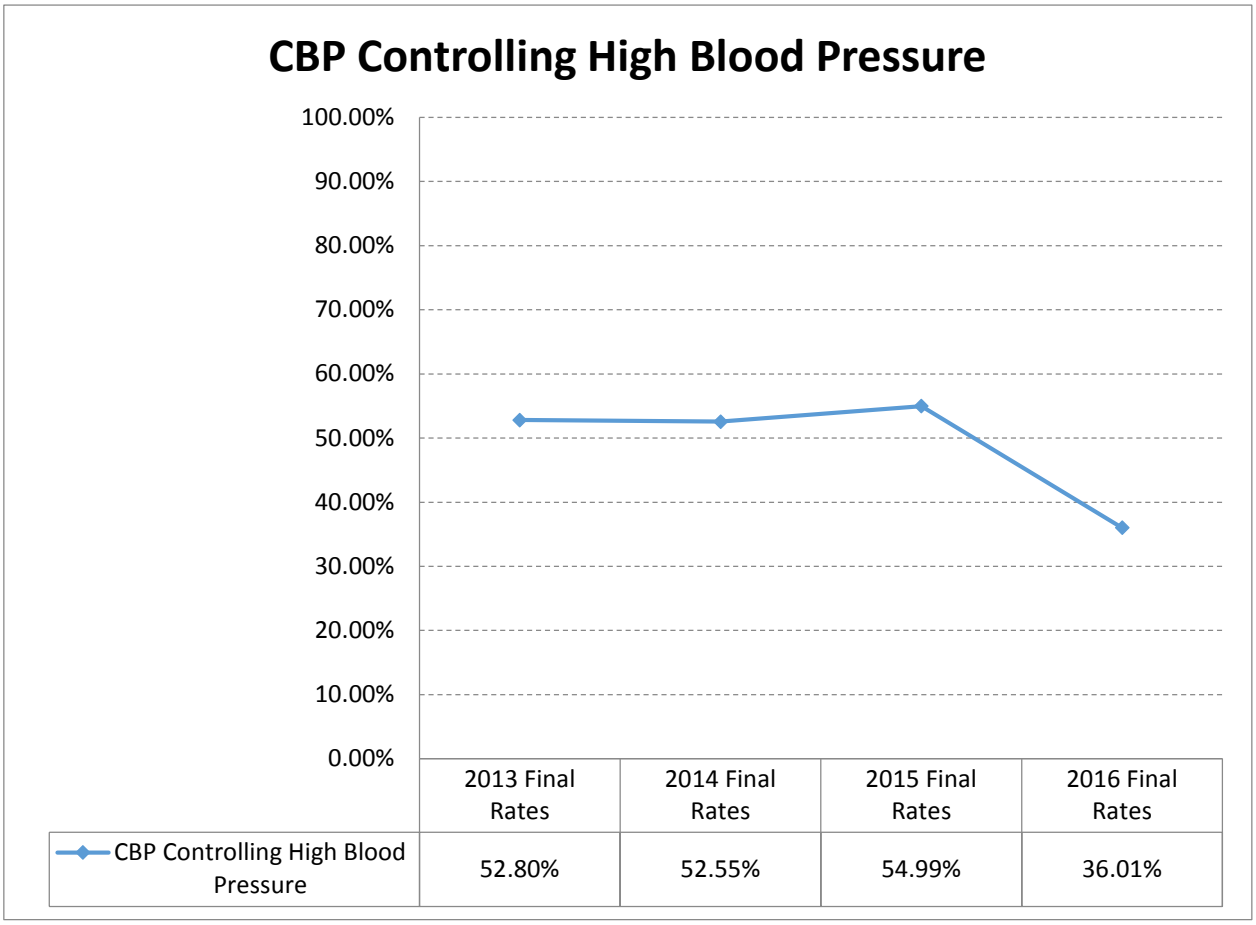
- Above the MPL for all the CDC HbA1c indicators.
- Rate increased a little over 5% for HbA1c Poor Control, lower rate is better.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2016 data.

Chronic Care/Disease Management Measures CBP - Controlling High Blood Pressure (MC)

CBP - Controlling High Blood Pressure (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CBP Controlling High Blood Pressure	52.80%	52.55%	54.99%	36.01%

Analysis and Findings/Barriers/Progress

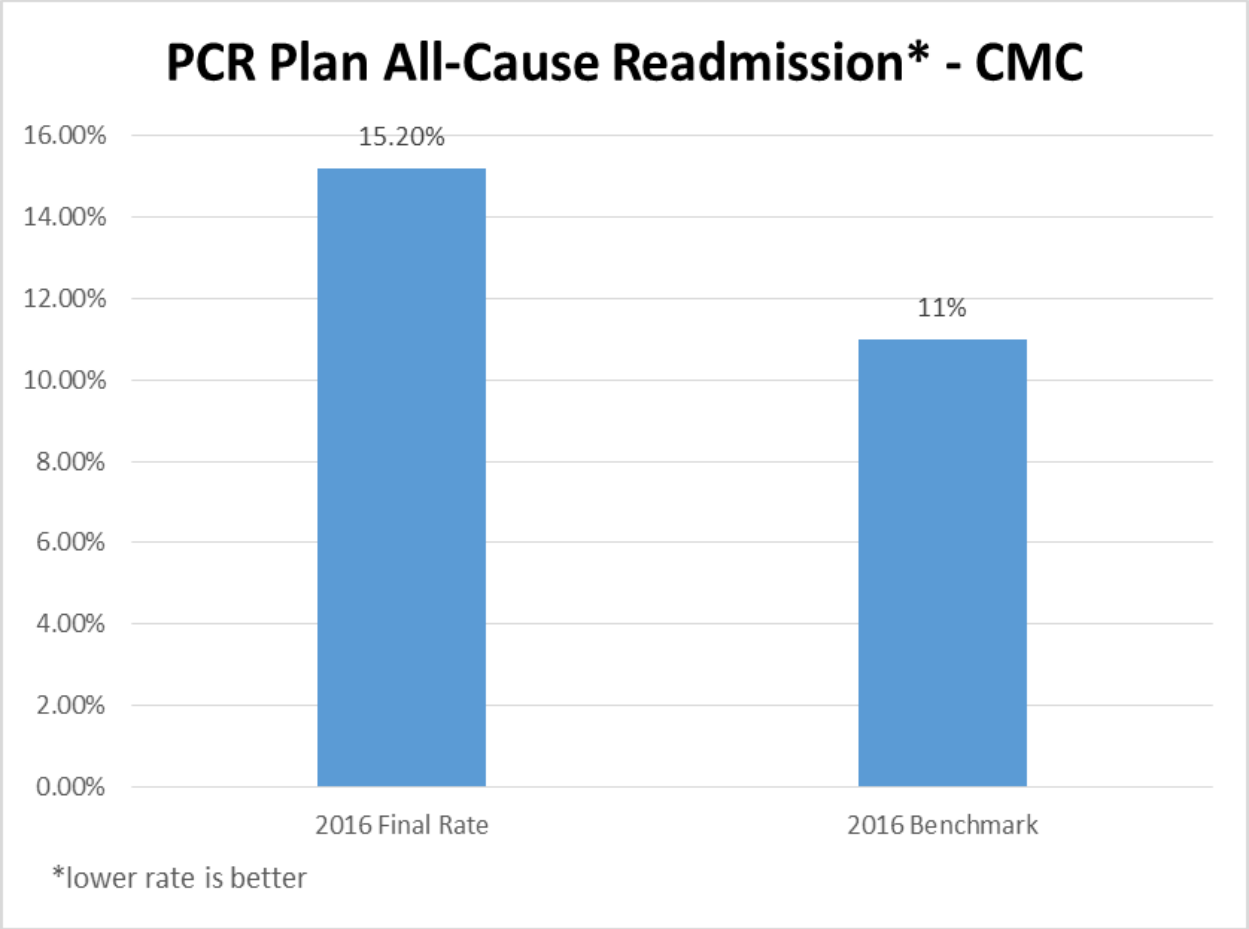
- Blood Pressure Control is below the MPL of 43.55%.
- Rates decreased due to delay in medical record review process.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- MMCD/DHCS mandated Improvement Plan:
  - Combined Improvement Plan with Performance Improvement Project. The project offered a $15 gift card for members who discussed hypertension with their PCP. The incentive form had to be signed by the PCP.

Quality Withhold Measure: Plan All-Cause Readmission

PCR – Plan All-Cause Readmission – (CMC)



Analysis and Findings/Barriers/Progress

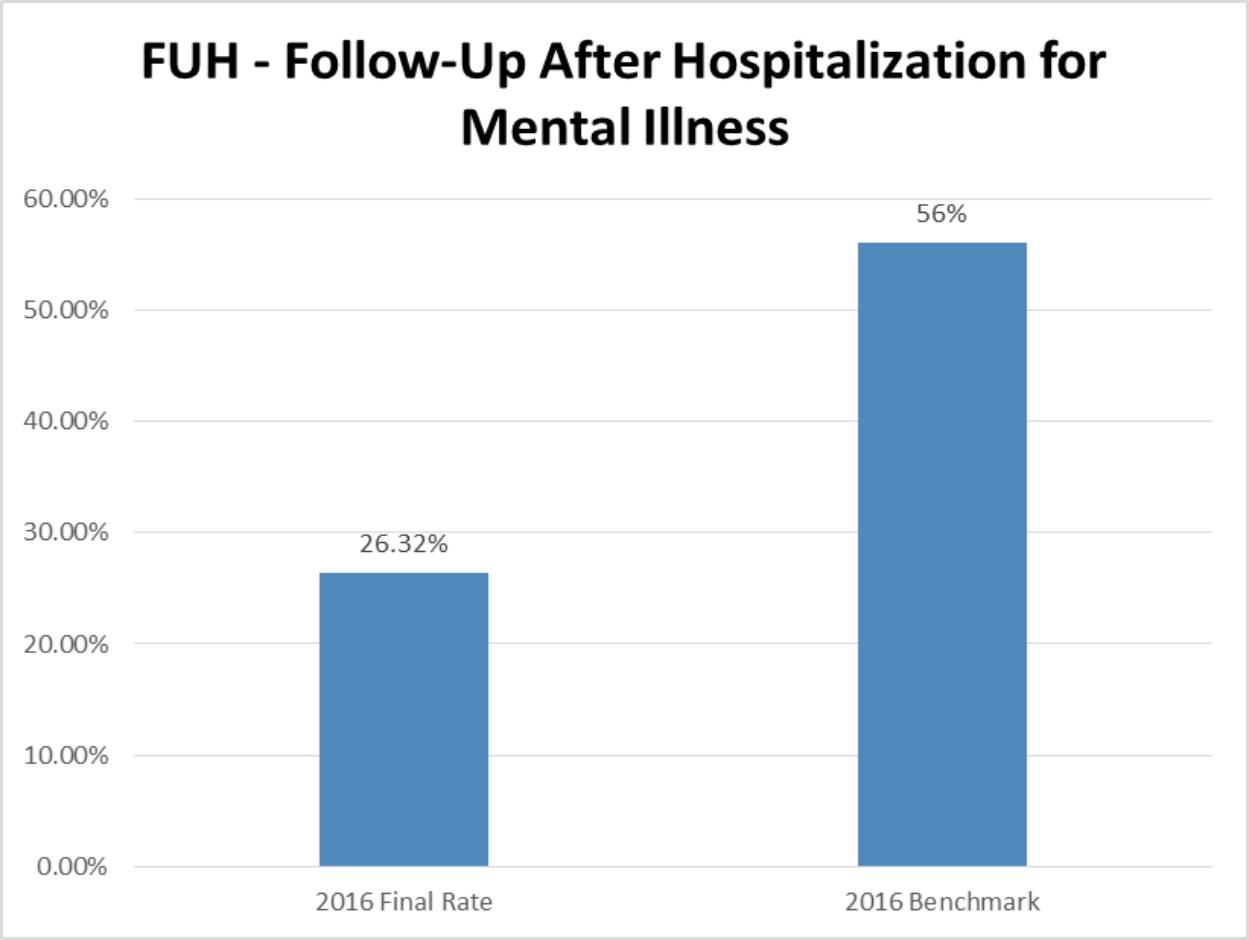
- Measure is higher than the 2016 benchmark, a lower rate is better.

Follow up/Actions:

- Focus on case management processes and follow up with members with transition discharge telephone calls.

Quality Withhold Measure: Follow-Up After Hospitalization for Mental Illness

FUH – Follow-Up After Hospitalization for Mental Illness – (CMC)



Analysis and Findings/Barriers/Progress

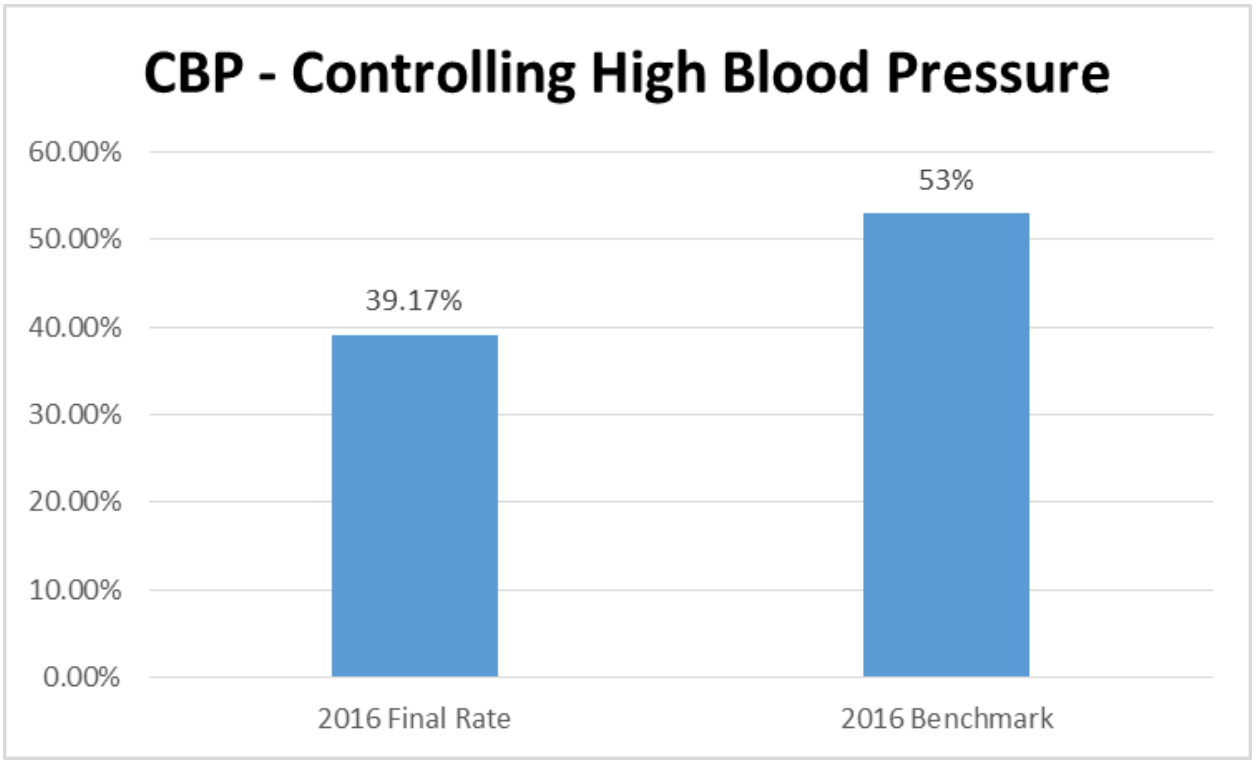
- Measure is below the 2016 benchmark.

Follow up/Actions:

- Monitor and collaborate with Behavioral Health delegates to ensure members obtain follow-up appointment after hospitalization for mental illness.

Quality Withhold Measure: Controlling High Blood Pressure

CBP – Controlling High Blood Pressure – (CMC)



Analysis and Findings/Barriers/Progress

- Measure is below 2016 benchmark.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.

B. Clinical Improvement Activities
External and Internal QIP's (2016 Measurement Year)

All Cause Readmissions CMS Quality Improvement Project –

B.1 Goal: To decrease readmission rates for any reason to below 11% by the end of 2018.

B.2 Intervention: Contact 90% of members within 72 hours of discharge from Regional Medical Center, to conduct a transition of care discharge call.

B.3 Design

This three year QIP began in January of 2016 and will continue until December of 2018. Case Managers use a daily census report from Regional Medical Center to identify all discharged members. The Case Manager makes three attempts to contact the member within 72 hours of discharge to conduct a successful transition of care discharge call that helps prevent a readmission to the hospital within 30 days of discharge.

Diabetes Retinopathy Eye Exam–DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the rate of diabetic eye exams among Medi-Cal Type 1 and Type 2 diabetic members aged 18 to 75 who reside in Santa Clara County, who have a Physicians Medical Group(PMG)/Network 50 Primary Care Provider and had a retinopathy diagnosis in the previous rolling 12 month period from 44.89% to 49.89%.

B.2 Intervention: Promote a reminder flyer and incentive for eligible PMG members for completing annual eye exam

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. On a monthly basis, a list of eligible members is generated to identify those that have not completed a diabetic retinopathy eye exam. The members are mailed a Health Education flyer with a reminder to complete a diabetic eye exam. Members are informed that if they submit proof \of a completed eye exam to Health Education they will receive a $15 Target gift card.

Controlling Blood Pressure -DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the percentage rate of Network 10 members aged 18-85, with a diagnosis of hypertension, whose blood pressure is adequately controlled, during the previous rolling 12 months from 45.8% to 50%.

B.2 Interventions: Promote a reminder and incentive for eligible Network 10 members for completing a blood pressure check.

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. On a monthly basis, a list of eligible members is generated to identify those that have not completed an annual blood pressure exam. The members are mailed a Health Education flyer with a reminder to complete a blood pressure exam. Members are informed that if they submit proof \of a completed blood pressure exam to Health Education they will receive a $15 Target gift card.

Decreasing Potentially Avoidable Readmissions –LTSS Performance Improvement Project(PIP)

B.1 Goal: By June 30th, 2017, decrease rate of potentially avoidable hospital readmissions within 30 days of hospital discharge of CMC members from all SNFs to hospitals from 22.8% to 17.8%.

B.2 Interventions: SNF community partners will submit 100% of member, hospital interfacility transfer forms (IFTFs) to SCFHP for review.

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. IFTF forms will be reviewed by SCFHP and appropriate level of care coordination will be provided by SCFHP to insure follow up care goals are met. This in turn will decrease potentially avoidable readmissions.

C. Initial Health Assessment (IHA)

C.1 Goal:
To ensure all SCFHP members completes a Stay Healthy Assessment (SHA) in accordance with the timeframes appropriate by age and that documentation is evidenced in their medical record

C.2 Interventions:
- SCFHP provides information on IHA to the members and providers annually in the Member Newsletter
- SCFHP continues to promote provider education on the IHA with its delegate and independent network providers
- Plan updated it's IHA specifications to align with the methodology of other health plans in the geographic area
- Plan runs IHA compliance reports on a quarterly basis

C.3 Results:
- Plan's IHA compliance rate increased slightly over the previous methodology.

C.4 Analysis of Findings/Barriers/Progress

- QI Nurse will audit medical records based on the new methodology to determine validity of the methodology

D. Patient Safety: Facility Site / Medical Record Review

D.1 Goal:

All contracted SCFHP PCP's receive a Facility Site Review Part A, B and C every three years. All newly contracted SCFHP PCP's complete and pass Facility Site Review Part A and C

D.2 Intervention:

- Complete FSR/MRR Review on all PCP sites that were due for a three year review.
- Complete FSR review for all newly contracted sites.
- Transition Part C reviews from Provider Services to Quality Nurse.
- Continue to Collaborate with Anthem Blue Cross.
- Review and update Medical Record Standards

D.3 Results:

- 52 PCP sites completed FSR reviews
- 51 MRRs completed
- Five Initial FSRs completed
- Two Collaboration meetings held with Anthem Blue Cross to share data.
- 51 FSR Part C reviews completed.

D.4 Analysis of Findings/Barriers/Progress

- 34 FSR Corrective Action Plans (CAPs) issued, monitored and validated. 30 CAPs closed (remainder issued have closure dates in 2017).
- 43 MRR CAPs issued, monitored and validated. 40 CAPs closed (remainder issued have closure dates in 2017).

E. Potential Quality of Care Issues Summary

E.1 Goal:

To increase awareness of the PQI process within the health plan.

E.2 Intervention:

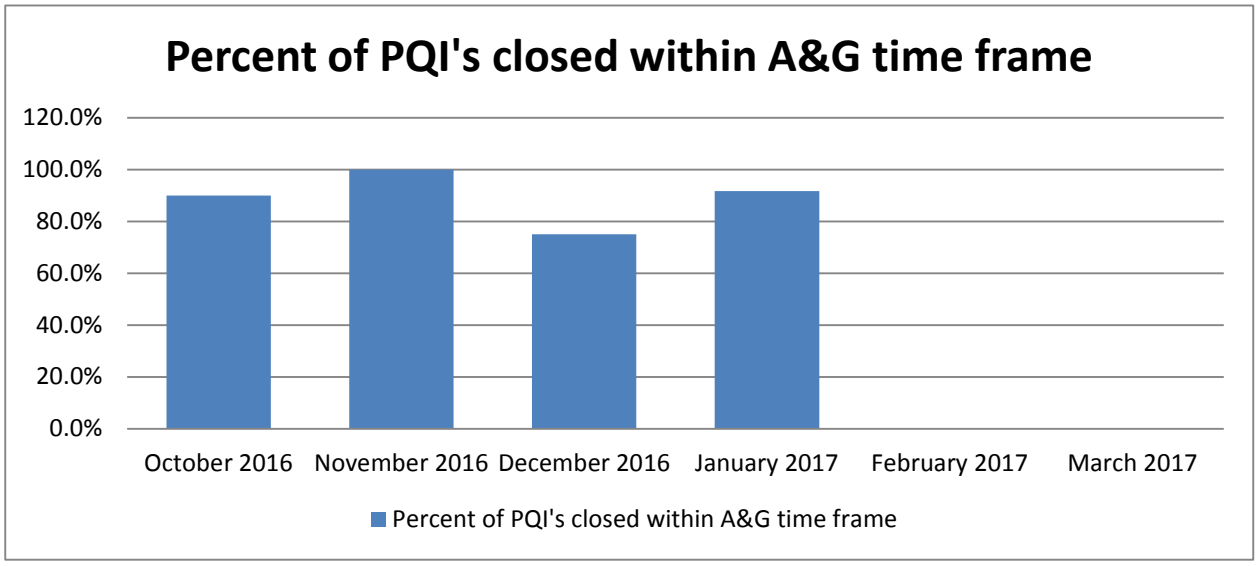
- Continue to monitor/track and trend member grievances for analysis of issues and correlation with other reports for identification of areas requiring improvement activities
- Continue to submit quarterly member grievances to the QIC for review and appropriate action related to access of care, quality of care, and denial of services
- Continue to monitor/track and trend PQI for identification of quality of care and systems issues.
- Continue to submit quarterly PQI report to QIC for review and appropriate action.

E.3 Results:

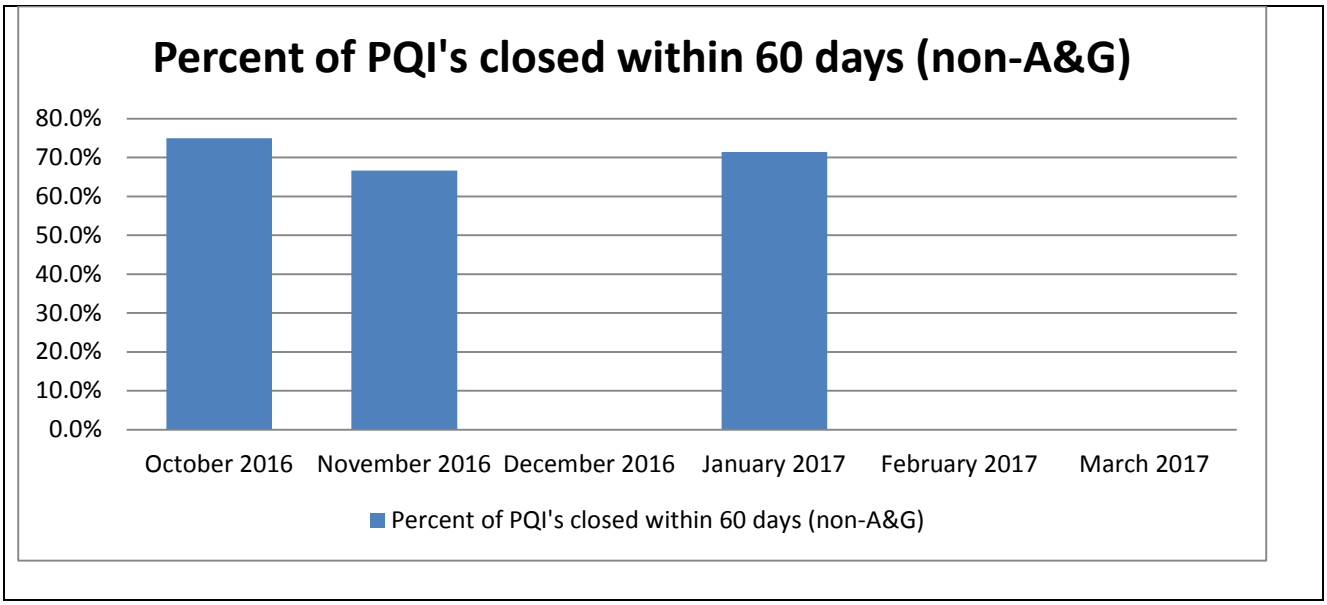
- 104 PQI's reported in 2016
- 72 were Level 1 – No Quality of Care Issue
- 29 were Level 2 - Improvement Needed
- Three were Level 3 – Unacceptable Quality of Care

E.4 Analysis of Findings/Barriers/Progress

- Reports need to go to QIC every quarter.



2016 QUALITY IMPROVEMENT PROGRAM EVALUATION
☑ Annual Evaluation



Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attachment 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services		Continuous	
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	- P&P's for health education system -List of health ed classes that cover all required health ed topic areas. -Provider/Vendor Contracts/MOU's	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	-P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator		Continuous	
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using SMOG, etc., -Field test material at CAC meetings	- P&P's that define appropriate reading levels -Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)	100%			Continuous	
	Health Ed		pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	-Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions -alcohol and drug use, including avoiding at risk drinking -Identifying depressive symptoms	- contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities	Baseline	Health Educator		Continuous	

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator, and Cultural and Linguistics		Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually		
Provider Training	Health Ed	Practitioner Education and Training	DHS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training by provider services -Health ed updates during JOC's	- sign in sheet of provider training -JOC minutes	All providers trained	Health Educator, Provider Services, QI		Continuous	
Incentives	Health Ed	MMCD on-going monitoring activities	MMCD PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	-Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation/update summary	Health Educator	30 days after end of program incentive	Continuous	
Incentives	Health Ed	-Justify continuation of on-going incentive program	MMCD PL 12-002	Justify continuation of MI program	-Provide brief explanation(update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submission to MMCD	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Website	Health Ed and C&L	Health Ed and member informing resources on SCFP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	Member newsletters Translated Health Ed referral forms on website Feb. '17
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	
Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	-Develop an evaluation tool/survey	-Evaluation results summary	Baseline	Health Educator	Every 36 months		
Health Education		Review plan's online web-based self-management tools.	NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	To ensure online web-based self-management tools are up to date	-Review and update online web-based self-management tools including the plan website and portal	-Updated web-based self-management tools	Baseline	Health Educator		Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services		-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI and Health Educator			
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	-Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	-Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator			

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Quality of Services	Access and Availability	Create Health Ed Work plan	pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002		-Incorporate GNA findings and annual and ongoing review of data into work plan -Approval of Health Ed Workplan by QI Committee -Submit Health Ed Workplan to MMCDHealthEducationmailbox@dhcs.ca.gov	-Approved Health Ed Workplan	Baseline	QI Manager and Health Educator	Annually	July '17	
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, APL 17-002	-Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from GNA findings.	-CAC Meeting minutes -Report GNA findings to CAC	Baseline	QI, Health Educator, and Marketing		Continuous	

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Services for Adults	Exhibit A, Attachment 10 Scope of Services Exhibit A Attachment 11 Case Management and Coordination of Care Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure IHA for adult members is performed within 120 calendar days of enrollment -Ensure performance of initial complete history and physical exam for adults to include health education behavioral risk assessment and member and family education.	For 2017, Stand alone project: See IHA work plan provider training -FSR (every 3 yrs)	-P&P for administration of a disease management program ~~-P&P for case management coordination of care of LEA (local education agencies)services~~	Baseline	QI and Health Educator		Continuous	Sept.'16 Policy QI.09 & QI.10
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attachment 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	-Provider Training and FSR results	Baseline	QI, Health Educator and Provider Services		Continuous	Risk Assessment tool implemented in 2016
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	-List of health ed classes that cover all required health ed topic areas.		Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	Policy QI.09 & Procedure QI.09.01 Health Ed referral form Health Ed page and referral form on SCFHP website
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	-Health Education Program	Organized delivery of health ed program	Health Educator		Continuous	Policy QI.09 & Procedure QI.09.01 Ongoing search for classes/materials in threshold languages Class audits
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using SMOG, etc, -Field test material at CAC meetings	-Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)				Continuous	Readability & Suitability checklists: no field testing needed for '16

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
	Health Ed			-Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions		-Health Ed courses/activities	Baseline	Health Educator		Continuous	CCS MI incentive DEE MI incentive Health Ed Classes April '16
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing and Health Educator		Continuous	EOB
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	-Inform members in writing of their rights annually	-Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.		Marketing, Health Educator	Annually		June '16
Provider Training	Health Ed	Practitioner Education and Training	DHS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training	-Certification log of provider training -JOC meeting minutes of health ed updates	All providers trained	Health Educator, Provider Services, QI		Continuous	Ongoing Certification of Training logs by provider services JOC health ed updates

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Incentives	Health Ed	MMCD on-going monitoring activities	MMCD PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	-Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation summary	Health Educator	30 days after end of program incentive	Continuous	CCS MI eval summary submitted Childhood obesity/nutrition MI eval summary submitted DEE MI eval summary submitted Postpartum MI eval summary submitted
Incentives	Health Ed	-Justify continuation of on-going incentive program	MMCD PL 12-002	-Justify continuation of MI program	-Provide brief explanation(updat e) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submitted to MMCD	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	N/A Update not due yet until '17.
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	-Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	Ongoing member newsletters

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	-Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	N/A No previous materials or current materials approved by health educator using Readability and suitability checklist
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services		-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers ~~-Submit P&P for application and use of Health Information Form (HIF) data submitted thru the Member Evaluation Tool (MET)~~		QI & Health Educator		Jun-16	Policy QI.10 IHA and HEBA Assessments Policy and Procedure Health Ed Referral form on provider tab on SCFHP website August '16
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	-Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	-Written information in Evidence of Coverage		Marketing, Health Educator			Evidence of Coverage June '16
Quality of Services	Access and Availability	Conduct group needs assessment to identify health education and cultural and linguistic needs	pg. 61 Exhibit A, Attachment 9 Access and Availability, DHCS APL Policy Letter 10-012		-Conduct GNA	-GNA Summary Report submitted to DHCS within 6 mos of completion of each GNA -Annual GNA update electronically submitted every yr on October 15th, except in yrs when full GNA report is completed and executive summary submitted to MMCD. -Electronically submit an Executive Summary of GNA Report every yrs	Every 5 yrs perform GNA Update Annual update GNA summary report	QI Manager and Health Educator	Every 5 yrs & Annual update	October 15th, 2016	Policy QI.09 & Procedure QI.09.01 GNA report completed and submitted to MMCD October '16

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01	-Form a Community Advisory Committee pursuant to Title 22 CCR Section 53876 (c)(CAC) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues affecting groups who speak a primary language other than English.	-Meeting minutes -Record of plan members on CAC		QI and Health Educator, Marketing		Continuous	

Santa Clara
Family Health Plan
The Spirit of Care

SCFHP Americans with Disabilities Act Workplan.

SCFHP maintains a robust Americans with Disabilities Act (ADA) Workplan. The plan is comprised of different metrics measuring patient safety, access, health education, grievance monitoring, and delivery of preventive care

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Workplan	ADA Workplan is reviewed and evaluated on an annual basis	Annual			
Responsible Party	Identify responsible individual for ADA Compliance	Annual			
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	Q1 2017-4 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	Q1 2017-4 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: CBAS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: LTSS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: Nursing Home	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Access	Number of referrals to: IHSS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of IHSS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of Nursing Home sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	Q4 2017		
Preventive Care	Medication Reconciliation Post-Discharge	Annual	Q4 2017		
Group Needs Assessment - Full	Group Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Every Five Years	CY 2021		
Group Needs Assessment - Annual Update	Group Needs Assessment Annual Update shared at: Consumer Advisory Committee Quality Improvement Committee	Annual	CY 2017		
Health Education	Plan monitors health education referrals for CMC members: Number of referrals from members who are also in CBAS, LTSS, IHSS or Nursing Homes	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		methodology still in development
Group Needs Assessment - Full	Group Needs Assessment Report will analyze results to understand underlying causes of barriers to health care access.	Every Five Years	CY 2021		
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual			

OPTUM™	**Optum™** **Policy and Procedure** **CM: Care Plans and Goals**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-010
	Original Issue Date: 11/15/2007
	Committee Approval Date: 6/14/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 6/14/2016

This Policy Applies To:					
☐ **All Staff**	☒ Clinical Operations ☐ Enrollment Services ☐ Health Solutions	☐ Marketing/Sales/Client Services ☐ Medical Affairs ☐ Technology	☐ Other		
☐ **All Programs**					
☐ **All Disease Management**	☐ Asthma ☐ HF	☐CAD ☐ Maternity	☐ COPD ☐ MSP	☐ Depression ☐ Other	☐Diabetes
☒ **All Case Management**	☐ Complex	☐ Maternity	☐ NICU	☐ Oncology	☐ Other
☐ **All Utilization Management**	☐ NICU	☐ Oncology	☐ Other		
☐ **Nurse 24**					
☐ **BioPharma**					
☐ **Wellness**	☐ Wellness Portal	☐ Health Coaching			
☐ **Maternity Home Care**					
☒ **Accreditation/Regulatory**	☒ NCQA	☒ URAC	☐ Joint Commission	☐ Regulatory	

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
1/7/2014	CM-010 CM: Care Plans and Goals
6/18/2014	CM-010 CM: Care Plans and Goals
6/3/2015	CM-010 CM: Care Plans and Goals
12/11/2015	CM-010 CM: Care Plans and Goals
6/14/2016	CM-010 CM: Care Plans and Goals

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	6/10/2016
Susan Garcia	VP Case Management and Triage	6/9/2016
Diane Orlando	VP Clinical Affairs	6/14/2016

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

POLICY STATEMENT:

The purpose of this policy is to outline the process for case managers to develop and prioritize case management care plans and goals.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Case Management	A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes.
Case Manager	A healthcare professional designated as the case manager with such appropriate background and specialty, such as registered nurse, social worker, physician, rehabilitation counselor, etc.
Long-Term Goals	Section of the individualized case management plan that aims to achieve sustaining health improvement or optimal health status specific to the program participant and may include anticipated case results and/or criteria for case closure.
Program Participant	An individual who is enrolled in any activities or services provided by an Alere Health program.
Short-Term Goals	Section of the individualized case management plan that addresses the acute or immediate health status of the program participant.

PROCEDURE:

A. Alere Health requires case managers to develop program participant specific, individualized case management care plans with prioritized long and short term goals upon the completion of the initial comprehensive nursing assessment and after each reassessment or change in the program participant's condition. The care management plan considers the program participant's and caregiver's goals, preferences and desired level of involvement. The case manager will evaluate the program participant's support systems, transportation/shelter/food needs, safety requirements, spoken and written language preferences, any visual or hearing needs, religious and cultural beliefs to develop an individualized, program participant centered care plan. Care plans are developed in collaboration with the program participant, family/caregiver, practitioner and other healthcare professionals (as needed) who have expertise in the program participant's diagnosis.

B. Care plans must include development and communication of program participant self-management plans. Self-management plans are components of the care plan and are activities that program participants can perform for themselves to manage their condition. Self-management activities may include but are not limited to:
   1. Maintaining a prescribed/recommended diet;
   2. Exercising as appropriate to condition;
   3. Avoiding certain medications, foods and alcohol while pregnant or for a specific condition;
   4. Charting daily readings (weight, blood pressure, blood sugar);
   5. Changing a wound dressing as directed;
   6. Hydrating appropriately, especially for a pregnant woman;

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

7. Parent/caregiver involvement during infant's NICU stay (breast feeding/holding/etc.);

8. Preparing for discharge of NICU infant.

C. The case manager will identify issues/problems based on the assessment of the program participant's needs and will assign short- and long-term goals that:
   1. Are measurable and have clearly identifiable timeframes;

   2. Describe specific interventions and resources needed to accomplish the goals;

   3. Include collaborative approaches to be used to facilitate the care plan as well as when coordinating and transitioning care; and

   4. Have time frames for re-evaluation, follow-up, and response to services.

D. The case manager will prioritize all goals by assigning: Priority, Progran Participant/Caregiver Preference or by choosing both. Program specific work instructions are available which outline how goals are prioritized for each program. Then the case manager assigns each goal as high, medium or low in the order of importance to be addressed and worked on.

E. The case management process includes reassessing and adjusting the care plan and its goals, as needed. The case manager will evaluate and update the care plans when there is a change in the program participant's needs and on a minimum basis according to the following schedule:
   1. Complex: Weekly;

   2. Chronic: Every other week;

   3. Oncology/Multi Acuity Program: Weekly for those program participants with high acuity; twice a month for those with moderate acuity and monthly for those with low acuity or when there is a change in the program participant's needs;

   4. NICU: weekly;

   5. Maternity: Every thirty (30) calendar days.

F. The case management plan includes an assessment of the program participant's progress toward overcoming barriers to care and meeting treatment goals. The case manager will identify barriers to meeting goals or complying with the care plan. The case manager will address all obstacles to a program participant achieving their goals.
   1. An assessment of barriers will examine the program participant's:
      a. Understanding of the condition and treatment.
      b. Desire to participate in the case management plan.
      c. Belief that participation will improve their health.
      d. Financial or transportation limitations that may hinder the program participant from participating in care.
      e. Mental and physical capacity to participate in care.

   2. A barrier analysis is performed for each goal and may include barriers such as:
      a. Care of spouse/family member/children;
      b. Change in eligibility;
      c. Degree of Illness;
      d. Denial of condition;

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

e. Functional limitations;
f. Inability to comprehend;
g. Lack of financial resources;
h. Lack of support systems;
i. Lack of transportation;
j. Language barrier;
k. Loss of family member / loved one;
l. Other medical conditions;
m. Program participant request;
n. Care plan inconsistent with guidelines;
o. Readiness to change.

3. The case manager will document the barriers and actions to be utilized for plan compliance in the program participant's care plan.

4. The care plan goals, barriers (even if no barriers are identified), and outcomes are documented in the program participant's record.

G. The case manager facilitates referrals to resources, as appropriate to the program participant's needs and client contracts. All referrals will be followed up by the case manager on the next program participant's scheduled communication or sooner at the case manager's discretion to determine whether the program participant acted on the referral. (see policy QI-033 Care Coordination - Referral Process for further details)

H. During contact with the program participant, the case manager will assess the program participant's progress toward overcoming barriers to care and meeting treatment goals. The case manager will reassess and adjust the care plan and goals as needed.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

OPTUM™	**Optum™** **Policy and Procedure** **CM: Data Collection Tools and Assessments**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-007
	Original Issue Date: 11/15/2007
	Committee Approval Date: 6/14/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 6/14/2016

This Policy Applies To:	
☐ **All Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☐ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Programs**	
☐ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☐ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☐ **Nurse 24**	
☐ **BioPharma**	
☐ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
6/18/2014	CM-007 CM: Data Collection Tools and Assessments
6/3/2015	CM-007 CM: Data Collection Tools and Assessments
12/11/2015	CM-007 CM: Data Collection Tools and Assessments
6/14/2016	CM-007 CM: Data Collection Tools and Assessments

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	6/10/2016
Susan Garcia	VP Case Management and Triage	6/9/2016
Diane Orlando	VP Clinical Affairs	6/14/2016

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

POLICY STATEMENT:

The purpose of this policy is to describe how Alere Health makes appropriate tools and information, designed for the purpose of program performance improvement, available for the case management team to utilize.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Case Manager	A healthcare professional designated as the case manager with such appropriate background and specialty, such as a registered nurse, social worker, physician, rehabilitation counselor, etc.
Program Participant Record	An electronic or paper file containing demographic, clinical, and non-clinical information about a program participant.
Treatment History	Therapies or procedures used to care for a program participant's identified health conditions and comorbidities. Treatment history covers at least the onset of the condition that qualifies the program participant for case management.

PROCEDURE:

A. The case management team is provided with a computer and telephone which enables documentation of information in the program participant's record with availability of the information to those with a need to know.

B. Alere Health's case management system is based on evidence based guidelines or algorithmic logic scripts and other prompts to guide case managers through an assessment and ongoing management of program participants. The system includes but is not limited to the following functions:
   1. Automated features that provide accurate documentation for each entry, recording actions or interactions with program participants, practitioners, or providers and automatic date, time and user stamps.
   2. Automated prompts and reminders for next steps or follow-up contact as required by the case management plan.

C. Other tools and information provided include but are not limited to the following:
   1. A structured initial orientation program with ongoing training and annual competencies;
   2. Organizational policies and procedures;
   3. Clinical guidelines and regulatory standards;
   4. Client-specific information;
   5. Workflow processes and algorithms;
   6. Websites approved by the Website Approval Committee;
   7. Approved reference materials;
   8. Access to medical directors and other disciplines (pharmacy, etc.) for consultation;

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

9. Community resource information;

10. Case reviews;

11. Frequent and consistent feedback from their immediate manager based on audit and case review results; and

12. Complaint and incident reporting systems.

D. The case manager conducts a thorough assessment including a needs assessment and interviews the program participant, family and/or caregiver as soon as possible after obtaining consent for case management, but no later than 30 days from the date of the of the determination that the member is eligible for case management services. All findings are documented in the program participant's record. The case manager will explicitly document any assessment items that are found to be not appropriate (not applicable) and the reason why.

E. Data supplied by the program participant, family or caregiver in the initial assessment should include at a minimum:
   1. Current health status and clinical history, including condition-specific issues;

   2. The case manager evaluates and documents the program participant's:
      a. Health status specific to identified health conditions and likely medical and behavioral health comorbidities,
      b. Clinical history, including disease onset; key events such as acute exacerbations, inpatient stays; and treatment history, such as physical/occupational/speech therapy, surgery, medication and radiation therapy.

   3. Treatment plan;

   4. Medication Safety (see policy CM-013 CM Medication Safety)
      a. Current and past medications including schedules and dosages
      b. Medication knowledge and adherence
      c. Use and adherence of medications including experienced side-effects
      d. Access to and use of current medication list
      e. Sharing of current medication list with treating provider(s)
      f. Need for medication reconciliation
      g. Need for medication therapy management services, as appropriate

   5. Resources required to meet immediate needs for health care and evaluation of available benefits from the health plan, and community resources. (see policy QI-033 Care Coordination-Referral Process);
      a. Assessment of program participant's health benefits and other pertinent financial information regarding benefits may include but are not limited to:
         1) Benefits covered by the client and by providers
         2) Services carved-out by the client
         3) Supplemental services such as community mental health, Medicare, Medicaid, long term care and support, disease management and palliative care programs
      b. Assessment of the program participant's eligibility for community resources.

   6. During the initial assessment the case manager assesses the caregiver's resources and involvement.
      a. Family/caregiver involvement in the program participant's care and decision making about the care plan
      b. Level of assistance the program participant needs and if a caregiver is available to provide needed assistance

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

7. Psychosocial status including evaluation of caregiver resources, the adequacy of the resources and the caregiver's involvement;
   a. Possible psychosocial issues that may affect the program participant's ability to adhere to the care plan may include but are not limited to:
      1) Beliefs or concerns about the condition or treatment
      2) Perceived barriers to meeting treatment requirements.
      3) Program participant's input, including perception of needs such as health care needs and social services and supports.

8. Safety concerns;

9. Initial assessment of mental health status, including cognitive functions;
   a. The case manager evaluates and documents the program participant's ability to communicate, understand instructions and process information about their illness.

10. Initial assessment of the activities of daily living;
    a. The case manager evaluates and documents the program participant's functional status which may include but is not limited to mobility and the ability to eat, bathe, toilet, and dress oneself.

11. Initial assessment of life-planning activities;
    a. The case manager evaluates and documents the program participant's planning surrounding wills, living wills or advanced directives and health care powers of attorney.
       1) If expressed life-planning instructions are not on record, the case manager determines if a discussion is appropriate based on the program participant's circumstances.
       2) If life planning activities are not appropriate to the program participant's situation, this will be documented in the program participant's clinical record.

12. Initial assessment of health behaviors;
    a. The case manager evaluates and documents the program participant's possible health behaviors such as nutrition, physical activity, and tobacco use that may impede the program participant's ability to adhere to the care plan.

13. Evaluation of cultural and linguistic needs, preferences or limitations to effectively communicate with the program participant;
    a. The case manager evaluates and documents the program participant's:
       1) Preferred spoken and written language
       2) Family traditions related to illness, death dying, parenting and childbirth, as applicable
       3) Health care treatments or procedures that are religiously or spiritually discouraged or not allowed
       4) The need for culturally and linguistically appropriate services reflecting individual needs, if applicable.

14. Evaluation of visual and hearing needs, preferences, or limitations;
    a. The case manager evaluates and documents if the program participant has normal hearing and vision or impairments. If impairments are present, the case manager documents what devices are needed to assist with functioning with the impairments.

15. Care coordination needs, including transitions of care. (see policy CM-012 CM: Care Transitions);

16. Verification of program participant's primary care practitioner

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

F. Subsequent assessments are conducted throughout the case management process and will include some or all of the above assessment categories as individualized to the program participant's health status and needs.

G. Documentation of initial assessments and subsequent assessments
   1. Data provided during the initial assessments is documented in the program participant's record.

   2. If any of the above items were not identified as issues/concerns, documentation must reflect that there was no issue ex: No safety concerns noted.

   3. If any of the above items are identified as not applicable, they are documented as not applicable ex: a baby in the NICU's health behaviors.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

OPTUM™	**Optum™** **Policy and Procedure** **CM: Identification, Case Opening and Closure Criteria**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-009
	Original Issue Date: 4/1/1999
	Committee Approval Date: 8/31/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 8/31/2016

This Policy Applies To:	
☐ **All Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☐ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Programs**	
☐ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☐ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☐ **Nurse 24**	
☐ **BioPharma**	
☐ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
6/18/2014	CM-009 CM: Identification, Case Opening and Closure Criteria
12/16/2014	CM-009 CM: Identification, Case Opening and Closure Criteria
6/3/2015	CM-009 CM: Identification, Case Opening and Closure Criteria
6/14/2016	CM-009 CM: Identification, Case Opening and Closure Criteria
8/31/2016	CM-009 CM: Identification, Case Opening and Closure Criteria

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	8/31/2016
Susan Garcia	VP Case Management and Triage	8/31/2016
Diane Orlando	VP Clinical Affairs	8/23/2016

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

POLICY STATEMENT:

This policy describes the processes for identification, case opening and closure for all of Optum's case management programs including Chronic, Complex, Maternity, NICU and Oncology.

REFERENCE DOCUMENTS:

QI-033 Referral Policy

DEFINITIONS:

Case Management	A collaborative process which accesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality and cost-effective outcomes.
Case Opening	A case is opened when an eligible individual is determined to be qualified for program enrollment by a case manager and accepts participation in the program.
Case Closing	A case is closed when activity on a case ceases.
Case Manager	A healthcare professional with appropriate background and specialty, such as registered nurse, social worker, physician, rehabilitation counselor, etc.
Discharge	To release from care.
Healthcare Professional	Employees or contracted consultants of the organization who are professionally licensed, certified and/or registered and qualified to provide clinical services, including telehealth services.
Practitioners	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.
Program Participant	An individual who is enrolled in any activities or services provided by an Optum program.
Providers	An institution or organization that provides services for program participants. Examples of providers include hospitals and home health agencies.

PROCEDURE:

A. Optum assesses the characteristics and needs of its program participant population and relevant subpopulations by:
   1. Quarterly:
      a. Tracking and trending program participant surveys;
      b. Tracking and trending program participant complaints;
      c. Hiring bi-lingual case managers where indicated or using Language Line;
      d. Conduct quality improvement subcommittee (QISC) work plan reports and reviews;
      e. Reviewing culturally and linguistically appropriate websites suggested by staff at the website committee meeting.

   2. Optum reviews and updates its case management processes and resources, if necessary, to address program participant needs annually by:
      a. Assessment of the needs of children and adolescents (refer to policy QI-034 Provision of Services to Minors);
      b. Assessment of the needs of individuals with disabilities;
      c. Assessment of the needs of individuals with serious and persistent mental illness (SPM), as applicable;

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

d. Collecting demographic and language data and identifying culturally specific needs;
e. Ongoing communication with client management regarding expected population changes;
f. An analysis of annual data is completed and posted in the annual program evaluation document with program processes and resource changes, as applicable, including goals and action plans.

B. Optum systematically identifies program participants who quality for case management, at a minimum, on a monthly basis.

C. Optum uses the following data sources to identify individuals as eligible for each case management program, depending on applicability: :
1. Claim or encounter data
2. Hospital discharge data
3. Pharmacy and lab data
4. Health appraisals or risk appraisals/scoring tool
5. Data collected through the UM management process including pre-certification data, concurrent review data, prior authorization data and hospital admission data.
6. Data supplied by purchasers, i.e., health plans, employer groups
7. Data supplied by individuals or caregivers
8. Data supplied by practitioners

D. Optum has multiple avenues for individuals to be considered for case management services, depending on applicability and including referrals from any of the entities listed below:
1. Health information line
2. Disease management program
3. Discharge planner
4. Utilization management program
5. Member or caregiver
6. Practitioner
7. Case management program
8. Client or third-party administrator
9. 24/7 BabyLine
10. Vendors of home service
11. Clinic or Provider

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

E. Eligibility
   1. All members referred to an Optum case management program are assessed against specific eligibility criteria. Client-specific workflows may be used where applicable.

   2. Eligibility data is automatically uploaded and run through an automated data certification process.

   3. The Triage Engine, a proprietary rule based algorithm, runs Optum's proprietary program identification on a daily basis for data files received daily and on a monthly basis for files received monthly.

   4. Eligibility is checked real time every time the triage process is processed. Eligibility is based upon the most recent eligibility file received from the client.

F. Enrollment Process and Stratification
   1. If eligibility criteria are met, case management staff will contact members for enrollment and stratification into the program according to client, program or referral type processes.

G. Cases may be closed when they meet any of the criteria listed below:
   1. Condition has improved or stabilized;

   2. All goals are closed;

   3. Program participant can independently self-advocate for health services;

   4. Program participant has determined no further needs or has requested closure or is no longer compliant with program (including unable to reach);

   5. Program participant is no longer eligible based on clinical criteria or coverage;

   6. Client requests closure;

   7. Program participant expired; or

   8. Program specific criteria

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

	**Optum™** **Policy and Procedure** **Program Content - Development, Review & Approval Process**

Policy Owner (Division/Department): VP Clinical Compliance and Integrity	**Document Number:** QI-004
	Original Issue Date: 8/1996
	Committee Approval Date: 3/23/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 3/23/2016

This Policy Applies To:					
☐ **All Alere Staff**	☒ Clinical Operations ☐ Enrollment Services ☐ Health Solutions	☐ Marketing/Sales/Client Services ☐ Medical Affairs ☐ Technology	☐ Other		
☐ **All Alere Programs**					
☒ **All Disease Management**	☐ Asthma ☐ HF	☐CAD ☐ Maternity	☐ COPD ☐ MSP	☐ Depression ☐ Other	☐Diabetes
☒ **All Case Management**	☐ Complex	☐ Maternity	☐ NICU	☐ Oncology	☐ Other
☒ **All Utilization Management**	☐ NICU	☐ Oncology	☐ Other		
☒ **Nurse 24**					
☐ **BioPharma**					
☒ **Wellness**	☐ Wellness Portal	☐ Health Coaching			
☐ **Maternity Home Care**					
☒ **Accreditation/Regulatory**	☒ NCQA	☒ URAC	☐ Joint Commission	☐ Regulatory	

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
3/26/2014	QI-004 Program Content - Development, Review and Approval Process
3/25/2015	QI-004 Program Content - Development, Review and Approval Process
3/23/2016	QI-004 Program Content - Development, Review and Approval Process

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	VP Senior Medical Director	3/23/2016
Gail Gibbons	VP Clinical Compliance and Integrity	3/23/2016
Diane Orlando	VP Clinical Affairs	3/23/2016

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

POLICY STATEMENT:

This policy describes the process by which Alere develops, reviews, evaluates, adopts, and integrates evidence-based guidelines and information received from Recognized Sources/Authorities and company Proprietary Program Content into programs.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Evidence-based Guidelines	Systematically developed descriptive tools or standardized specifications of care to assist Practitioner and Program Participant decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus. Practice guidelines may be called practice parameters, treatment protocols, clinical criteria and clinical guidelines. (NCQA)
Program Content	Includes all the educational information and interventions Alere directs towards Program Participants and Practitioners to improve management of a condition, reduction of risk and/or health maintenance (i.e. materials, practitioner reminders, scripts for phone calls). Program Content is consistent with evidence-based guidelines and may include additional information gathered from Recognized Sources/Authorities.
Proprietary Program Content	Program Content developed and owned by Alere.
Recognized Sources/Authorities	Organizations that develop or promulgate evidence-based guidelines. Recognized sources or authorities include, but are not limited to nationally recognized organizations, such as the American Heart Association (AHA) or American Academy of Pediatrics (AAP), government research sources, such as the National Institute of Health (NIH) or Center for Disease Control (CDC), and clinical literature from respected medical sources.

PROCEDURE:

A. Alere uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities and proprietary program content as the basis for program and intervention design.

B. Alere offers program content materials in multiple modalities. This includes verbal (telephonic), print, digital, or in person in accordance with program policies and/or client agreements.

C. Annual Review and Approval of Program Content Materials
   1. Program source materials such as: evidence-based guidelines, and key program content from recognized sources/authorities are monitored, reviewed and approved at least annually by the Scientific Advisory Board (SAB) or other designated quality committee.
      a. This review includes review of government research sources and clinical or technical literature, and proprietary program materials.
      b. Board–certified practitioners, practicing physicians, subject matter expert physicians are involved in the review process as applicable.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

2. Program participant and practitioner materials, including wellness program, digital program information and tools are reviewed at least annually to ensure consistency with evidence-based guidelines and other key program source materials.

3. Internal staff educational/telephonic scripts that support program participant education are reviewed with guideline changes and updated as needed to ensure they are consistent with program policies, procedures, and source materials.

D. Evidence-based Guideline Updates
   1. Designated staff monitors nationally recognized organizations that develop or promulgate evidence-based guidelines in order to identify when changes to guidelines occur.

   2. Updated guidelines are reviewed and approved by medical advisory and distributed to program and content subject matter experts to implement changes to applicable program materials.

E. Development of Proprietary Program Content
   1. Proprietary program content is developed with involvement from actively practicing physicians and/or other qualified practitioners with current knowledge relevant to the subject matter and/or clinical decision support tools to assure the following:
      a. Materials are based on scientifically valid and documented clinical principles and processes.
      b. Materials are based upon principles appropriate to the functions of the company programs.
      c. The company uses the results of quality review studies in developing and updating clinical support tools.
      d. The special needs of program participants.
      e. All proprietary content is reviewed and approved by medical advisory and may include additional subject matter expert clinicians as necessary.

   2. Key program materials are evaluated at the time of development and at least every three years to ensure that the language used in the material is easy to understand by the program participant. The following methods may be utilized:
      a. We utilize acceptable industry tools (MS Word Flesch-Kincaid) to test readability. Goals for testing include updating content in response to federal guidelines changes. Readability levels of all program materials range between 4^{th}-8^{th} grade level or below to the extent practical and/or to use plain language to provide clear explaination of medical terminology or health information.
      b. Usability testing: Includes assessing the targeted audience, efficiency, memorability, and satisfaction
      c. Conducting focus groups that represent the demographic population including but not limited to consumers, program participants and/or internal staff.

   3. Ongoing evaluation of key program materials is conducted in the following manner:
      a. Reviewing program participant satisfaction survey results related to program materials
      b. Reviewing program participant feedback related to program materials
      c. Reviewing special communication needs assessment

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

F. Review of New Information
   1. Alere utilizes up-to-date medical findings in preparing program content by reviewing the source of new information, e.g., government research sources, professional societies, foundations or clinical or technical literature.
      a. Members of the SAB or designated quality committee, in addition to Alere clinicians and program specialists are responsible for ongoing review of new information that might relate to Alere programs.

   2. The medical advisory review of new information includes:
      a. An assessment of costs and benefits to program participants in terms of the ability to improve outcomes for the program participants.
      b. Documentation of the decision to implement a change or not.

G. Designated staff tracks and manages documentation that consists of information related to program source materials, including adopted evidence-based guidelines, guideline updates and some key information gathered from recognized sources/authorities.

H. Practitioners with patients in high-acuity programs are notified via the practitioner's welcome letter that they have access to a designated practitioner's website where a list of current program sources, i.e., nationally recognized evidence based guidelines can be found.

I. Providing Program Information to Staff
   1. Training is provided as needed to staff who may communicate with program participants and/or practitioners as indicated below:
      a. Training consists of identifying program support information and reviewing content with staff
      b. Training is provided on an ongoing basis; at the time of new employee orientation, and any time program materials or evidence-based guidelines are updated.
      c. Licensed care management staff is provided access to all program content source materials.

J. Integration of Approved Program Source Materials into Program Content
   1. At least annually or upon adoption of new or updated evidence-based guidelines and/or information from recognized sources/authorities, designated staff reviews both program participant and practitioner program materials and update materials as needed.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

OPTUM™	**Optum™** **Policy and Procedure** **Program Satisfaction/Feedback**

Policy Owner (Division/Department): Quality Department	**Document Number:** QI-020
	Original Issue Date: 4/1999
	Committee Approval Date: 3/23/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 3/23/2016

This Policy Applies To:	
☐ **All Alere Health Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☒ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Alere Health Programs**	
☒ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☒ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☒ **Nurse 24**	
☒ **BioPharma**	
☒ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
3/26/2014	QI-020 Program Satisfaction/Feedback
3/25/2015	QI-020 Program Satisfaction/Feedback
3/23/2016	QI-020 Program Satisfaction/Feedback

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	VP Senior Medical Director	3/23/2016
Diane Orlando	VP Clinical Affairs	3/23/2016

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

POLICY STATEMENT:

The purpose of this policy is to describe the process by which Alere Health obtains and analyzes feedback about satisfaction with the programs and services provided to program participants, practitioners, and clients.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Client	Employer group, health plan, payor or sponsoring organization contracted with Alere Health.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law. (NCQA)
Program Participant	An individual who is enrolled in any activities or services provided by an Alere Health program.

PROCEDURE:

A. As specified by Alere Health's Annual Quality Program, client contracts, regulatory requirements, and/or accreditation standards, Alere Health solicits information from program participants, practitioners and/or clients in a variety of methods including mail, telephonic, in person, and/or online.

B. Program Participant Feedback & Satisfaction
   1. All Alere Health Disease Management, Nurse 24, Case Management, WCH Home Care, Depression Management, Coaching (telephonic or online) and Wellness portal programs evaluate program participant satisfaction at least annually, or per specific client contract.

   2. Program participant satisfaction surveys collect information based on the program participant's experiences and satisfaction with the Alere Health program. Categories for data collection may include the following components:
      a. Overall program
      b. Program staff
      c. Educational information
      d. Program participant - reported health outcomes
      e. Access to the program
      f. Number of program participant contacts with the program
      g. Program recommendation to others

   3. Program participant complaints and program participant satisfaction results are collected for review of program participant feedback in our quality committee meetings.

C. Practitioner Feedback & Satisfaction
   1. All Alere Health's Disease Management programs evaluate program practitioner satisfaction at least annually.

   2. Other Alere Health programs evaluate program practitioner satisfaction in accordance with client agreements.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

3. Practitioner satisfaction surveys collect information based on the practitioner's experiences and satisfaction with the Alere Health program. Categories for data collection may include the following components:
   a. Perception of the usefulness of program content
   b. Satisfaction with personal interactions with the program
   c. Perception of the program's impact on patients' use of services
   d. Perception of the program's impact on patients' health status relative to the target condition.

4. Practitioner complaints and practitioner satisfaction results are collected for our review process of practitioner feedback in our quality committee meetings.

D. Client Feedback & Satisfaction
   1. Alere Health evaluates client satisfaction for all CM, UM and Nurse24 programs in accordance with client agreements and in aggregate on the book of business at least annually.

   2. Other Alere Health programs evaluate program client satisfaction in accordance with client agreements.

   3. Client complaints and program participant satisfaction results are collected for our review process of client feedback in our quality committee meetings.

E. Report to Quality Committees
   1. Analysis of the information includes comparison of the results against past performances/thresholds and an analysis of the cause of any deficiencies noted.

   2. Results are utilized to improve the services provided including barrier analysis; corrective action plans and remeasures results after actions are taken.

   3. Results are reported to the quality committees, opportunities for improvement are identified, action plans to improve results are developed and remeasured at least annually.

Optum Confidential and Proprietary. Do not distribute without written consent by Optum. Unauthorized use or coping without written consent is strictly prohibited.

2016 Quality improvement program description and work plan

Approvals:

Dan Sullivan, vice president, senior medical director	3/31/2016
Betsy Piazza, senior vice president, care management	3/30/2016
Diane Orlando, vice president, clinical affairs	3/30/2016

Table of contents

Our mission
Our mission is to empower consumers to take ownership of their health.

Our vision
Our vision is to bring hope, help, health and happiness to those in need. Our health advocates and licensed health care professionals help individuals lead healthier lives by managing chronic conditions, offering specialty care and improving overall health and well-being.

Our core values
Integrity, Compassion, Relationships, Innovation, Performance

Introduction
In 2014, Optum announced the acquisition of Alere Health and its subsidiaries. Optum is a leading provider of health care consulting, technology, information management and population health management services designed to modernize the health care system and improve overall individual and population health. Alere Health is a leader in population health management with over 25 years of experience serving regional and local health plans, employers, and states. The acquisition by Optum, official as of January 9th, 2015, reflects the importance and growing appreciation of the value Alere Health brings to its customers, and especially our shared customers and partners.

At Optum, we're passionate about making the health system work better for everyone. Optum is a health services and innovation company on a mission. We have 94,000 people dedicated to improving the health system for everyone in it. We power modern health care by combining data and analytics with technology and expertise. We focus on three key areas of change: modernizing the system's infrastructure, advancing care and supporting people as they take control of their own health.

The backbone of our strategy is to address the barriers to behavioral change, starting with the individual and where they are in their life, considering socio-economic, environmental and behavioral factors, in addition to their health needs. Across Optum, we embrace a shared purpose of lowering the impact of chronic illness on those in our programs by employing evidence-based behavioral change methodologies, high-touch, personalized services and the innovative use of technology. By also enabling the sharing of clinical information within the health care ecosystem we can improve each individual's quality of life and deliver value to our customers. For the remainder of this document, the Optum services provided by legacy Alere Health will be referred to as Alere Health.

Quality improvement goals 2016
- Continue to improve overall clinical performance with clinical and quality outcomes
- Continue to improve customer satisfaction
- Continue to evaluate and enhance the effectiveness of Alere Health programs by launching identified quality improvement projects
- Aggressively pursue operational process improvement to drive service delivery efficiency and effectiveness while maintaining a high level of quality and customer service
- Continue to improve program participant engagement
- Continue to reduce unplanned utilizations
- Continue to support health plan client's HEDIS and STAR metrics ratings
- Maintain URAC case management, utilization management and health call center accreditations

Confidential property of Optum. © 2016 Optum, Inc.

- Maintain NCQA Wellness and Health Promotion with Performance Measures accreditation
- Achieve re-accreditation of NCQA Disease Management and Case Management programs

At Alere Health we provide the following suite of integrated programs and resources:

- Wellness solutions offer a comprehensive integrated suite of programs and services that leverages industry-proven methodologies to develop, implement, track and measure customized health improvement strategies. Our wellness programs integrate with the client's existing programs to enable a single view of an individual's health status across the care continuum. Services include the health portal, health and productivity assessment, Alere Health personal health record, screening services, and virtual coaching. Alere Health also recently incorporated social media and gaming strategies to keep program participants engaged. Alere Health's wellness and health promotions program has achieved NCQA Accreditation with Performance Measures.
- Disease management programs help individuals at-risk and those diagnosed with chronic health conditions to better manage their health through education, empowerment and support. The programs available include heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, asthma, maternity, musculoskeletal pain and depression. Alere Health program staff proactively contact individuals to assess the severity of their condition, the presence of comorbid conditions and any barriers to care. Our disease management programs provide guidance and education using digital, mail and/or telephonic interventions, as well as monitors biometric and symptom data and program progress. In addition, program staff members help increase compliance with evidence-based treatment guidelines and practitioner treatment plans, and change behavior through contemporary behavioral change strategies. Alere Health's disease management programs are accredited by NCQA.
- Nurse24 is a nurse-driven telephonic support program that empowers program participants to better manage their health. Nurse24 offers assistance to program participants coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses are available 24/7 to monitor and process health care inquiries that help program participants make informed health care decisions. Alere Health's Nurse24 program is accredited for Health Call Center by URAC and is certified as a Health Information Line by NCQA.
- Complex case management provides services for program participants with chronic and complex diagnoses involving multiple chronic conditions, catastrophic injuries and illnesses, which may be compounded by major social, psychological and financial issues. The major goals are to improve quality of life and reduce health care costs. The Complex Case Management program is both URAC and NCQA accredited.
- Oncology case management program is a comprehensive cancer treatment and support program that uses structured approaches to improve compliance and enhance quality of life or improve end-of-life care. Health care professionals strive to manage the disease and treatment side effects and provide effective and efficient coordination of care. The Oncology Program utilizes a program participant-centric primary case manager model and a team approach to educate, monitor and support program participants. The Oncology case management program is both URAC and NCQA accredited.
- Maternity risk assessment and case management program offers a personalized approach which addresses the rising number of high-risk pregnancies with poor birth outcomes and the increasing cost of neonatal intensive care unit (NICU) care. The program includes the early identification of pregnancy risk, which combined with our periodic assessments and education, improve overall outcomes. Alere Health's OB risk assessment and education program is NCQA accredited for disease management. The maternity case management program is both NCQA and URAC accredited for case management.
- Neonatal Intensive Care Unit (NICU) care management program improves outcomes of infants admitted to the NICU or other specialty care units. Alere Health improves clinical outcomes by providing case and utilization management to all infants admitted to the NICU, increases family satisfaction and lowers client health care costs. Distinctive program features

Confidential property of Optum. © 2016 Optum, Inc.

include: unparalleled nursing; practitioner, informatics and programmatic expertise; a database of more than 200,000 NICU program participants from which we produce proprietary clinical guidelines; robust management tools with real-time reporting; 24/7 access to NICU nurse case managers and detailed family educational materials. The NICU case management and utilization management programs are both URAC and NCQA accredited for case management and URAC accredited for utilization management.

- Biopharma Program is a pharmaceutical support unit that offers innovative solutions to pharmaceutical companies seeking to improve compliance and persistency through programs that support program participants by educating them about their condition and prescribed treatment regimen. These programs are designed to apply scripted education and information to help program participants understand their diagnosis and treatment and to make educated choices about their care.

Quality program structure

The Quality Improvement Program and Work Plan describe the structure, program content, and roles and responsibilities of quality resources. An effective quality management program must be systematically data-driven, and focused on measuring and improving program quality and safety. Creating involvement by all organizational departments unites the organization in working toward common goals and objectives through interaction and communication. For an organization to be credible in today's health care market, it must establish a quality program (from both the internal and external customers' perspective). Improving quality means improving processes, and that requires monitoring and continuous assessment to maintain standards and identify opportunities for improvement. A good quality program ensures that the risk of customer dissatisfaction and negative outcomes are significantly reduced, resulting in a better work environment, optimized program participant care and safety, improved customer loyalty and repeat business.

Alere Health recognizes that it must focus on quality to ensure exceptional service and exceed customer expectations. To this end, Alere Health utilizes best practice industry standards from URAC, NCQA, and the Joint Commission, as well as recognized evidenced-based guidelines from reputable organizations. Additionally, Alere Health continuously monitors gaps between actual and desired practices, processes and results for improvement opportunities.

Quality improvement process

Alere Health's Quality Improvement Program includes process planning, measurement and improvement activities for all programs. Specific measures are collected across multiple service lines to allow tracking and trending of common processes. The quality plan contains measures specifically tailored to evaluate their high volume, high-risk, and problematic areas. The goal of the quality improvement process is to continuously improve care and service provided.

The Quality Program utilizes innovative prospective, concurrent, and retrospective methods integrated throughout the organization to achieve its goals, which includes improving the quality of products and services, increasing program participant and practitioner satisfaction, optimizing resource utilization, and continuously improving processes to facilitate achievement of Alere Health's mission and vision. Statistical methods and tools are used to measure, assess and enhance processes by identifying opportunities for improvement, and then developing, implementing, and monitoring improvement strategies.

The program includes clinical and operational functions that directly or indirectly impact the quality of services provided to program participants, practitioners and client organizations. It is designed to involve all disciplines and employees. Organization-wide, quality teams participate in data collection for various measures and process improvement activities. Project teams are chartered by the Quality Improvement Committee (QIC) or one of its subcommittees to conduct cross-functional interdisciplinary projects.

Confidential property of Optum. © 2016 Optum, Inc.

Data is systematically collected, analyzed, summarized, and presented with recommendations to the Quality Improvement Committee and its subcommittees. The identification of opportunities for improvement, generated by continuously monitoring activities, leads to interventions designed to improve the overall program performance and the quality and safety of service provided to program participants.

Alere Health's Work Plan is the main report reviewed at quality committee meetings. It contains indicators of the quality of care and service program participants receive. Program-specific performance indicators represent the scope of the program to monitor planned activities and quality initiatives. Yearly objectives or goals are set based on the review of the previous performance and internal operations expectations. Quality improvement projects are monitored via the work plan and project-specific documents that identify the scope and time frame of each project. The work plan is reviewed and analyzed at the appropriate quality committee each quarter.

A formal program evaluation is conducted yearly to assess the overall effectiveness of the quality program and to determine program efficacy. The evaluation addresses all aspects of the quality improvement process as outlined in this program description and is presented to the QIC and the Executive Management Team (EM) for approval.

Quality program and work plan

- Aim: To promote processes that improve organizational performance; provide a customer-driven quality program; identify and implement changes that increase customer satisfaction; identify, reduce and eliminate redundancy and inefficiency; and assist in maximizing financial performance through increased cost efficiency.
- Rationale: The quality program is designed to measure the level of excellence of care and services; identify opportunities for improvement; provide a methodology for planning and implementing change and assist in achievement of organizational goals. Issues addressed include customer service, quality of care, regulatory and financial.
- Measures: Data is collected on specific key indicators. Numeric calculations are based on and compared to predetermined thresholds. Results are analyzed for improvement opportunities based on these thresholds and identified needs.
- Quality Improvement Projects: When potential opportunities for improvement are identified, quality teams initiate a QI project specific to that concern. This application is a scientific methodology to impact change to these identified opportunities. This facilitates development, implementation and evaluation of process change.

Quality programs charter elements

- Quality program design and implementation
- Client and operational performance monitoring
- Operational and clinical data analysis
- Quality improvement activities and projects
- Best practices identification and communication
- Quality assurance and process control
- Program participant and practitioner rights and responsibilities
- Customer satisfaction and complaint analysis

Behavioral health care

Alere Health incorporates recognized motivational principles training for health care professionals that interact and engage program participants. It is our goal to collaborate with program participants in order to facilitate their ability to make informed decisions with their practitioner(s) that take into account the best scientific evidence available as well as the program participant's values and preferences. Our objective is to ensure all program participants receive information to

Confidential property of Optum. © 2016 Optum, Inc.

encourage and reinforce self-management skills. Our health care professionals are trained to assess program participant's medical and behavioral health via frequent telephone communications, and to provide medication management and referrals to behavioral health services, when indicated. Motivational principles facilitated by a collaborative and program participant-centered approach are used to elicit, strengthen and encourage the program participant's motivation for change and self-management.

Designated practitioners

Behavioral health care practitioner

Alere Health ensures oversight of the behavioral health aspects of its programs by contracting with a psychiatric consultant who sits on the scientific advisory board and the quality improvement committee. The practitioner is involved in the review of evidence-based guidelines and program content materials, development of new products, and oversight of the behavioral health aspects of Alere Health's programs.

Medical directors

The senior medical director is a member of the quality improvement committee and is responsible for the following key functions:

- Participates in the design, review and implementation of clinical programs
- Provides clinical oversight of the medical directors, and clinical quality metrics
- Ensures Alere Health obtains and maintains appropriate industry accreditations

Alere Health has multiple practitioners who participate in the development of program content and provide oversight for the development, implementation, ongoing improvement and maintenance of quality programs. This team also provides input to the executive management team for strategic decision-making and planning.

Actively practicing practitioners

Alere Health involves actively practicing practitioners in many components of the quality improvement program. Practitioners sit on several committees, including the Scientific Advisory Board. Other practitioners participate on a consultation basis as needed.

Organizational structure

Accountability to the governing body

The Executive Management Team is Alere Health's governing body and is comprised of executive leadership from operations, medical affairs, heath management strategy, human resources, finance, legal, technology, product, marketing and sales, and client management. The executive management is responsible for organizational governance and has delegated the responsibility of the quality management/improvement program to the quality improvement committee and its subcommittees. The quality improvement committee and its subcommittees are the functional building blocks of the Company's quality oversight process. Executive management meets regularly, participates on the quality improvement committee and is responsible for reviewing and approving Alere Health's Quality Program, QI Work Plan and Annual Evaluation each year.

Functional areas and responsibilities

Alere Health is committed to ensuring our business units are connected by clear, consistent communications, policies and procedures, unified strategic goals and adherence to our mission and vision. We strive to continuously improve our programs and services through performance and operational measurement, opportunity and barrier analysis, and appropriate quality improvement activities. Operational areas of Alere Health work together to develop, implement and continuously improve the array of programs offered, and fulfill program objectives. A brief summary of the roles and responsibilities of our key operational areas is provided below:

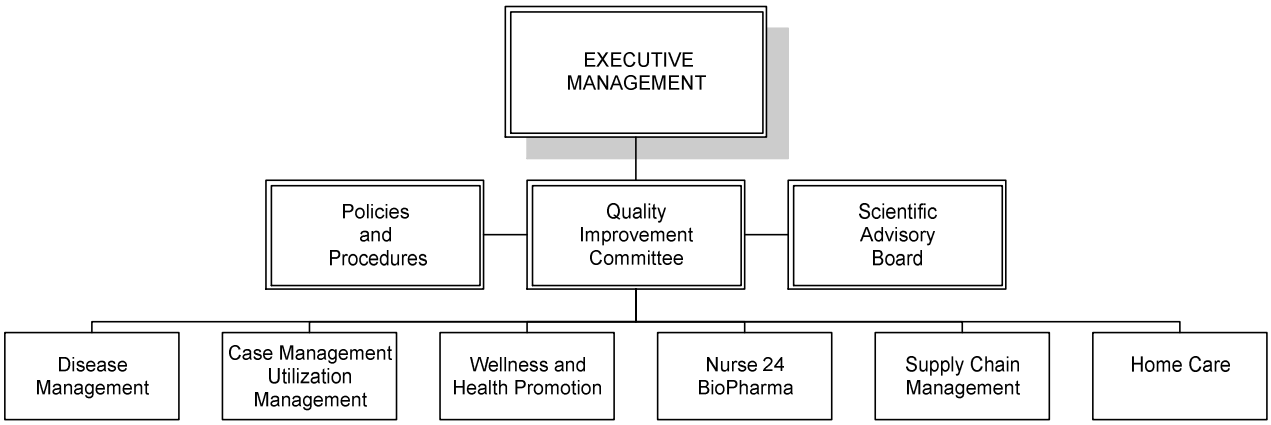
Confidential property of Optum. © 2016 Optum, Inc.

- Clinical leadership provides leadership for and manages the health intelligence function of the company, which includes the following core areas and their responsibilities:
  - Clinical integrity is responsible for ensuring that the quality of all program clinical content is consistent with approved evidence-based guidelines and represents "best practices" in the industry.
  - Reporting and analytics is responsible for providing data-driven performance management.
  - Medical affairs is responsible for providing strong clinical expertise and support to clinical operations and clinical quality.
- The operations leadership team manages the operational functions which includes the following core areas of responsibility:
  - Enrollment services are responsible for program participant outreach, educating on the benefits and elements of the program, gaining acceptance to the program and when applicable, completing a health risk assessment.
  - Fulfillment is responsible for the print and fulfillment of the educational materials and communications sent to the program participants and the program participant's practitioners.
  - Device management is responsible for medical device procurement, recertification (testing), preparation, shipping, initial set-up and on-going troubleshooting of the devices within the program participant's home.
  - Clinical operations is responsible for arming program participants with knowledge, skills and motivation that will help them make informed decisions about their care and improving outcomes.
- Other key business functions include:
  - Human resources is responsible for providing strategic leadership to the Alere Health management team by focusing on talent management, employee engagement and implementing strategic projects that support a workplace culture that promotes the company values. In addition, the department provides leadership guidance and coaching, and day-to-day issue resolution of employee issues and concerns.
  - Finance is responsible for directing the organization's financial goals, objectives, and budgets; overseeing the investment of funds and managing associated risks, supervising cash management activities, executing capital-raising strategies to support a firm's expansion, including dealing with mergers and acquisitions; and preparing financial reports that summarize and forecast the organization's financial position, such as income statements, balance sheets, and analyses of future earnings or expenses.
  - Legal and regulatory affairs are responsible for ensuring that Alere Health complies with all regulations and laws pertaining to our business.
  - Product is responsible for all aspects of product management from ideation of new products to enhancement of existing products. Product leads our Research and Development (R&D) effort and works closely with the clinical/operational and technical teams on product delivery and monitoring. Product marketing falls within this group, allowing it to manage projects from start to finish.
  - Marketing is responsible for promoting and marketing Alere Health's programs.
  - Sales is responsible for contacting potential customers and providing market feedback to Alere Health.
  - Client services is responsible for ensuring Alere Health's health management services and tools meet the needs of our clients and potential clients.
  - Technology solutions is responsible for all aspects of internal and external customer-facing applications and services. The technology solutions team manages the telecom infrastructure, help desk(s), application development of new features and functions, development of clinical and non-clinical applications, and data processing.

Confidential property of Optum. © 2016 Optum, Inc.

Quality improvement structure

The organizational chart below describes the quality oversight reporting structure of Alere Health's Quality Improvement committees.



Quality improvement committee (QIC)

The quality improvement committee is a multidisciplinary committee that retains operational accountability for the design and implementation of the quality program. Chaired by the vice president, clinical affairs, membership includes representatives from clinical quality, medical affairs, human resources, finance, product, marketing, legal and regulatory affairs, clinical operations, supply chain management, technology, health intelligence, and sales/client services. This committee is scheduled to meet at a minimum four times per year.

This committee has the authority, as vested by the governing body, of overseeing the quality and safety of services provided to program participants. Key responsibilities and functions include but are not limited to:

- Recommending policy decisions.
- Analyzing and evaluating the results of QI activities.
- Ensuring practitioner participation in the QI program through planning, design, implementation or review.
- Instituting necessary actions.
- Ensuring follow up as appropriate.
- Ensuring all quality committees maintain signed and dated meeting minutes.
- Providing oversight of quality committees to ensure opportunities for improvement are identified and appropriate actions are taken.
- Ensuring program participant safety is monitored and appropriate action taken, when needed.
- Ensuring adequate resources are available for integration of quality improvement activities throughout the company.
- Conducting an annual review and approval of Alere Health's quality program and QI work plan and annual program evaluation documents.
- Reporting to the executive council.

Policy and procedure committee (PPC)

The QIC has given the policy and procedure committee authority to retain operational accountability for review and approval of enterprise policies and procedures. The PPC is a multidisciplinary committee chaired by the policy and procedure manager. Membership includes representatives from medical affairs, clinical operations, supply chain management, clinical quality, human resources, legal and regulatory affairs, product, marketing, technology and client services. The committee is scheduled to meet quarterly, but is required to meet at least

Confidential property of Optum. © 2016 Optum, Inc.

three times per year. Responsibilities and functions include, but are not limited to, ensuring annual review of policies and procedures and maintaining a centralized library that houses company policies and procedures.

Quality sub-committee
Alere Health's sub-committees oversee the day-to-day activities of programs related to wellness, disease management, clinical enrollment, nurse information line, case management, utilization management, homecare, supply chain management, policies and procedures, and the scientific advisory board. These committees are chaired by quality vice presidents and directors. Members include representatives from the following core functions: clinical operations, medical affairs, clinical integrity, analytics, performance management, product, learning and performance and client services. They are scheduled to meet quarterly. Responsibilities and functions include tracking and trending day-to-day operations, identifying, developing and implementing opportunities for improvement and overseeing quality initiative projects.

Scientific advisory board (SAB)
The scientific advisory board provides expert, scientific evaluation and approval of peer-reviewed literature and evidence-based guidelines for the clinical management of Alere Health programs. Voting members are board-certified medical experts from appropriate specialties who serve Alere Health in a consulting/advisory capacity. This committee meets via teleconference or e-communication at least annually or more often as needed. Responsibilities and functions include, but are not limited to, reviewing evidence-based guidelines at least once every two years, review of new information related to Alere Health's programs, and costs and benefits to program participants to improve outcomes for the population managed.

Staffing, data sources and analytical resources

Alere Health accepts nothing short of exceptional customer service, market-leading products and "best-of-class" services. To ensure excellent services and products, quality is integrated throughout Alere Health. All core departments have designated staff responsible for conducting quality assurance processes. In addition, the Quality department ensures appropriate accreditations and/or certifications are achieved and maintained for each product brought forward.

Quality initiatives may be initiated or managed in departments or by a quality committee. Task forces may be formed consisting of representatives from the impacted core business units. Alere Health also employs individuals with Six Sigma certification to lead selected quality initiative projects. This provides expertise in program design, statistics and analysis, and ensures the ability to design sound studies.

Having access to and the ability to manage data is necessary to support measurement aspects of quality initiative activities. The clinical applications deliver a unique, seamless experience to program participants, a robust intuitive user interface, a streamlined workflow supporting our full suite of services, and an application tightly integrated with our touch points.

Culturally and linguistically diverse membership

Alere Health understands that health care organizations delivering services that respect and respond to health beliefs and practices, and cultural and linguistic needs of diverse program participants can help bring about more positive health outcomes. Alere Health's objective is to provide appropriate services to all program participants. Opportunities for improvement are identified based on these results.

Alere Health provides program participants with access to a national language line service when translations are requested or needed. Alere Health contracts with a national telephonic language

Confidential property of Optum. © 2016 Optum, Inc.

service that offers translation services for more than 150 languages. Employees who communicate with potential or current program participants have access to this service and utilize it when needed. In addition, written program materials are available in Spanish and are distributed in accordance with client agreements.

Additional resource materials can also be mailed to program participants that include lists of interpreter resource services and aids available for program participants with special communication needs. Cultural Diversity and Sensitivity training is mandatory for all employees who communicate with program participants. It is provided during orientation and as part of continuing education thereafter.

Alere Health's objective is to provide information, training and tools to employees that support culturally competent communication. Alere Health has developed and implemented assessment tools that are utilized by staff who communicate directly with eligible individuals and program participants. These tools help identify program participant special needs, such as hearing and/or vision impairment, special language needs including health literacy issues, and/or special cultural race/ethnicity needs. Special communication needs are evaluated at least annually as part of Alere Health's Population Assessment. Opportunities for improvement are identified based on these results.

Alere Health staff screens each program participant to identify special needs that may impact program participation, such as hearing, vision, physical or cognitive limitations. Alere Health uses Telecommunications Device for the Deaf (TDD) and/or Telephone Typewriter (TTY) devices to communicate with program participants with hearing limitations. In addition, Alere Health monitoring devices are available with high volume controls and all program participants receive printed program materials.

Individuals with visual limitations can participate in our programs by communicating telephonically with our health care professionals. In addition, some program materials are available in 12-point font or on audiotape and some monitoring devices are available in Braille.

Health Literacy is the degree to which individuals are able to obtain, process and understand basic health information and services needed to make appropriate health decisions. This includes the ability to read and comprehend prescription bottles, appointment slips and other essential health-related materials. The ability to read, understand and act on health information is a shared responsibility between program participants and practitioners. Alere Health understands that program participants with low health literacy are less likely to comply with prescribed treatment or seek preventive care. They are at higher risk for hospitalization and tend to remain in the hospital longer and require additional care, thus driving up annual health care costs.

Program participants are often reluctant to admit they have difficulty understanding health information and instructions, and often have well-practiced coping mechanisms that mask their problems. Alere Health's health care professionals also assess program participants for barriers that might be related to cognitive abilities. If a program participant is limited in his/her ability to communicate, understand instructions and process information the health care professional will seek permission to discuss the program participant's participation and care with the designated caregivers.

Program participants with complex health needs

Many of our program participants have serious life-limiting or advanced comorbid chronic diseases, such as metastatic cancer, progressive neurological and neuromuscular diseases, infectious diseases, major organ failure and traumatic injury. Case managers continuously assess the health needs of our program participants. In addition, our disease management programs address program participants' chronic and comorbid conditions and have the ability to

Confidential property of Optum. © 2016 Optum, Inc.

refer a program participant with complex health needs to case management services or other internal or external specialists or programs, when available.

Safety management

Safety is the cornerstone of high-quality health care. Alere Health's programs are administered by health care professionals with the goal of arming program participants with the information and support they need to improve self-care. An integral part of many of Alere Health's programs is to ensure program participant safety by frequently assessing health status, medication adherence, and mental well-being, as well as care coordination and care transition planning. Health care professionals are provided with comprehensive policies, procedures, guidelines, training and tools to evaluate and identify potential risks to program participants.

Key elements

Program participant assessment

Alere Health's health care professionals conduct a comprehensive assessment of each program participant upon enrollment in the program and on an ongoing basis. This assessment includes medication management, cognitive function, depression screening and other safety factors, such as home safety, fall risk and whether the individual has the ability to participate in a device-monitoring program. Once safety issues are identified, the health care professional provides appropriate education and customized interventions for the program participant.

Medication management

Case management (CM) and disease management (DM) Programs conduct a full medication review during the initial assessment on all program participants and during transitions of care. Health care professionals provide education on medication side effects and assess the program participant's adherence with their medication regimen. If there is any concern or need for medication reconciliation identified, the health care professional will work with the program participant, other health care providers or the program participant's practitioner for resolution. Any FDA alerts about actual or potential problems with prescription, over-the-counter (OTC) medications and medical devices that might pertain to our program participants, are part of ongoing training provided to health care professionals.

Transition/coordination of care

Whenever a CM or DM program participant's health status changes (for example, moving from home to a hospital as the result of a chronic condition; moving from the hospital to a rehabilitation facility after surgery), case managers provide care coordination and referrals as needed. The need for medication reconciliation is assessed and education regarding any medication or treatment plan changes is provided.

Medical director consultation

Alere Health Medical Directors provide clinical oversight to all Alere Health programs. They are available 24 hours a day, 7 days a week for disease management, case management and Nurse24 programs for consultation on complex cases, standard treatment plans, quality of care issues, and medication questions. Medical Directors are available during business hours for all other programs and as needed. Medical directors are required to have a current, unrestricted clinical license, qualifications to perform program specific clinical oversight, board certification and post-graduate experience in direct patient care.

External quality of care (EQOC)

Quality of care complaints are defined as an oral or written expression of dissatisfaction relating to the program participant's practitioner, treatment plan, health care facility or health plan benefits. All EQOC issues are entered into the Alere Health complaint/safety reporting portal. Client reports are generated per client agreements. If the issue pertains to a treatment plan, the health care professional may consult with their supervisor and the Alere Health medical director.

Confidential property of Optum. © 2016 Optum, Inc.

Care gaps/CareAlerts
Alere Health identifies gaps in care that could indicate lack of appropriate screenings/tests or adherence to a program participant's treatment plan. Care gaps display to internal staff so they can address issues with the program participant and his/her practitioner as needed. CareAlerts are written notifications to practitioners and/or program participants that address some of these same issues.

Urgent and emergency medical conditions
An urgent medical condition is defined as a medical condition that requires care within 24 hours to prevent serious deterioration of health following the onset of an unforeseen condition or injury, such as a sore throat, fever, minor lacerations, and some broken bones. The health care professional will advise the program participant or caregiver to call the practitioner or go to the ER.

An emergency medical condition is defined as a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. This includes harm to self or others, headache with loss of neurological function, chest pain or shortness of breath not relieved by current treatment plan. In these situations, health care professionals will advise the program participant or their caregiver to go to the ER or call 911. In situations when the program participant or their caregiver is unable or unwilling to go to the ER or call 911, the health care professional will activate emergency medical services.

Alere Health staff makes follow-up calls to program participants within 24 business hours of the report of the incident to determine the outcome of the incident, offer support and resources and also contact the program participant's practitioner.

Program oversight/reporting relationships
The QIC is responsible for the oversight of safety management and reviews reports at least annually.

Monitoring and evaluation of outcomes
The below safety events are entered into the Alere Health complaint/safety reporting portal by health care professionals:

- Alere Health staff initiates a 911 call or a police welfare check to a program participant's home.
- Program participant is contemplating suicide and the situation is determined to be imminent.
- Program participant is threating to harm another person and the situation is determined to be imminent.
- Program participant reports an incident of child or elder abuse.
- Program participant reports a fall or injury as the result of using an Alere Health device.

The above situations are monitored and evaluated by the quality department. Designated individuals are responsible for investigating reported safety events. A log is maintained to identify trends and patterns. Reports are presented to the QIC for evaluation and identification of opportunities for improvement.

Satisfaction performance

Alere Health utilizes program participant, practitioner and client satisfaction results, as well as complaints to assess service delivery and quality of care. Process improvement opportunities are identified by analyzing trends in satisfaction results. Tracking complaints yield a picture of

Confidential property of Optum. © 2016 Optum, Inc.

perceived or actual breaks in quality of care or service. Alere Health's quality improvement committee reviews satisfaction results, complaints, and opportunities for improvement at each meeting. The quality improvement committee maintains overall responsibility for satisfaction performance.

Program participant satisfaction
Measuring program participant satisfaction is one of the best mechanisms for soliciting feedback from program participants related to their perspectives and issues. Overall impressions as well as specific comments can be used to improve processes, identify specific problems, and develop quality improvement projects to continuously improve program participant's experiences.

All Alere Health disease management, Nurse24, case management, coaching (telephonic or online) and wellness portal programs evaluate program participant satisfaction at least annually, or per specific client contract. Categories for data collection may include the following components:

- Overall program satisfaction
- Program staff
- Educational information
- Program participant - reported health outcomes
- Access to the program
- Number of program participant contacts with the program

Practitioner satisfaction
Measuring practitioner satisfaction is one of the best mechanisms for soliciting feedback directly from the program participant's treating practitioners. Overall impressions as well as specific comments can be used to improve processes and identify specific problems to assure practitioners understand and see value with Alere Health's programs.

All Alere Health's disease management programs evaluate program practitioner satisfaction at least annually. Other Alere Health programs evaluate program practitioner satisfaction in accordance with client agreements. Practitioner satisfaction surveys collect information based on the practitioner's experiences and satisfaction with the Alere Health program as provided to their patients. Categories for data collection may include the following components:

- Perception of the usefulness of program content
- Satisfaction with personal interactions with the program
- Perception of the program's impact on program participants' use of services
- Perception of the program's impact on program participants' health status relative to treatment plan goals

Client feedback and satisfaction
Alere Health evaluates client satisfaction for all programs annually. Assessing client satisfaction provides Alere Health with actionable data that includes unbiased client feedback and client perceptions of quality, products, and services. Once client satisfaction results are reviewed and analyzed, opportunities for improvement are identified and work plans are put into place.

Complaints
Alere Health monitors and reports complaints in compliance with established regulations, accreditation standards and/or other contractual requirements. Alere Health further recognizes that complaints indicate perceived or actual breaks in the quality of the care and service provided by Alere Health. Appropriately documenting each of these episodes, as well as tracking and trending, is essential to providing optimal customer service and quality care. Alere Health addresses individual customer issues as well as identifies process improvement opportunities.

Program participants in the disease management, Nurse24, wellness, and case management programs have the right to communicate complaints to Alere Health and receive instructions on

Confidential property of Optum. © 2016 Optum, Inc.

how to use the complaint process, including knowing Alere Health's standards of timeliness for responding to and resolving issues of quality and complaints.

Program participants are informed of their rights via written program materials, staff interactions or Alere Health's website. Language Line interpretation services are available for program participants, his/her representative, caregiver or practitioner to register oral complaints.

Any staff member may receive a complaint from a program participant, his/her representative, caregiver, client, practitioner, vendor, or other 3rd party. Alere Health staff are required to enter a complaint into Alere Health's secure, online complaint/safety reporting portal within 1 business day, if possible. The staff member receiving the complaint will utilize good customer service techniques to resolve the complaint during the initial contact. All complaints are entered into the complaint/safety reporting portal, even those that are resolved during the initial contact/first call. Once the complaint is entered, investigation of the root cause begins.

The investigation may include discussions with staff that received the complaint, review of the program participant's electronic record and/or program materials and communications. Once completed, the findings and action plan are documented in the complaint/safety reporting portal. Alere Health's goal is to resolve/close all complaints with the complainant within 28 calendar days of receipt.

Wellness and health promotion (WHP) programs

The wellness and health promotion program empowers individuals to improve their health and make sustainable lifestyle changes by providing a comprehensive set of tools and services. These tools and services are designed to educate and motivate healthy and at-risk individuals as well as those with chronic conditions to make lifestyle changes and to take other steps to target, engage, and reduce health risks.

Individuals are motivated to participate in our wellness program and to make healthy lifestyle changes through targeted, personalized and integrated programs. These programs are reinforced by population health challenges and communications. Our science-based programs provide a high level of flexibility and choice. Core elements that deliver this experience include: Annual program strategy and design, Health and Productivity Assessment, incentive management, self-management tools, screening services, coaching services, and a personal health record.

Client engagement

Alere Health assesses the client's current wellness and health promotion program, as well as:

- Leadership engagement
- Communication strategies
- Corporate culture
- Work facilities and policies
- Existing wellness program
- Benefit design
- Workforce demographics which include employees' race/ethnicity and language needs and
- Other resources offered by the client.

Alere Health provides the client with information that describes the advantages, disadvantages and the effectiveness of offering incentives to eligible individuals. The following activities are frequently tied to incentives:

- Completing health assessments.
- Participating in activities.
- Achieving improved health outcomes during the assessment stage and annually thereafter.

Confidential property of Optum. © 2016 Optum, Inc.

- Alere Health does not manage incentive fulfillment, but we have the capability to provide data to third parties that do, such as program participants who completed health assessments and activities.

A customized written implementation plan is developed for each client that includes the following elements: objectives, quantifiable goals, a communication plan, activities to engage the population, and steps to address areas identified by the client assessment. The plan also details the type and frequency of reports that will be required and provided to the client.

During the assessment stage and annually thereafter, Alere Health reviews the client's demographic and special needs reports. Alere Health has the capability to provide the health assessment, education materials, and self-management tools in Spanish. The coaching staff has access to a national interpreter service and can meet many language needs. Program participants with hearing impairments can participate in the wellness program, since most materials are available both in digital format and by mail upon request.

Alere Health uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities and proprietary program content as the basis for program and intervention design. Program source materials, such as evidence-based guidelines and key program content from recognized sources/authorities are monitored, reviewed and approved at least every two years by the Scientific Advisory Board/Group. In addition, the health and productivity assessment and the wellness program self-management tools are reviewed and approved every two years by subject matter experts.

Engaging the population
To increase health awareness and skills for improving and managing health for the population, Alere Health offers evidence-based services to all eligible individuals on at least the following topics:

- Healthy weight (body mass index (BMI)) management
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthful eating
- Managing stress
- Avoiding risky drinking
- Identifying depressive symptoms
- Clinical preventive services

Individuals are motivated to participate in the wellness program and to make healthy lifestyle changes through targeted, personalized and integrated programs. These programs are reinforced by population health challenges and communications. Alere Health's science-based programs provide a high level of flexibility and choice. Core elements that deliver this experience include:

- Program participant health portal
  - Customized, personalized user experience
  - Engaging content and calls to action, leading to positive outcomes
  - Customized client key initiatives and programming
  - Mobile responsive
- Health and productivity assessment (HPA)
  - Science-based, behavioral health strategy questionnaire
  - Personalized report provides behavioral and medical risks
  - Recommends appropriate interventions and programs for personalized experience
- Screening services
  - Reach entire population with at-home and on-site screening
  - Quantifiable results to identify health risks
  - Results auto-populate program participant health data record

Confidential property of Optum. © 2016 Optum, Inc.

- Self-management tools/virtual coaching
  - Online science-based behavior change programs
  - Personalized, actionable information tailored to the individual
- Healthwise® Knowledgebase
  - Provides comprehensive, current, evidence-based information that supports a variety of health care decisions
  - URAC-accredited online resource
  - Available in English and limited Spanish
  - Includes goal-specific topics including activity, diet, weight, tobacco and stress. Condition-specific libraries cover a wide range of disease states as well as personal and family health topics, such as CHF, asthma, diabetes, CAD, pregnancy, first aid and mental health.
  - Decision tools to help people understand the facts, compare their options, and make informed decisions about a broad range of health topics.
- Coaching
  - Behavior change coaching using social cognitive theory and various other applicable theories
  - Flexible, unlimited, multi-modal communication with a coach
  - Promotes and increases individual engagement
- Personal health record (PHR)
  - Tailored PHR with program participant health history and metrics
  - Integrated with Alere Health clinical application

Health portal

The health portal's content, tools and resources are organized and prioritized based on the client's needs and assessments and usually include the following features:

- Client-specific promotions and activities
- Program participant message center
- Secure single sign-on capability
- Customized content delivery
- Incentive tracking and management system
- Integration of third-party programs
- Health and productivity assessment
- Health resources, content and tools
- Personal health records
- Access to digital behavior change programs
- 24/7 access

Health and productivity assessment

Alere Health's health and productivity assessment (HPA) is a fully integrated tool that provides the opportunity to identify at-risk and high-risk individuals, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. It is available in digital format and in print.

Upon completion of the HPA, individuals receive a targeted action plan with recommended programs prioritized based on their risk factors and readiness to make changes. In this way, the system provides targeted programming at the "teachable moment" when individuals are most aware of their health.

The HPA can be administered annually and helps individuals identify risk factors they can address to better manage their health. It includes questions on demographics, health history including medical conditions, current treatment and medication status, preventive screenings/immunization status, self-perceived physical and mental health status, readiness to

Confidential property of Optum. © 2016 Optum, Inc.

change lifestyle risk factors, safety behaviors and special needs, such as hearing impairment, vision impairment and language preference.

The individual's HPA report provides an overall summary of his/her risks and reference information to help him/her understand the results and comparison to previous results when applicable. In addition, it provides a clinical summary describing the risk factors, as well as information on recommended virtual coaching (VC) to assist the individual in making behavioral changes to reduce these risks.

Alere Health uses the following data sources to identify the WHP needs of eligible individuals and develop targeted follow up: HPA results or equivalent clinical data, demographic, biometric, claims and referral data gathered from client activities. Specific criteria are applied to the available data so the individual can be directed to targeted activities that include information about increasing health awareness and skills, opportunities for engagement and activity, self-management tools, coaching and preventive health services for at least the following: Healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, and clinical preventive services.

Health advisor
Upon completion of the HPA and according to client contract, program participants are provided the option of calling into the Health Advisor team as an added program feature. After welcoming the program participant to Alere Health and providing a brief overview of the call objectives and time expectations, the Health Advisor will review the individual's HPA results and summarize the primary components (Alere Health and client-based services) of the wellness program. Program participants will receive guidance on risk-appropriate intervention activities, the process to receive incentive points/credits and referrals to applicable disease management, coaching services or other client resources.

Screening services
Alere Health has the capability to capture biometric data and currently contracts with vendors to provide screening data in accordance with client agreements. Standard screenings include, but are not limited to, tests such as total cholesterol, high-density lipoprotein, low-density lipoprotein, triglycerides, A1C, cotinine and blood pressure. The services include a feedback report for each individual as well as an aggregate client management report after each event. Results of health screenings are used in combination with health assessment data to trigger education either on-site or telephonically, depending on the service contracted.

Self-management tools/virtual coaching
Alere Health's virtual coaching programs are comprehensive tools that address the following wellness and health promotion areas: healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, and managing stress.

The virtual coaching program allows a member to choose a focus area such as reach a healthy weight, improve your diet, feel less stress, be more active and live tobacco free. After selecting a focus area, the program participants are asked to set a goal, complete a short Initial health assessment and are then presented with a personalized action plan. The action plan utilizes the principals of behavior change to provide the program participant with personalized, actionable to-do's to help them meet their health goals. The virtual coaching program is self-paced, allowing the program participant to move through the curriculum at their own pace. Program participants can also find educational materials on their action plan in the form of articles, videos, and seminars.

The virtual coaching program contains resources and tools that help individuals determine risk factors, provide guidance on health issues, and recommend ways to improve health, support reducing risk or maintaining low risk. Examples of some of the self-management tools included in

Confidential property of Optum. © 2016 Optum, Inc.

each focus area are interactive quizzes, worksheets that can be personalized, digital logs of physical activity, caloric intake and portion size charts.

Virtual coaching content is reviewed at least every two years to ensure that the language is easy to understand and that program participants' special needs, including hearing and vision impairments are addressed.

Coaching solutions

The coaching program encourages program participants to make positive lifestyle changes to promote the life-long practice of good health, prevent chronic conditions and reduce health care costs. It incorporates telephonic, digital and print modalities to maximize the impact of the intervention. Education and guidance are offered in the following areas: healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services and customized programs designed to address other health issues.

Individuals are identified for the program if their HPA indicates a specific health risk criteria and a willingness to make changes to improve health. Enrollment outreach begins as soon as an individual completes the HPA in digital format and is identified as eligible for the program.

Coaching communications, like all Alere Health interventions, are personalized according to each program participant's values, preferences, and readiness to make lifestyle changes. Coaching outreach is driven by a program participant's specific needs. Alere Health systems allow the coach to view, input or edit the following program participant information: demographics, contact preference, HPA results, contact history log, goal tracking, behavioral change tracking, barrier analysis, planned follow-up schedule, external referral and follow-up times, preferred language, job characteristics, health organizations available for referral and national or community resources.

The program utilizes a primary coach model that allows a program participant and a health coach to develop a personal relationship in which a coach can help identify motivators and identify and assist the program participant in overcoming barriers. Coaches help program participants develop action plans that include specific incremental goals and ways to overcome barriers and boost confidence to sustain long-term behavior change. Coaches can also provide referrals to disease management and case management organizations, EAPs, managed behavioral health care organizations, and national or community resources, in accordance with client agreements.

Communications range from weekly to monthly, depending on the program and the program participant's preference. Each program participant receives a coaching workbook that includes information about what to expect once enrolled in the program, goal-setting resources, and worksheets and tools that promote healthy behavior change.

Communication assistance is available to program participants with special needs. In addition, program participants have unlimited access to a coach for six months. Access to Health Coaches is available by telephone from 9 a.m.-7 p.m. Monday to Thursday, and from 9 a.m.-6 p.m. Friday to Sunday in the program participant's time zone as well as by secure email.

Alere Health coaches have a variety of clinical backgrounds and include registered dietitians, exercise physiologists, respiratory therapists, and Master's-level counselors and social workers. Coaches undergo an extensive training curriculum that includes: evidence based guidelines around health promotion topics, coaching strategy, behavior change theory, cultural competence, goal setting, the referral process, confidentiality, emergency situations and concise online communication techniques. They use established science-based behavior-change principles, motivational interviewing and positive reinforcement to help individuals identify and work on health risks they're ready to address. Coaches are continuously evaluated by supervisors and given feedback on their performance.

Confidential property of Optum. © 2016 Optum, Inc.

Quit for Life
The Quit For Life® program is the tobacco track for coaching within the Alere Health coaching solution. It is the nation's leading tobacco cessation program. The Quit For Life® Program employs an evidence-based combination of physical, psychological and behavioral strategies to enable program participants to take responsibility for and overcome their addiction to tobacco use. Using an integrated mix of medication support, phone-based cognitive behavioral coaching and web-based learning and support tools, the Quit For Life® Program produces an average quit rate of 43% for employers.

The Quit For Life® program is the only commercial tobacco cessation program in the U.S. with proof of effectiveness published in multiple peer-reviewed scientific journals over the course of 25 years. We treat each tobacco user as a unique individual and tailor the intensity of treatment based on each individual's specific needs and attributes so his or her participation in the program is most likely to result in a successful quit.

Weight Talk
The American Diabetes Association® supported Weight Talk® Program, which is the weight focused track for coaching within the Alere Health coaching solution, is an evidence-based personal coaching program designed to achieve measurable, sustainable weight loss. Unlike "self-help" weight loss products, the Weight Talk® program is delivered through regular phone-based coaching sessions with a dedicated coach, supported by specialized calls with registered dietitians. The experience is highly personalized, deeply supportive, and proven effective. Program participants set realistic weight loss goals and then learn how, through small, tailored changes across multiple behaviors, to achieve and maintain a healthy weight for the rest of their lives.

Designed by international obesity expert Dr. Jennifer Lovejoy, the Weight Talk® program delivers impressive results. Program participants can expect a reduction in weight by at least 5 percent, with significant improvements in nutrition, activity, stress, blood pressure, cholesterol, and overall health, and also meaningful increases in their confidence and knowledge to maintain their new weight and healthy behaviors.

Program oversight/reporting relationships
Wellness program data is reported at least quarterly, via the Quality Improvement Work Plan, to the designated quality committee for review and analysis of data, discussion of barriers, identification of opportunities for improvement, and development of QI initiatives.

Monitoring and evaluation of outcomes
Alere Health has achieved Full NCQA Accreditation with Performance Measures. This means measuring and monitoring the metrics listed in the NCQA Technical Specifications, in addition to measures related to access, coaching operations, and program participant satisfaction. NCQA WHP Technical Specifications are a prescribed set of metrics established by NCQA that require annual audits by a Certified HEDIS Compliance Auditor (a comparable process to the Health Plan's annual HEDIS audit). The following lists the categories of measures that are included:

- Health assessment completion.
- Health promotion for the population.
- Staying healthy.
- Prevalence and number of core risks identified on health assessment.
- Risk Reduction: BMI reduction and maintenance, smoking or tobacco use quit rate, and physical activity level.

Wellness and health promotion 2016 goals

- Building out the Quit for Life tobacco cessation program within our Apollo clinical/portal applications from the legacy 4D platform. This will allow for Alere Health to provide a more enhanced experience for our Quit for Life program participants and more integrated approach to transitioning between products and services.

Confidential property of Optum. © 2016 Optum, Inc.

- Define various program structures for our Lifestyle and Weight Talk coaching products to support external payer client needs and support the growth of Alere Health products and services.
- Launch, test and learn opportunities such as the Mental Health/Quit for Life pilot to address the mental health needs of those we are able to communicate with via tobacco cessation efforts.
- Identify digital opportunities to enhance our current product offering and to allow program participants to engage further via digital components and less with a live operations agent.
- Develop metrics and benchmarks to track the health and quality of the Wellness Solutions/Portal-Incentives product; institute process for monitoring and taking proactive actions to enhance quality, correct issues and continue to collect value points to enhance our go-to-market story.
- Conduct ongoing user testing for the portal to assist in identifying areas for improvement and satisfaction.
- Develop and launch several enhancements to next gen portal including:
    - Multi-lingual portal (Q1)
    - Action Plan (Q2)
    - Health Assessment Report (Q2)
    - Goal Setting Process (Q3)
    - Navigation (Q3)
    - Expanded Focus Areas (Q4)
    - Incentive Dashboard (Q4)
    - Library (Q4)
    - Others as determined by ongoing review of user testing and customer needs

Disease management (DM) programs

Alere Health has NCQA accredited disease management programs for the following chronic diseases and conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure, musculoskeletal pain management, depression, high-risk pregnancy and first year of life.

Goals and objectives

The goal of Alere Health's disease management programs is to help program participants manage their conditions and achieve compliance with nationally recognized guideline recommendations. This is done through a unique combination of multimodal interventions and through the development of a therapeutic alliance between program participants and the clinician, program participant-empowering education, and nurse-program participant relationships. Health care professionals work with program participants and treating practitioners to:

- Slow disease progression and development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines, medication adherence and practitioner care plans
- Manage medications and enhance symptom control.
- Educate program participants about recommended preventive screenings and tests in accordance with national evidence-based guidelines.
- Reduce unnecessary hospitalizations.
- Prevent medication errors.
- Empower program participants to become more actively engaged in the management of their health.

Program content/evidence-based guidelines

Alere Health uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities, and proprietary program content as the basis for program development,

intervention, and design. Program source materials are monitored, reviewed and approved at least annually by the scientific advisory board.

Access to health care professionals
Health care professionals are available by telephone, via IM CHAT, or secure email 24 hours a day, 7 days a week.

Identification and stratification
Identification and stratification is the first step in the program enrollment process. Alere Health has the ability to integrate data from the following data sources when applicable and available:

- Medical claims
- Pharmacy data
- Behavioral health data
- Health assessment results
- Laboratory results
- Utilization and case management data
- Health management results
- Wellness and coaching program data
- Electronic health records and
- Data from individuals and practitioners

At the core of Alere Health's programs is a rigorous ongoing identification process that includes predictive modeling and data analysis. Alere Health utilizes Impact Pro™, a leading predictive modeling application, combined with proprietary risk stratification criteria to group individuals into different risk categories for disease management. The key advantage of the predictive modeling and stratification approach is that we can incorporate multiple data sources into the process. Individuals are stratified based on utilization markers in their medical claims data. The risk scores are further determined based on an individuals' input and gaps in care information. This method allows individuals to be engaged in a meaningful experience using multi-technology modalities with data-driven support that is individually centered and promotes shared care management between an individual's personal practitioner and Alere Health's health care professionals.

Program participants are further stratified according to their actual clinical history and findings as documented at the time of their initial assessment. Program participants are not only re-evaluated on a monthly basis from claims, but also each time a health care professional communicates with them. Program participants using remote biometric monitoring devices are further stratified as often as daily when data is received by Alere Health. This drives real time intervention(s) based on biometric risk scoring.

Alere Health enrolls individuals in one program at a time. If an individual meets the specific criteria for multiple program enrollments and those programs are available through Alere Health, he/she is targeted for the program at the highest level in the hierarchy. Alere Health's standard hierarchy for programs and conditions is as follows:

1. NICU Case Management (CM)
2. Burn Trauma/Catastrophic CM
3. Complex CM
4. Oncology CM
5. Chronic CM
6. FYOL
7. DM - Maternity
8. DM – HF
9. DM - COPD
10. DM - CAD
11. DM - Diabetes
12. DM - Asthma

Confidential property of Optum. © 2016 Optum, Inc.

13. DM - MSP
14. DM – Depression

Consistent application of criteria process
Alere Health technology and operations have comprehensive processes in place to ensure the consistent application of criteria to identify eligible individuals for each DM program and then stratify appropriately. When client data files are received, the procedures listed below are followed:

- All received data from the client or client's data vendors is catalogued and tracked through the system processes.
- Client data is standardized, certified, and transferred to a cumulative database containing client-specific tables.
- All processes are automated where practical to ensure consistent, controlled processing.
- Proprietary, program-specific identification and stratification algorithms and criteria are run against the client data and potential program participants are identified each time associated data files are received.
- As part of the identification and stratification process, program participants are stratified into high or low acuity, with specific levels of intervention as appropriate, based upon the associated data.
- Identified program participants are automatically verified for eligibility and loaded to the clinical application where the enrollment team also confirms eligibility and disposition.
- Member eligibility is automatically checked every time new eligibility data is received from the client.
- A detailed hierarchy for programs and conditions is applied to ensure the program participant is placed in the program that is ranked highest based on their condition.
- Alere Health evaluates the accuracy of the rule-based identification process using a variety of methods, including: reviewing and updating program criteria ICD-9, IDC-10 and CPT codes at least annually; updating NDC/GPI codes monthly, and utilizing IT quality improvement projects to determine removal of false positives. In addition, enrollment staff confirms the condition with the identified individual prior to enrollment.

Disease management system
Alere Health's clinical platform allows the health care professional to view, input or edit the following program participant information: demographics, contact preferences (including language, vision and hearing needs), contact history log, self-management goal-tracking, information on condition monitoring, treatment plan and adherence to plan, comorbidities and other health conditions, health behaviors, medications, psychosocial issues, results from depression screening, lab results if applicable, and schedule for follow-up contacts.

Interventions based on program participant needs or risk level
Targeted interventions include verbal and written education specific to a program participant's chronic condition, complications, and assigned risk level. This ensures program participants receive the most appropriate interventions and yield the best health improvement opportunities.

There are also instances in which program participants require special considerations and/or exceptions. This may prioritize one intervention over another and may exclude a program participant from a particular intervention such as:

- Urgent safety issues such as the threat of harm to self or others will need to be resolved prior to beginning any other interventions. Alere Health will refer these cases to local authorities, the employer's EAP, behavioral health practitioner or facility in accordance with law and regulation, the client contract, or other interventions as appropriate.
- If the program participant has just been discharged from the hospital and does not feel well enough to participate in Alere Health's designated disease management program then he/she can be put on a temporary absence until he/she is able to fully participate and resume regularly scheduled phone calls.

Confidential property of Optum. © 2016 Optum, Inc.

- Positive depression screening results: The program participant will be referred to the employer's EAP, a behavioral health practitioner or facility, or case management in accordance with the client contract.
- Health behaviors such as tobacco use, especially if enrolled in our chronic disease or maternity programs: Alere Health will refer the program participant to his/her practitioner or an available smoking cessation program.
- Psychosocial needs/issues such as problems with a caregiver, food, transportation, communication or with paying for medications. Alere Health will refer him/her to local community resources, if available or the client's designated case management program in accordance with the client agreement.
- Physical disabilities such as inability of a program participant to use a program biometric device. He/she will be enrolled in a telephonic-only program.
- Mental/cognitive disability: If the program participant has trouble communicating or understanding, the health care professional may ask to talk with a caregiver, family member or authorized representative.
- Hearing disability: The health care professional will inform the program participant or caregiver of the availability of the TDD or TTY service.
- Vision disability: If the program participant mentions he/she has limited vision, the health care professional will communicate with the caregiver to obtain information that requires reading, for example medication names and dosages.
- Language barrier: If the program participant or staff member feels an interpreter would be helpful, the program participant will be connected to the contracted language line.

Comorbidities assessment

Comorbidities are initially identified at the time of the initial assessment and stratification. During this process, an individual is targeted for enrollment in the DM program that Alere Health believes will be the most effective and have the greatest impact on his/her quality of life. As a program participant answers questions during initial and ongoing assessments, other health issues or related conditions (like migraine headaches, obesity, hypertension, and depression) may be introduced. The health care professional discusses these health issues and the primary condition with the program participant and incorporates them into the plan of care, addressing all relevant gaps in care, and support better management of that condition as well as the assigned program condition. This allows us to provide a holistic approach when addressing the program participant's needs at any given time.

Depression screening

Health care professionals screen all high and moderate acuity program participants for depression risk during the initial assessment and periodically thereafter using the two question Whooley survey. A "yes" response to either question indicates a positive screening. Identification of postpartum depression in a previously pregnant program participant may result in a referral to case management, dependent on client contract. Alere Health offers a postpartum depression program for maternity program participants that utilize the Edinburgh Postpartum Screen Assessment. Health care professionals provide encouragement to the program participant along with resources and referrals to client-specific behavioral health services. In addition, Alere Health provides comorbid management of depression in the DM Chronic programs. This management is focused on compliance with the treatment plan prescribed by their behavioral health provider, and evaluation of the severity of their depression which would result in a referral to a behavioral health vendor or their practitioner.

Healthy behaviors

Alere Health health care professionals know that an individual program participant's health behaviors may impede his/her ability to manage a condition, which is why health care professionals provide continuous emotional support and encouragement to change behavior. Alere Health DM programs offer a self-management strategy that reinforces a program participant's capacity for self-reliance and self-determination through education, affirmation,

Confidential property of Optum. © 2016 Optum, Inc.

information, advocacy, collaborative planning and problem-solving. Through educational materials and telephonic interactions, Alere Health helps program participants identify behavioral health issues and encourages them to improve lifestyle-related behaviors to meet their goals. Health care professionals may also refer program participants to local and national entities like Weight Watchers® or fitness programs, in accordance with client agreements.

Because Alere Health knows that program participants need to learn behavioral skills to successfully manage their disease, our health care professionals have participated in comprehensive Cognitive Social Theory training. This behavior change method helps the nurse identify the barriers to changing a behavior and focuses efforts on helping the individual address those barriers by incorporating the program participant's individualized motivation.

For example, if a program participant with diabetes is not getting an annual LDL test, the nurse will probe the underlying reasons and work with the program participant to resolve the issue. Setting short-term obtainable goals is one of the techniques involved in this training so that program participants gain a quick win and are motivated to continue. The goal is to increase the probability of a positive change and set the program participant up for success.

Behavioral health

Alere Health understands that providing general information to a program participant about his/her chronic condition is not always sufficient. It is important to understand the issues that may be preventing a program participant from accessing or adhering to his/her practitioner's treatment plan. Psychosocial concerns related to a health condition such as: lack of family support; transportation; financial barriers; cultural, religious, ethnic beliefs; and health literacy contribute to overall health and well-being.

Health care professionals assess and identify barriers that might be related to psychosocial circumstances and cognitive abilities. If barriers are identified, the program participant is referred to a health care professional who will work toward understanding and addressing identified issues in a language and at a literacy level the program participant can understand. Often, referrals are made to special resources to assist program participants and work toward eliminating barriers relating to access to care including transportation and finances. If it is determined the program participant has limitations related to his/her ability to communicate, understand instructions or process information about his/her illness, the health care professional will get permission to discuss participation and care with the designated caregiver.

Obtaining consumer input

Alere Health is committed to process and program improvement. Feedback from program participants and consumers provides valuable information to maximize program effectiveness. In addition to tracking and trending complaints and satisfaction survey results from program participants, practitioners, and clients, Alere Health communicates with client organizations in an effort to obtain feedback about program content, relevancy, delivery and customer service. Changes may be made to printed program materials, oral communications or delivery modes, as needed.

Caregiver/family support available to program participants

Health care professionals assess caregiver support during the initial assessment. After the program participant's initial assessment is completed, the health care professional will communicate with the designated caregiver with the program participant's consent. He/she will confirm/secure caregiver authorization from the program participant and evaluate the type of assistance caregivers can provide. Once assessments are completed, the health care professional evaluates whether caregiver support is adequate to meet the program participant's needs.

Confidential property of Optum. © 2016 Optum, Inc.

Coordination with treating practitioners

To optimize continuity of care, activity-based interventions are coordinated with treating practitioners. Program participants are encouraged to communicate with their practitioners about their health conditions and treatment. Alere Health confirms treating practitioner information during the enrollment process.

Program materials are sent to the practitioner within 45 days of enrollment of their patient and include a welcome letter with a brief program description and details about how to use the program. The welcome letter also includes instructions for accessing the decision support materials and clinical practice guidelines which are provided on a practitioner website and is updated whenever changes are made. Practitioners are also directed to this site upon request.

Decision support information includes evidence-based guidelines and notification of care opportunities. Actively practicing practitioners are involved in the development and review of these materials through communication with the Clinical Integrity team and the Scientific Advisory Board. Evidence-based guidelines are available at all times on Alere Health's practitioner website and upon request. Care Gap/Alert notifications are also provided to practitioners in an effort to fill gaps in care before they escalate into high-risk or high-cost events. These reports are data-driven, easy-to-understand and offer actionable information. Alere Health provides the following care gap reports:

- Alert report: This report is faxed to a practitioner when pre-determined clinical criteria are not met or when a nurse believes clinical information requires practitioner review and program participant intervention within 24 hours.
- Status report: This report is faxed to a practitioner when a nurse determines clinical and/or psychosocial information should be transmitted to the practitioner, but does not require review within 24 hours.
- Medication report: This report is faxed to a practitioner when a nurse or a Pharmacy Benefit Manager (PBM) upload identifies a medication issue or absence of a condition-specific guideline medication requiring practitioner review. It lists all the medications the program participant is taking and includes a request to review the program participant's records for other class medications that may be appropriate for managing his/her condition.
- Health data fax: This report is faxed to a practitioner when a health care professional requests specific health data results from the practitioner's records, such as lab results or other biometric data. This is then used to develop a personalized plan of care for the program participant.
- CareAlert: This report is faxed or mailed to a practitioner when an analysis of a program participant's medical, pharmacy, and/or lab claims data indicates a gap in standard care, preventive testing or medication compliance. Alere Health's CareAlert functionality applies predictive modeling algorithms to identify drug interactions, dangerous side effects and clinical gaps in care across an entire population. This identifies opportunities to improve safety and quality of care for program participants. Customized engagement strategies allow treating practitioners and health care professionals to monitor a program participant's progress, medication adherence and potential risk management issues. CareAlerts are sent per client contract.

Referrals to additional resources

When appropriate, the Alere Health health care professional may refer a program participant to additional programs such as case management, behavioral health programs, wellness, coaching or community resources. Information available to program participants, practitioners and health plan clients in order to facilitate referrals may include treatment plan, testing, treatment and adherence data, comorbidities, depression screening results, assessment of health behaviors and psychosocial behaviors as appropriate to the referral type. Alere Health health care professionals follow up with the program participant at the next scheduled contact to determine the referral outcome.

Confidential property of Optum. © 2016 Optum, Inc.

Program oversight/reporting relationships
Oversight to the Alere Health's disease management programs is provided by Alere Health executive management, the quality improvement committee and contracted consultants who are professionally licensed, certified and/or registered and qualified to provide clinical services.

Monitoring and evaluation of outcomes
Disease management data, including participation rates are reported at least quarterly via the QI Work Plan to the designated quality committee for review and analysis, discussion of barriers, identification of opportunities for improvement, and development of QI initiatives. Further analysis occurs at the QIC each quarter. Quality activities and formal Quality Improvement Projects are approved at these committee meetings.

Asthma DM program

The asthma program strives to improve quality of life, increase productivity and reduce clinical service utilization, such as admissions, and absenteeism. It helps individuals identify and manage asthma triggers, allergies, exercise, weather and emotions related to the condition by:

- Learning about their disease and the health risks associated with it.
- Adhering to their practitioner's care plan and medication regimen.
- Recognizing and controlling symptoms that may worsen the condition.
- Identifying individual asthma triggers such as dust, mold, cold air, cigarette smoke, allergies and exercise, and how to manage them.
- Learning medication therapy options and appropriate rescue inhaler usage.
- Understanding when to seek medical attention.

Evidence-based guidelines

- Guidelines for the Diagnosis and Management of Asthma (EPR3), 2007
- Diagnosis and Management of Asthma, ICSI, July 2012

Targeted interventions

- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times a year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times a year
  - Text messages for program participants who have opted in

Monitoring performance

- Controller Meds
- Short-acting beta agonist usage
- Flu and pneumococcal vaccinations
- Contact rate
- Hospital readmissions

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:

- Moderate level:
  - No hospital/ER visits in the past six months

Confidential property of Optum. © 2016 Optum, Inc.

- High level:
  - No oral steroid use
  - No hospital/ER visits in the past twelve months
  - Experienced shortness of breath less than once per day in the past 4 weeks
  - Awakened by symptoms less than 2 times per week in the past 4 weeks
  - Used rescue inhaler or nebulizer medication less than once per day in the past 4 weeks

Coronary artery disease DM program

The coronary artery disease (CAD) program strives to generate reductions in trends in myocardial infarctions, mortality rates, CAD-related admissions, and costly treatment procedures, such as repeat angioplasty and bypass surgery. By working with program participants to alter their regular routines, we can frequently reduce disabling symptoms that may also result in absenteeism and a reduced quality of life. Alere Health helps program participants understand and manage their condition to prevent disease progression, disability and the development of other chronic conditions by helping them:

- Adhere to their practitioner's care plan and medication regimen.
- Recognize early symptoms of a heart attack and when to seek medical treatment.
- Make healthy lifestyle choices like eating healthfully, exercising and quitting smoking, which may keep blood pressure, cholesterol and other risks in check.
- Learn about treatment options.
- Monitor their blood pressure at home as appropriate.

Evidence-based guidelines

- AHA/ACC Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update
- AHA Guideline: Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women: Update, 2011
- AHA 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk
- 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JNC 8)
- 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (ATP4)
- 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk
- 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults

Targeted interventions

- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Biometric monitoring

The CAD blood pressure monitoring program includes current interventions for the CAD program in addition to weekly blood pressure and symptom monitoring. The systolic and diastolic blood pressure values are graphed and display indicators for values outside of set clinical guideline

Confidential property of Optum. © 2016 Optum, Inc.

parameters. Symptom answers are graphically displayed with indicators for missing and significant data.

Call outreach
The health care professional will attempt an outreach call to the program participant after device data review and finding that their blood pressure is out of normal range or having 3 or more days of reported symptoms. (American Heart Association 140/90 or if comorbid Diabetes 130/80)

Monitoring performance
- LDL Test w/in 12 months, Beta Blocker Post MI
- Aspirin usage
- Antilipidemic usage
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Chronic obstructive pulmonary disease DM program

The chronic obstructive pulmonary disease (COPD) program strives to reduce medical service utilization (hospitalizations), reduce absenteeism, increase productivity and improve quality of life. It helps program participants maximize remaining lung function and recognize early symptoms of a lung infection or worsening of their condition by teaching them to adhere to their care plans and medications, how to recognize and control symptoms that worsen their condition, and how to access smoking cessation resources.

Evidence-based guidelines
- Initiative for Chronic Obstructive Lung Disease (GOLD) 2014
- ATS Standards for the Diagnosis and Care of Patient with Pulmonary Obstructive Disease, 2014
- Diagnosis and Management of Stable Chronic Obstructive Disease: A Clinical Practice Guideline
- ICSI Chronic Obstructive Pulmonary Disease Guidelines, 2013, March

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate

Biometric monitoring
Program participants may use the biometric monitoring device to answer symptom questions once a day. The data is transmitted to Alere Health wirelessly or via a telephone line. A health care professional reviews device symptom data daily.

Confidential property of Optum. © 2016 Optum, Inc.

Call outreach
The health care professional will attempt an outreach call to the program participant after device data review and:
- Finding that symptoms are out of normal range for two or more days in a row or
- Per the health care professional's clinical judgement

Monitoring performance
- Bronchodilator use and smoking/tobacco use
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Diabetes DM program

Alere Health's diabetes program helps program participants manage diabetes through medication, diet and exercise by teaching them:
- About diabetes and health risks associated with complications.
- To change unhealthy behaviors, such as smoking, poor nutrition, and/or lack of exercise.
- To recognize and control diabetes symptoms.
- To adhere to practitioners' treatment plans and medication regimens.
- Ways to improve self-care skills, including daily foot exams and glucose monitoring.
- To complete preventive exams and screenings that can lead to early detection of diabetes complications.

Evidence-based guidelines
- ADA Clinical Practice Recommendations, 2014, January
- Standards of Medical Care in Diabetes-2014
- ADA, National Standards for Diabetes Self-Management Education and Support, 2014, January

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate

Biometric monitoring
The Alere Health DayLink® Monitor (DLM) is placed in a program participant's home to capture blood glucose monitoring and symptom data. Blood glucose levels and diabetes symptom data are collected daily and reviewed by a health care professional every 14 days.

Call outreach
An outreach call is made to the program participant to verify information following the 14 day data review if:
- Blood glucose values are out of normal range (ADA guidelines are 70-130 mg/dl or <180 mg/dl two hours after a meal)

Confidential property of Optum. © 2016 Optum, Inc.

- Blood glucose values greater than 250 mg/dl twice in one week or more
- Program participant reports any symptoms via DLM

Monitoring performance
- Annual A1C test/control, LDL test/control, microalbumin test/control and foot and retinal exams
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Heart failure DM program

The heart failure (HF) DM program is targeted for high-risk individuals with heart failure. This program helps program participants slow disease progression, disability, and development of other chronic conditions. It does this by teaching program participants:
- About their disease and health risks associated with it
- How to recognize/control heart failure symptoms that may worsen their condition
- To adhere to their care plans and medication regimens
- To weigh themselves daily and assess weight change
- To change unhealthy behaviors, such as smoking, inactivity and poor nutrition
- To recognize when to seek medical treatment

Evidence-based guidelines
- ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, 2013 October.
- ICSI Guideline - Heart Failure in Adults, 2013, July.
- HFSA, Comprehensive Heart Failure Practice Guideline, 2010, June.

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate (if purchased)

Biometric monitoring

When indicated, the Alere Health DayLink® Monitor (DLM) is placed in a program participant's home to record his/her weight and heart failure symptoms. The DLM consists of a scale and monitoring unit. Program participants are asked to weigh themselves each morning and evening. Their weights are transmitted to Alere Health wirelessly or through telephone lines. Once received, the data is automatically reviewed and assigned an acuity score based on assessment of weight, symptom responses and other available data. System reports are generated and reviewed daily by licensed staff. Program participants and/or their practitioner may be contacted based on daily monitoring results.

Confidential property of Optum. © 2016 Optum, Inc.

Monitoring performance
- ACE inhibitor or ARB use, beta blocker use, aspirin use, daily weights
- Flu and pneumococcal vaccinations
- Hospital readmissions

Musculoskeletal pain management DM program

The musculoskeletal pain management (MSP) program helps program participants understand and better manage chronic musculoskeletal pain and maximize their ability to perform daily activities. The program addresses the following conditions: back pain (neck, upper and lower back), fibromyalgia, osteoarthritis, rheumatoid arthritis, regional musculoskeletal disorders (RMD) and tension and migraine headaches.

Alere Health staff help program participants use appropriate health care services focused on improving their ability to function. Alere Health provides telephonic and online pain management strategies and also provides educational materials to maximize the impact of interventions.

Program components include:
- Medication compliance and lifestyle integration, leading to improved quality of life.
- Ways to reduce exacerbation or recurrence of musculoskeletal pain.
- Information that assists the program participant in preventing further injury or deterioration.
- Evaluating day-to-day activity and helping remove aggravating factors to reduce missed work days.

Evidence-based guidelines
- Pain: Carpal tunnel
  - Carpal Tunnel Syndrome (Acute and Chronic). Work Loss Data Institute, 2013, May
  - Carpal tunnel syndrome. ACOEM, 2011
- Pain: Elbow
  - Elbow (Acute and Chronic). Work Loss Data Institute, 2013, May
  - ACOEM, Elbow Disorders, 2012, December
- Pain: Forearm, wrist, and hand, not including carpal tunnel syndrome
  - Forearm, wrist, and hand (acute and chronic), not including carpal tunnel syndrome. Work Loss Data Institute, 2013, May
  - Hand, wrist, and forearm disorders, not including carpal tunnel syndrome. ACOEM, 2011
- Pain: Shoulder
  - Work Loss Data Institute - Shoulder (Acute and Chronic), 2013, June
  - ACOEM, Shoulder disorders, 2011, July
- Pain: Low back pain
  - Work Loss Data Institute - Low Back - Lumbar and Thoracic (Acute and Chronic), 2013, December
  - ICSI Guideline: Adult Acute and Sub-acute Low Back Pain, 2012, November
- Pain: Neck and upper back
  - Work Loss Data Institute - Neck and Upper Back (Acute and Chronic), 2013, May

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - Nurse24 access 24/7
  - Health portal access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in

Confidential property of Optum. © 2016 Optum, Inc.

- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Monitoring performance
- Migraine Therapy
- RA:DMARD Usage
- Hospital admissions
- Adherence to treatment plan

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:
- No hospital/ER visits in the past six months
- No open care gaps for medications
- Effective treatment plan in place to relieve pain

Depression DM program
Alere Health has a behavioral health management program for program participants with major depression disorders and/or anxiety disorders. The goal of the program is to teach and help facilitate medication compliance and follow-up care, prevent non-adherence or lapses of medication administration, encourage program participants to partner with their practitioner and also how to recognize symptoms. The program strives to enhance program participants' management of depression and/or anxiety by:
- Increasing compliance through understanding and individual support
- Enhancing overall well-being by practicing healthy behaviors
- Knowing what to expect from behavioral health therapies and medications
- Making healthier lifestyle choices and avoiding health risks
- Adhering to practitioner office visits and follow up
- Partnering with the practitioner to create a treatment plan

Evidence-based guidelines
- APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder - 3rd Edition, 2010
- ICSI - Adult Depression in Primary Care Guideline, 2013, September
- Generalized Anxiety, Panic Disorders, Phobias, Obsessive-Compulsive Disorder, Stress inclusive of PTSD.
- American Psychiatric Association, Practice Guideline for the Treatment of Patients with Panic Disorder, 2009
- Canadian Psychiatric Association, Clinical Practice Guideline for the Management of Anxiety Disorders, 2014
- Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition ©American Psychiatric Association
- National Institute for Health and Clinical Excellence, Management of Anxiety in Adults in Primary Secondary and Community Care, 2007
- Acute Stress Disorder and Posttraumatic Stress Disorder (2004) Guideline Watch (2009) American Psychiatric Association
- VA/DoD Guideline, The Management of Posttraumatic Stress, 2010

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials

  - 24/7 nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Monitoring performance
- Compliance with medications
- Compliance with practitioner visits for managed behavioral health conditions

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:
- No hospital/ER visits in the past six months
- No open care gaps for medications
- No difficulty making and keeping therapy appointments
- No thoughts of self-harm

Maternity (high-risk pregnancy) DM program
The maternity disease management program provides risk assessment, targeted education, stratification and referrals for case management services, and a delivery outcome assessment including postpartum depression screening according to client contract.

The initial maternity risk assessment is conducted at program enrollment, ideally between 12 and 15 weeks gestation, to determine risks for pregnancy complications. During the assessment, individualized education is provided to the program participant based upon responses. At the conclusion of the assessment, program participants are stratified into the low-risk pregnancy disease management program or if one or more risks are identified, the case management program. A second risk assessment is conducted at about 28 weeks gestation at which time a previously low risk program participant may become identified as high-risk and referred to case management. After each risk assessment, a report summarizing clinical findings and verbal education is sent to both the program participant and the practitioner.

Evidence-based guidelines
- American Congress of Obstetricians and Gynecologists (ACOG)
- Centers for Disease Control and Prevention (CDC)
- ICSI: Routine Prenatal Care and Management of Labor
- National Institutes of Health (NIH)
- Case Management Society of America (CMSA)
- American Academy of Pediatrics (AAP)

Targeted interventions
All program participants in the maternity high-risk pregnancy disease management program receive education, printed materials and clinical support in addition to the following:
- Scripted education based upon responses to the risk assessments followed by written educational reminders in the report summary.
- Printed welcome packet which includes personalized risk assessment report summaries and a pregnancy guide book.
- Access to BabyLine™, the 24 hour toll-free telephone line, and access to evidence-based education on a health portal.

Confidential property of Optum. © 2016 Optum, Inc.

Monitoring performance

- First prenatal visit
- Smoking
- Flu vaccination
- Postpartum depression

Disease management 2016 goals

- Expand action plan key focus areas to incorporate a more dynamic action plan, starting with diabetes and adding additional conditions during 2016.
- Enhance the member experience for disease management by providing digital interactive tools within the newly developed action plan on the Alere Health portal.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update DM processes and program participant resources if necessary.
- Achieve NCQA reaccreditation for all DM programs.
- Continue to reduce hospital readmission rates and evaluate need for any improvements to post-hospitalization follow up.

First year of life program (FYOL)

Alere Health's first year of life care management program provides care management for infants up to 15 months of age. This is accomplished through collaboration with a multi-disciplinary team that includes practitioners, payers and other resources necessary to facilitate appropriate health care services. Through on-going program touches, type and frequency determined by stratification level, caregivers are guided and supported to better understand and meet the needs of the infant during this critical time of growth and development.

The Alere Health first year of life program provides both assessment and management for infants post NICU or newborn nursery discharge through the first year of life, as well as caregiver education and anticipatory guidance by experienced care managers. A tiered care management approach is utilized based on infant risk stratification at program enrollment with subsequent re-evaluation of risk based on needs.

The program focuses on areas that are important for all infants such as nutrition, immunizations, growth and development, home safety, follow-up visits with practitioners, and caregiver education, as well as issues specific to individual infants such as ongoing medical needs, home health care or DME needs, medications and/or social issues. In addition to reinforcing the benefits of adherence to the recommended practitioner visits, immunizations, screenings and care management of the most medically and/or socially fragile, education is provided on multiple topics including parenting, safety, developmental milestones and family planning.

Access to health care professionals

The FYOL program ensures that program participants and practitioners have timely access to program staff. Business hours are Monday through Friday, from 8 am to 8 pm EST and from 9 am to 6 pm EST on Saturdays.

Eligibility

To be enrolled in the first year of life program, infants must be younger than one year old and in the home environment.

Enrollment

Enrollment outreach is made to the caregivers of eligible infants. This includes a program announcement postcard and telephonic outreach by non-clinical staff. The announcement postcard notifies caregivers about the program, encourages them to contact the program for more information and to enroll, and alerts them to expect a program call. When the caregiver is reached for the program enrollment call, the program and benefits of enrollment are explained.

Confidential property of Optum. © 2016 Optum, Inc.

Enrollment is voluntary and includes completion of program consent and an infant risk assessment. The infant risk assessment covers multiple categories to determine if risk(s) are present. The presence of one or more risks stratifies the infant to moderate for further clinical assessment. If no risks are identified, stratification is low.

Clinical assessment
Infants with moderate risk receive a clinical assessment by a registered nurse. The clinical assessment allows for the collection of in-depth information about the infant's health and developmental status. The clinical assessment results in moderate or high stratification.

Ongoing management
Infants in the moderate or high stratification levels receive ongoing care management provided by experienced registered nurses. Scheduled outreach for infants in the moderate risk level follows the Early and Periodic Screening Diagnostic and Treatment (EPSDT) schedule based on age, at a minimum at months 1, 2, 4, 6, 9 and 12. Infants stratified as high-risk, receive monthly outreach calls. Individualized support, care planning with interventions designed to close gaps in care, and coordination of care are provided based on the infant's individual needs. In the event that the infant re-stratifies to the low risk level, the infant will receive the low risk level workflow.

Infants in the low risk level receive telephonic Interactive Voice Response (IVR) touches on the EPSDT schedule at months 1, 2, 4, 6, 9 and 12. The IVR calls contain a brief assessment designed to identify the potential development of risks and messaging regarding the importance of practitioner visits, encouragement for compliance with the next visit and information regarding important milestones or benefits specific to the infant's age. Automatic warm transfer from the IVR to the program is offered should the assessment identify a potential risk alert. If warm transfer is accepted, the caregiver is transferred to the program staff for assessment of risk. If the transfer is declined, the caregiver is encouraged to contact the program for further assessment.

Evidence-based education during contacts includes
- Regular schedule of practitioner visits, immunizations and screenings
- Feeding and elimination
- Developmental milestones
- Parenting
- Safety

Satisfaction survey
Program enrollees are called via IVR at age 15 months for a program satisfaction survey.

Disenrollment
Program disenrollment can occur at any time. Disenrollment reasons include: requested by the caregiver, loss of eligibility and program completion.

Program fulfillment
- Announcement postcard
- Program participant welcome letter with guide
- Practitioner welcome letter
- Program participant unable to reach for ongoing management letter

Guide: a reference book entitled "Your Baby's First Year of Life" is sent to the caregiver of all program participants. "Your Baby's First Year of Life" stresses the importance of following the practitioner visit schedule, immunizations, feeding, safety and resources. It also provides a place for caregivers to record when the next visit is scheduled to take place, questions for the practitioner, immunizations and milestone memories. It is based on the EPSDT schedule of care and the guidelines and resources detailed below.

Confidential property of Optum. © 2016 Optum, Inc.

Transition plan
The health plan case manager, health care practitioner and guardian can request the latest FYOL care plan summary. The care plan summary may be used for the purpose of care transitions.

Guidelines and resources
The FYOL program utilizes evidence-based guidelines/resources that include:
- Bright Futures: Guidelines for Health Supervision of Children and Adolescents, AAP
- AAP Guidelines for Pediatric Home Health Care
- Pediatric Home Care for Nurses, 3rd edition, Votroubek and Tobacco, 2010
- EPSDT schedule of care

First year of life quality improvement 2016 goals
- Improve well-baby visits and immunization compliance
- Support caregivers to advocate for their infants and provide a safe and healthy environment
- Identify and provide timely interventions and/or care coordination for at risk infants

Nurse24 health information program

Alere Health's nurse24 program is a nurse-driven telephonic/online support program available to a client's entire population 24 hours a day, 365 days a year. Staff members responding to program participant clinical inquiries are registered nurses with active and verified licenses and are qualified to provide clinical services. Telephonic, chat and secure electronic messaging services are available to program participants and are recorded unless a program participant refuses to be recorded.

Telephonic communications
- The first message a caller hears when reaching nurse24 is *"If this is an emergency, hang up and dial 911 or your local emergency services."*
- Depending on client contracts, incoming telephone calls are first routed to non-clinical staff to determine appropriate call routing.
- All callers with a medical/clinical need or question are transferred to a registered nurse, no messages are taken.
- If the caller has a non-medical/clinical need or question, the call is assessed and handled by the non-clinicians (ex: requests transfer to the health plan, returning a call to another Alere Health department, etc.).
- Staff have access to a contracted national interpreter line when needed.
- Health Assistants (HA) have clinical monitoring, oversight and immediate availability of a licensed clinical staff person for clinical issues beyond service requests. They do not perform clinical activities. Health Assistants:
  - Are qualified and trained to perform screening of service requests.
  - Are supported by policies and procedures on the collection of non-clinical data.
  - Are trained in the principles and procedures of screening, collection and transfer of service requests.
  - Through an established process, promptly transfer a telephone call or other communication requiring clinical intervention to a licensed registered nurse.

Secure electronic communications
- Online chat and secure messaging are available through the program participant health portal. Electronic messages are answered within 24 hours of receipt.
- All communications, including call dispositions are documented in the program participant's electronic record.
- Registered nurses respond to questions from callers regarding clinical triage and health Information.

Confidential property of Optum. © 2016 Optum, Inc.

Health care professionals are required to identify themselves by first name, title and company name to every caller prior to responding to the caller's questions about Alere Health's nurse24 Program, including questions about where Alere Health obtained their information and how the program works. Health care professionals also screen callers to determine whether triage or health education services are required.

Health education services may include:

- Answering questions about medications or health related issues on calls or chats.
- Advising callers and chat program participants on self-care options prior to a health care visit.
- Helping callers and chat program participants communicate effectively with their practitioner.

Triaging services may include:

- Helping callers determine whether to seek care based on symptom assessment.
- Helping callers determine what level of care is most appropriate for their condition.

Alere Health's nurse24 program is accredited by URAC for Health Call Center (HCC) and certified by NCQA for Health Information Line (HIL).

Program content/clinical decision support tools

Alere Health utilizes an accredited knowledgebase called Healthwise® Coach to guide triage activities. The nurse24 registered nurses have additional tools, including evidence-based guidelines to help triage calls effectively and appropriately. Alere Health's nurse24 staff have access to consult with or seek advice from a Medical Director with a current, unrestricted license(s), qualified to provide advice for services provided and post-graduate experience in direct patient care. At a minimum of annually, the Medical Director(s), N24 leadership, Clinical Integrity VP and Scientific Advisory Board practitioners, still in active practice, review the results of quality review studies used in developing and updating clinical decision support tools.

Linkage to contact history

The nurse24 staff can link callers to their previous utilization of nurse24 services by viewing their documented electronic record. If a caller is enrolled in another Alere Health program, nurse24 staff can view his/her clinical record as well as his/her primary nurse's availability and can perform warm transfers when needed.

Clinical triage

Clinical Triage is defined by URAC as classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools. Trained in telephone triage, the registered nurses help callers navigate questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors. Alere Health has policies and procedures in place to ensure clinical triage communications are handled in a timely manner by a clinical staff person and that individuals calling with potentially emergent situations are provided a safe mechanism to access emergency treatment.

Follow up

Callers who were advised to seek care for their urgent or emergent health conditions are called back by the registered nurse to assess that needed care was obtained, the outcome and the caller's current health status. In addition, callers who left secure messages are responded to within 24 hours of receipt.

Feedback to caller's practitioner

Alere Health has a policy and procedure for communicating pertinent health issues obtained during the triage process to practitioners at the caller's request or if contracted.

Confidential property of Optum. © 2016 Optum, Inc.

Monitoring/evaluation of outcomes and reporting structure
Alere Health monitors access to the health information line at least monthly by reviewing data related to average answer speed and abandonment rates. In addition, the nurse24 registered nurses' performance is evaluated at least monthly to ensure appropriate triage and follow up occur. Outcome reports, including satisfaction and complaints are presented internally to the appropriate QI committees for review, evaluation, barrier analysis, identification of opportunities for improvement and development of interventions at least quarterly.

Quality improvement projects
The following are N24's quality improvement projects:
- Safety: Disclaimer Notification and Documentation QIP #1a and b to continue in 2016
- Program Participant Satisfaction Improvement Project QIP #2 – I to continue in 2016

Nurse24 2016 goals
- Meet goals for incoming calls average speed of answer and call abandonment rates.
- Maintain the chat goal of ≤45 seconds' average speed of answer while exploring opportunities for improvements.
- Continue tracking and trending all clinically triaged calls.
- QIP #1a – Increase use of disclaimers when speaking with program participants.
- Continue consistent Staff Performance results.
- Improve Complaints Entered ≤1 business day result by 5 percentage points consistently.
- Continue Healthwise® Coach Product resource with regular reviews, updates and internal approvals.

Case management (CM) program

Alere Health has both URAC and NCQA accredited case management programs for complex, maternity, oncology, and NICU. These programs are designed to provide intensive resources to assist program participants to understand their diagnoses, prognoses and make educated choices about their care. The NICU program is also URAC accredited for Health Utilization Management (HUM). All of Alere Health's case managers and utilization managers are registered nurses with a minimum of a current, unrestricted license to practice in their resident state of the United States. In addition, many also hold additional state licenses as applicable to their position.

Objectives and goals
The goal of Alere Health's case management programs is to help the program participant and their family meet their comprehensive medical, behavioral health and psychosocial needs. Case managers build relationships by educating, supporting and empowering the program participant, their family and their care giver. The case managers work with the program participant, care giver and their treating practitioners (licensed or certified professional who provides medical care services) to:
- Ensure proper treatment plan in the appropriate setting
- Assure program participant/care giver compliance with the treatment plan
- Manage the side effects of all treatments
- Coordinate all care - whole member management
- Advanced Directive/End-of-Life Planning as appropriate
- Maximize state of health and improve the quality of life for the program participant
- Reduce costs associated with managing program participants in active treatment

Program content/evidence-based guidelines
Alere Health's programs were developed and based on evidence-based guidelines, information from recognized sources and proprietary program content. Program materials are reviewed every two years by at least two appropriate practitioners and approved by the Scientific Advisory Board. Appropriate practitioners are physicians with board certifications in an

Confidential property of Optum. © 2016 Optum, Inc.

appropriate specialty. The systematic review of the program guidelines and information include:

- Reviewing program content against the evidence used to develop the programs.
- Assessing whether program participant materials are consistent with current evidence, and if they are not, putting actions in place to make them consistent.
- Assessing whether staff training materials are consistent with current evidence and assuring actions are taken to make them consistent as applicable.
- Reviewing program content for cultural and linguistic appropriateness.

Alere Health's case management electronic information systems' ongoing evaluations include regular multidisciplinary team meetings that include representatives from operations, client services, technology solutions, applications development, product management, project specialists, training/performance and quality. The purpose of the meetings is to update the attendees on system performance issues, IT updates, release scheduling plans and to point out any special projects. The frequency of the meetings varies according to projects, actions required and planned releases. These meetings occur quarterly but may occur more frequently when needed. Meeting agendas, minutes, and/or release results are shared with the team members following the meetings and are reported to appropriate oversight committee.

Case management consent and disclosures

As early as possible in the case management communication with the program participant, Alere Health requires, at a minimum, that a verbal consent is obtained and clearly documented in the electronic medical record. Generally, consent is obtained while in the process of screening or informing the program participant about the case management program. After enrolling the program participant, Alere Health's staff answer questions that the program participant may have and a welcome packet is sent. The welcome packet includes a welcome letter with information from the case manager as well as contact information, a copy of Alere Health's program participant's rights and responsibilities and a disclosure document that reiterates the case manager's role, including that they are accountable for coordinating care, and the nature of the case management relations, particularly when a third party payer is involved.

Program participants are also informed of any process or requirement used to determine when information obtained in the case management relationship will be disclosed to the third parties. The program participant is informed of any process for them to be provided with written or electronic notification of case management actions and recommendations. Program participants are made aware of the availability of a complaint process and the method to access it. Also at this time the program participant, their family, and/or care giver is informed about self-management, shared decision making, and knowledgeable use of medications training that will be made available as needed.

Program participant education and engagement

Educating program participants is a fundamental role of a case manager and is key to program participant's achieving their care plan and self-management goals. All Alere Health case managers are trained in behavioral change models and motivation and engagement principles upon hire. In order to assist program participants to meet their care plan and self-management goals, case manager program interventions include, but are not limited to:

- Providing health education/information that supports the program participant, and the family/caregiver's ability to achieve the program participant-centric case management goals.
- The use of culturally and linguistically appropriate services to reflect individual learning needs as applicable.
- The use of individual and personalized health education tools to reinforce self-management skills.
- Informing program participants and the families/caregivers of their role relative to transitions of care and interactions with health care practitioners.

Confidential property of Optum. © 2016 Optum, Inc.

Case management process

The applications supporting these programs include algorithmic logic scripts and other prompts to guide case managers through assessment and ongoing management of program participants. The clinical aspects of these prompts or scripts also include automated features that provide accurate documentation for each entry; recording actions or interaction with program participants, practitioners, or providers; and automatic date, time and user stamps. To facilitate program participant-centered care planning, the application includes features to set prompts and reminders for next steps or follow-up contact.

The purpose of the case management programs is to ensure that program participants receive appropriate care at the appropriate time so that health outcomes can be improved and utilization of emergency rooms and hospitalizations can be reduced. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a program participant's health needs using communication and available resources to promote quality cost-effective outcomes. The case management process includes the following components:

- Initial assessment and documentation of the program participant's current health status, treatment plan, clinical history, medications, and daily activities including medical and behavioral health condition-specific issues.
- Evaluation of cultural and linguistic and visual and hearing needs, preferences or limitations.
- Evaluation of caregiver resources and involvement.
- Evaluation of any safety concerns including medication safety and need for reconciliation of medications and the need for medication therapy management services.
- Evaluation of available benefits within the organization.
- Management of care transitions including the identification of problems causing care transitions and prevention of unplanned transitions, when possible.
- Initial assessment of life-planning activities if applicable.
- Evaluation of community resources.

Case managers facilitate and document in collaboration with the program participant/care giver:

- An individualized program participant-centered case management plan including prioritized short and long term goals, that consider the program participant's and caregivers' goals, preferences and desired level of involvement in the case management plan.
- Identification of interventions with timelines to meet the goals.
- Identification of barriers to meeting goals or complying with the plan.
- Facilitation of program participant referrals to resources and follow-up process to determine whether program participants act on referrals.
- Development of a schedule for follow up and communication with program participants.
- Development and communication of program participant self-management plans.
- A process to assess progress against case management plans for program participants.
- As part of the case management process, case managers will assess the need for coordination of follow-up services for evaluation and management including referrals for:
  - Health care services
  - Behavioral health care services
  - Social services and support
  - Providers
- Locating available community resources, including vendors to assist with program participant-identified and health care-related issues.
- Collaborative approaches are used for the purpose of facilitating the case management plan as well as the coordination and transitioning of care.
- All referrals will be followed up by the case manager on the next program participant's scheduled communication.

Confidential property of Optum. © 2016 Optum, Inc.

Measurement and quality improvement
Alere Health's case management programs measure and work to improve program performance, program participant experience, program effectiveness and program participant participation via our case management program work plans. Measures are identified based on evidence-based and/or clinical practice guidelines, client requirements, state or federal laws and/or accreditation requirements.

Alere Health case management programs have a process to use case review findings to determine if case management program performance measures are being met. Each case management program maintains no less than two quality improvement projects that address opportunities for error reduction or performance improvement related to the services covered by the accreditation. They also have additional measures for evaluating the effectiveness of the case management program.

Medical director rounds/team reviews
The purpose of the medical director rounds/team reviews is to support the case management process through the review of individual cases, which may result in:

- Improved quality health care
- Decreased fragmentation of care
- Enhancement of the program participant's quality of life
- Efficient utilization of program participant care resources, and
- Cost containment

Cases enrolled in case management services are reviewed by the program medical director or other supervisor in collaboration with the case manager at regular intervals specific to each program. Medical Director rounds/team reviews include meetings with the medical director, clinical supervisor and those case managers who have identified cases that would benefit from consultation with the medical director.

The medical director's role is to coach case managers on program participant advocacy, identify areas for program participant self-advocacy, and provide education on clinical conditions specific to cases. The case manager's role is to assess the urgency of the situation, follow the process for urgent or non-urgent consultation, prepare to present cases, have key questions ready and provide appropriate follow up.

Complex case management (CCM) program

Complex case management programs focus on program participants with significant chronic or life-limiting diagnoses including, but not limited to, the following: cancer, cardiovascular disease, cerebrovascular disease, diabetes, infectious diseases, respiratory disease and trauma.

Access to health care professionals
The complex case management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages to these individuals. The case management department responds to regular communications within one business day. Specific access hours are:

- 8:30 a.m.-5 p.m. Monday through Friday (in the program participant's time zone).
- Program participants may reach a registered nurse 24 hours a day, seven days a week-including holidays.

Identification/stratification/enrollment
Alere Health has developed a three-tier electronic and case manager screening process that identifies individuals who might benefit from the program that consists of:

- Technology process

Confidential property of Optum. © 2016 Optum, Inc.

- Alere Health collects data from multiple sources that may include claims, pharmacy, utilization information (including hospital discharge data), client targeted referrals and referrals from Alere Health programs, individuals or practitioners. Once automated electronic screening of these data sources is conducted, the data is sent to staff to initiate the enrollment process. Individuals must have at least one chronic or life-limiting diagnosis as follows:
  - Cancer and possible cancer indicators: Lung, brain, head and neck, pancreatic, liver cancer; metastatic cancer; malnutrition, dehydration, nausea/vomiting, chronic pain.
  - Cerebrovascular disease: Stroke requiring intensive rehabilitation or prolonged facility admission.
  - Complex diabetes: Diabetes with heart disease, peripheral vascular disease, cerebrovascular disease, kidney failure.
  - Cardiovascular disease: Heart failure, cardiomyopathy, cor pulmonale.
  - Infectious disease: Diseases indicating immunosuppression, opportunistic infection, presence of other disease, or causing encephalopathies (histoplasmosis, Jakob-Creutzfeldt, leukoencephalopathy).
  - Respiratory diseases: Severe asthma, chronic obstructive pulmonary disease, respiratory failure.
  - Progressive neuromuscular disease: Amyotrophic lateral sclerosis, bulbar palsy.
  - Major organ failure: Heart failure, liver failure, kidney failure.
  - Trauma: Severe trauma with head injury and/or requiring prolonged facility care or complex home care.

- Prequalification process
  - Staff members contact eligible individuals by telephone and inform them of the program purpose and benefits. Program eligibility is verified by utilizing a symptom assessment tool. IGAO (Issues, Goals, Actions, and Outcomes) is a structured method of identifying, recording and addressing case management needs. This method provides a rigorous structure for care delivery that is highly reproducible and measurable. The issues and goals are organized into seven care domains: Knowledge and Choice, Treatment Plan, Family and Living Environment, Pain and Symptom Management, Practitioner and Provider Coordination, Terminal Care Planning, and Benefit Plan. The individual must have issues present in at least two care domains to qualify for a case management program. When this is confirmed, the individual is assigned to a case manager and warm transferred when possible.
- Qualification and enrollment process
  - The case manager conducts a more comprehensive assessment by telephone or on-site to confirm the individual's condition, obtains verbal acceptance and formally opens a case in the appropriate case management program. Written consent is obtained for the record when an on-site visit is conducted to complete an initial assessment. Written consent is attempted for those cases with a telephonic initial assessment. At this point the individual is enrolled in one of the case management programs and a case is opened. Cases identified as not meeting the criteria for the CCM programs will be directed to internal disease management services or back to the health plan for external disease management services.
- Interventions
  - All program participants receive a welcome packet which includes general program information, a medical release of information form, Alere Health's Rights and Responsibilities Statement, and contact information.
  - Program participant communications with a health care professional:
    - Complex case management:
      - On-site or telephonic initial assessment
      - Weekly and as needed communications with a health care professional
    - Chronic case management:
      - Telephonic initial assessment

- Bi-weekly and as needed communications with a health care professional (multi-acuity):
  - Telephonic initial assessment
  - May have an onsite visit as needed
  - Monthly and as needed communications with a health care professional

Quality improvement projects for 2016

- Improve Medication Management for Program Participants (QIP 1, Safety)
- Program Participant Voluntary Disenrollment Rates (QIP 2)

Complex and chronic case management 2016 goals

- Reducing unplanned transitions by continuing to analyze, identify areas for improvement and implement identified interventions.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

Maternity case management

Alere Health's maternity case management program provides obstetrical case management in collaboration with a multi-disciplinary team that includes providers, payers and other members necessary to facilitate appropriate health care services. Program participants are elevated to this more intensive level of care based upon responses to the initial or follow-up health risk assessment, other interactions such as BabyLine™ calls or by direct referrals to the case management program by practitioners or health plan case managers.

Access to health care professionals

The maternity case management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages to these individuals. The case management department responds to regular communications within one business day, and attempts to reach program participants who trigger to case management within 72 hours. Case managers are available Monday through Thursday from 9 am to 11pm EST and Friday from 9 am to 8 pm EST. Outreach is conducted up to 8 pm EST.

Identification of eligible individuals/case manager assessment

An initial maternity disease management risk assessment is typically conducted between 12 and 15 weeks gestation to determine potential risk for pregnancy-related complications for all eligible enrollees. A second risk assessment is conducted at 28 weeks gestation. At the conclusion of each assessment, program participants are systematically stratified into the low-risk pregnancy disease management program or the high-risk maternity case management program. At-risk or high-risk triggers include:

- History of pregnancy complication in a previous pregnancy (for example, history of preterm labor, history of gestational diabetes, history of pregnancy-induced hypertension, history of preterm delivery, history of postpartum depression).
- Current high-risk pregnancy condition (for example, multiple gestation, hyperemesis gravidarum, preterm labor, vaginal bleeding, placental problems, abnormal amniotic fluid levels, infections).
- Comorbid medical conditions (for example, diabetes, chronic hypertension, cardiac conditions, blood clotting conditions, renal conditions).

Confidential property of Optum. © 2016 Optum, Inc.

- Behavioral health or psychosocial issues (for example, smoking during pregnancy, alcohol use during pregnancy, recreational drug use during pregnancy, barriers to obtaining adequate prenatal care, potential or identified domestic abuse).

Evidence-based guidelines
- American Congress of Obstetricians and Gynecologists (ACOG)
- ICSI: Routine Prenatal Care and Management of Labor
- Centers for Disease Control and Prevention (CDC)
- Case Management Society of America (CMSA)

Case management assessment
The telephonic initial assessment process allows for the collection of in-depth information about the program participant's situation and functional status. It identifies the absence or presence of signs and symptoms of disease or pregnancy complications. The assessment allows the case manager to determine the program participant's ability to manage her pregnancy, and any barriers that may prevent the program participant from realizing a positive pregnancy outcome. The assessment is designed as a comprehensive approach to problem solving. The case management plan is developed to address barriers identified as interfering with the program participant's ability to improve her health status and sense of well-being. To complete the assessment, information is collected from all relevant sources while maintaining confidentiality and meeting compliance and regulatory requirements.

Case management interventions
Experienced high-risk perinatal case managers:
- Perform a comprehensive telephonic clinical assessment to identify risks.
- Create a care plan with mutually agreed upon long- and short-term goals.
- Initiate appropriate clinical interventions based on agreed upon triggers and the program participant's condition.
- Coordinate care management, benefits and resources with the client and or health plan.
- Evaluate the program participant's progress and identify changes in condition, coordinate care and communicate with practitioner regarding implementation of the treatment plan.
- Provide referrals to appropriate health care and community resources.
- Access to the 24/7 BabyLine™, which provides advice and guidance by experienced registered nurses from enrollment to six-weeks postpartum.
- The organization identifies and evaluates practice patterns and treatment plans based on outcome analysis to achieve appropriate care and cost effective outcomes.

Quality improvement projects for 2016
- Preventing Smoking and Exposure to Secondhand Smoke(QIP 1 – Safety)
- Spacing Conception(s) Post Delivery (QIP 2)
- Hospitalizations (Inpatient and Emergency) Counts – Monthly

Maternity case management 2016 goals
- Continue to identify at-risk mothers for unplanned transitions of care by analyzing, identifying and implementing areas for improvement.
- Reducing unplanned transitions by analyzing and identifying areas for improvement.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

Confidential property of Optum. © 2016 Optum, Inc.

Oncology case management program

Alere Health's oncology case management program focuses on pediatric and adult individuals with a cancer diagnosis and who are in active treatment. The case managers are required to hold a URAC approved certification within four years of accepting an oncology case management position.

Program content/evidence-based guidelines

Alere Health's oncology program is based on proprietary treatment guidelines developed and reviewed on an ongoing basis by the oncology utilization management committee. This committee is made up of practicing oncologists representing multiple specialty services and approved by the scientific advisory board. Guidelines are based on the latest research, literature and practice evidence from a combination of various reputable medical journals and nationally recognized cancer organizations including the National Comprehensive Cancer Network, American Society of Clinical Oncology, American Cancer Society, Association of Community Cancer Centers, and the National Cancer Institute.

Access to case management

The oncology case management program ensures that program participants and practitioners have timely access to program staff. Specific access hours are:

- 8:30 a.m.-5 p.m. Monday through Friday (in the program participant's time zone)
- Program participants may reach a registered nurse 24 hours per day, seven days a week, including holidays

The oncology case management goal is to close gaps in care within the cancer population. Service is designed to enhance and facilitate existing cancer delivery systems for eligible individuals. Activities focus on improving outcomes through program participant education and counseling, proactive assessment and interventions review and coordination of care. By incorporating best practices and coordination with practitioners and program participants, Alere Health provides an integrated solution to proactively manage this expensive and debilitating disease. This is demonstrated through consistent clinical, quality and financial outcomes, including a cancer-specific return on investment.

Identification and stratification

Individuals are identified for this program if they have a cancer diagnosis. Acuity levels are assigned after initial automated stratification and completion of the initial assessment, but may change at any time based on other assessments. Nurses may change acuity based upon the clinical needs of the program participant.

- Low acuity
  - Program participants may have just completed a treatment, or are waiting to begin treatment, or have completed one treatment and need to heal before starting another treatment. This also applies to the program participant who has completed all treatments and is receiving preparatory education to discharge them from the program.
- Moderate acuity
  - Program participants with sporadic symptoms or less severe side effects who can benefit from individualized education and interventions before they seek emergency care. (Karnofsky 80-90 or Eastern Cooperative Oncology Group [ECOG score of 1-2]).
- High acuity
  - Program participants with high potential to be exacerbated by cancer treatment. These program participants have, or are at risk for significant symptoms and side effects that could lead to emergency care or hospitalization. (ECOG $\geq$2 or Karnofsky $\leq$70).

Interventions

- Low acuity
  - Telephonic initial assessment
  - Printed welcome packet

Confidential property of Optum. © 2016 Optum, Inc.

  - Telephonic communications at least monthly
- Moderate acuity
  - Telephonic or on-site initial assessment
  - Printed welcome packet
  - Telephone calls at least bi-weekly
- High acuity
  - On-site initial assessment
  - Printed welcome packet
  - Telephone calls at least weekly

Discussing end-of-life issues with program participants and their caregivers/families is a standard component of Alere Health's case management programs and is initiated early in the program participant's course of care.

Participation in the oncology case management program ends when the active cancer treatment episode concludes. During a program participant's routine team review, or any time during the management process, a member of the clinical team may determine that participation should end. This may be appropriate if case management goals have been achieved, the program participant is deceased, an individual is no longer eligible under current insurance policy, the program participant/family no longer wishes to participate, the program participant is not compliant with the case management program or the account/client requests closure.

When active cancer treatment concludes, the program participant enters a period of preparation to assure readiness for discharge. During this time, the case manager defines the transitional needs and a plan for the program participant, whether they involve preparation for long-term follow-up care or transition to hospice or other facility. In the event of recurrence of the diagnosis, the program participant will be re-evaluated for readmission to the program.

Quality improvement projects for 2016

- Improve Medication Management for Program Participants (QIP 1, Safety)
- Program Participant Voluntary Disenrollment Rates (QIP 2)

Oncology case management 2016 goals

- Reducing unplanned transitions by analyzing and identifying areas for improvement.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of the program participant and relevant subpopulations to update the case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Report all program metrics via the work plan at the quarterly quality meetings.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

NICU case management/utilization management program

The NICU care management program is a unique combination of case management and utilization management and holds URAC accreditation in case management and health utilization management and is also NCQA accredited in case management.

The NICU utilization management program consists of oversight of the appropriateness of care and treatment of premature and fragile neonates, supported by Alere Health's Clinical Management Guidelines. Inpatient care is reviewed concurrently to support, educate and

advocate for families, identify and address potential inefficiencies and fragmentation, advance the definition and progress of the plan of care, and ensure development of an optimal discharge plan.

Program content and evidence-based guidelines
Alere Health utilizes internally developed clinical management guidelines and level of care criteria based on scientific evidence and expert opinion reflecting current medical practice. These guidelines are used by Alere Health to make utilization review recommendations based on medical appropriateness. The guidelines also outline discharge planning activities that serve as the basis for care planning, along with the American Academy of Pediatrics anticipatory guidance education materials. Once the infant is discharged to home, the American Academy of Pediatrics Guidelines are utilized for ongoing care planning.

Alere Health employs a development process that meets all regulatory and accreditation requirements and produces sound and explicit guidelines. The guidelines are evaluated annually and updated as necessary. They are developed with practitioners and other providers with current, expert knowledge in the subject matter under review.

Access to health care professionals
The NICU care management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages. The NICU program operates during normal business hours from 8 a.m.-5 p.m. in all time zones. During these hours, a NICU employee is available to direct all incoming calls from both health care providers and family members. If the NICU employee is unavailable, the incoming call is directed to the voice mail/e-mail system. In addition, there is a 24/7 on-call case manager who can be reached through our voice mail/pager system. During non-business hours, weekends, and holidays, utilization review employees are available via phone/e-mail.

Instructions for accessing employees are provided through the Alere Health phone system, ensuring that a health care provider or family has access to utilization and care management personnel at all times.

The scope of duties within the utilization management function includes case management from birth through the first year of life and quality review of members from admission through the initial episode of care. This includes inpatient, sub-acute and home care coordination as well ongoing telephonic case management, as needed.

Identification of eligible individuals
Case management services are provided to infants who meet any of the following conditions:
- Birth weight ≤ 2000 grams
- Surgical candidates
- Diagnosis of Neonatal Abstinence Syndrome
- ECMO Therapy
- Organ transplant candidates
- Complex needs or comorbid conditions
- Complex psychosocial needs

Inpatient services
Medical appropriateness review for all levels of NICU infants is completed according to Alere Health's developed and approved criteria and coordination with the client. Proactive case management, including onsite or telephonic medical record/case review, is conducted for concurrent review, discharge planning and coordination of services.

Sub-acute or home care services
Activities related to sub-acute or homecare settings are conducted according to client-specific protocols and contractual agreement. Proactive care management and medical appropriateness

Confidential property of Optum. © 2016 Optum, Inc.

reviews of alternative care (rehabilitative or skilled) and home care settings are completed concurrently and include:

- Alternative care review
- Coordination of durable medical equipment (DME) and home health care services
- Coordination of home infusion therapy services

Interventions

- Care Plans
  - An individualized assessment of each infant is the basis of a plan that addresses the specific needs of the infant and the family. The plan is necessary to achieve the best clinical outcome, provide appropriate discharge planning and ensure that necessary post-discharge care and support is provided.
- Baby Steps
  - Introduces the Alere Health NICU case manager and outlines services provided by the program. It provides answers to many questions families may have such as, why their infant maybe in the NCIU, ways to care for themselves and their newborn, milestones for their infant and planning for their infant to go home.
- Educational materials produced by the American Academy of Pediatrics are also provided to program participants. These materials provide anticipatory guidance on topics, such as breastfeeding, safety, car seats, choosing a pediatrician and immunization.

NICU utilization management staff qualifications

First line utilization management reviews are completed by case managers who are licensed registered nurses. Applicants are carefully screened prior to their employment and are oriented in the principles and procedures of utilization review for URAC and client-specific standards.

Alere Health medical directors hold board certification in Neonatal-Perinatal Medicine by the American Board of Medical Specialties (ABMS) or the Advisory Board of Osteopathic Specialists. Alere Health medical directors provide clinical oversight of the program. Expert practitioners in the field of neonatology are available for review and consultation as needed.

Case managers are required to possess a URAC-recognized certification in case management within four (4) years of hire. All case management supervisors hold a URAC-recognized certification in case management and provide nursing leadership and oversight of the program. Alere Health case managers have an average of 14 years of NICU experience.

Medical appropriateness determinations

Notifications of admissions are received by one or more of the following mechanisms:

- A participating hospital and/or the client notify Alere Health via a toll-free telephone number, by fax or through the web portal.
- A participating hospital notifies the Alere Health case manager of a new admission.
- Immediately upon notification of the admission, Alere Health verifies the infant's member and benefit eligibility via client specific computer access or a client representative

Review methodology

The case manager reviews the hospital medical record for the appropriate information; consults with the attending neonatologist, RNs, social worker, and family; and documents the review in the Alere Health case management system. When a review is conducted over the phone, clinical updates are received from the hospital case manager, the attending neonatologist, and/or NICU nursing staff. Telephone calls or faxed reports may be used to acquire the necessary information.

Each infant is reviewed on a frequency determined by the severity of illness review. Influencing factors are:

- The Alere Health Grouper assignment (The grouper assignment is a classification system that categorizes infants by weight and diagnostic group)

Confidential property of Optum. © 2016 Optum, Inc.

- The admitting diagnosis(es)
- The clinical management guideline(s) applied
- The level of care criteria and discharge criteria

Inpatient
The case manager attends multidisciplinary meetings and "rounds" weekly to collaborate on the infant's treatment plan. Review of medical records for inpatient case management includes:

- Identification of the member and the admitting practitioner
- Member face sheet for demographics and coordination of benefits
- History and physical/admitting note, physical status of member, and plan of care
- Birth weight, gestational age, Apgar scores
- Diagnoses (primary, secondary and tertiary, if applicable)
- Assigned Alere Health grouper
- Level of care: recommended and actual
- Estimated length of stay
- Proposed procedure(s), treatment(s) or service(s)
- Dates of procedure(s), treatment(s) or service(s)
- Practitioner orders for appropriate laboratory requests, X-rays, medications, etc. as they relate to the infant's condition
- Diagnostic results for diagnostic procedures
- Medication and intravenous fluid documentation
- Nurse entries for member condition and consistencies in charting (consistency with other clinical documentation)

Audits
Staff performance is assessed through case audit and inter-rater evaluations.

Discharge
Typically the NICU program discharges the program participant/care giver after the infant has been discharged to home

Quality improvement projects for 2016

- Preventing Smoking and Exposure to Secondhand Smoke (QIP 1, Safety)All Attempts Made Toward Initial Family Contact <48 Hours of IA (QIP 2)
- Report/Review Hospitalization (Inpatient and Emergency) Counts - Monthly

NICU case management and utilization management 2016 goals

- Reduce unplanned neonatal readmissions by analyzing and identifying areas for improvement post-discharge.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

Confidential property of Optum. © 2016 Optum, Inc.

BioPharma program

Alere Health's pharmaceutical support unit offers innovative solutions to pharmaceutical companies seeking to improve compliance and persistency through programs that support program participants by educating them about their condition and prescribed treatment regimen. Individuals targeted for participation in the pharmaceutical support programs may have limited knowledge of their diagnosis/condition, and side effect/symptom management needs. These programs are designed to apply scripted education and information to help them understand their diagnoses and treatment and to make educated choices about their care. Each program offered within the Alere Health pharmaceutical support unit is a unique client-specific program focused on a specific drug product and FDA-approved indications and labeling. Alere Health health care professionals deliver telephonic support to program participants in a pharmaceutical support program.

Non-compliance with prescribed medications and treatment is a significant problem and a key driver of health care costs. Several factors contribute to this problem, including lack of program participant knowledge about the expected efficacy of a drug, how to take medications and how to prevent or manage side effects. Because practitioners see a high number of patients in a short amount of time, they may not have time to educate patients adequately about their illnesses. That includes fully explaining the treatment regimens and the consequences of non-compliance as well as informing program participants about potential side effects and how to properly manage them.

Goals and objectives

The programs strive to improve compliance and persistency with the client product through:

- Personalized educational and psychosocial support
  - Alere Health pharmaceutical support programs encourage program participant autonomy and self-determination by providing education that supports program participants and families in clinical decision-making. We help program participants develop the skills necessary to take control of their lives. We support program participants, their families and caregivers as an advocate for health care information as it relates to the specific prescribed drug treatment regimen.
- Improved quality of life
  - Alere Health pharmaceutical support program participants have consistently indicated that our programs have positively impacted their quality of life by providing education and proactive management information related to their condition, clinical symptoms and needs.

Pharmaceutical support program process

Alere Health health care professionals help program participants focus on altering behaviors and provide ongoing educational support designed to improve adherence to prescription medications. Clinical and technology capabilities and procedures address the following elements:

- An individual's right to decline participation or dis-enroll from support programs and services offered by Alere Health.
- Initial assessment of program participant's health status, including diagnosis and current treatments is completed by a registered nurse.
- Documentation of current clinical status.
- Ongoing status of continued compliance and persistency with the product.
- Evaluation of cultural and linguistic needs, preferences or limitations.
- Evaluation of program participant and/or caregiver resources related to the prescribed regimen.
- Evaluation of available benefits relative to the prescribed drug regimen and information on potential options to narrow or close financial or access gaps.
- Identification of barriers to meeting goals or complying with the plan.
- A defined communication schedule for contact with the program participant based on analysis of side effect data, compliance data and known "drop off" points in therapy.

Confidential property of Optum. © 2016 Optum, Inc.

- Coordination of services with other client-specific resources and vendors to improve and enhance the program participant experience, and improve the opportunity for treatment completion.
- Program participant/caregiver education and support provided through client approved scripting and education materials.
- Proactive management of anticipated clinical symptoms or needs are assessed by registered nurses only.
- Program participant safety issues.
- Program participant advocacy.

Client-specific objectives and goals are further addressed through customizations in the following areas: enrollment activities, call frequency and cadence, disease-specific assessments, medication adherence objectives, adverse event reporting, multiple referral sources, hours of operation, program reporting, and program participant satisfaction surveys.

FDA labeling and fair balance requirements

All pharmaceutical support programs are delivered utilizing approved scripting and information-based on FDA-approved labeling for the drug and it's indications for use. Alere Health program personnel work closely with the client's clinical, product marketing and professional development and review committees to assure that scripting and educational materials are compliant with the client's understanding of FDA required labeling and Fair Balance requirements. Alere Health does not provide any materials that are not approved by or provided by the client for use.

Alere Health's pharmaceutical support program scripts are embedded in the clinical application of all programs, placing appropriate approved program scripting and educational information at the fingertips of clinical personnel. The delivery of the approved scripting to program participants is monitored and reviewed on an ongoing basis by the program management and quality improvement program staff. Satisfaction levels of the program participants in these programs is measured and reported on an ongoing basis to the client.

Identification of eligible individuals

The pharmaceutical company's sales and marketing units develop and support these programs. The field sales staff provides additional support through its direct-to-practitioner education. The most common referral sources include:

- Practitioner offices (forwarded to the pharmaceutical company database vendor)
- Practitioner office providing the program number to the program participant for self-referrals
- Product Support lines administered by the pharmaceutical company
    - Information provided by the specialty pharmacy about the program, self-referrals resulting from product website information, magazine ads and/or condition-specific informational websites.

Enrollment

Program participants have generally signed opt-in consent prior to contact with the program, but the processes are defined by the pharmaceutical company requesting services. Participation is not limited to the product user. It is also open to the product user's caregivers, friends, family or other interested parties.

Alere Health confirms consent to participate in any outbound call activities prior to enrollment in any of the outbound contact programs. Alere Health exchanges program participant information with the pharmaceutical company database vendor only after confirming that proper HIPAA compliant agreements are in place. Alere Health does not routinely share individual program participant level data with pharmaceutical company program personnel. Alere Health does provide periodic recorded program participant calls for quality monitoring to the pharmaceutical company. The calls are de-identified to protect the privacy of the caller.

Confidential property of Optum. © 2016 Optum, Inc.

Questionnaires
An initial questionnaire is completed with all incoming calls. All inbound and outbound calls are recorded for quality monitoring purposes and each caller is made aware of this at the start of the call. Agreement to participate on a recorded line is required. Questionnaires include basic information about a program participant's diagnosed condition and his/her current experience with the product. The information collected is used to confirm eligibility (receiving the drug for an approved indication) and to define the call sequencing or scheduling based on product experience.

Follow up calls
Calls are provided via outbound call schedules as defined in the individual client product design. The number of calls and information given to enrolled program participants varies based on market research completed by the pharmaceutical company requesting services aimed at touching program participants at times when product users are likely to experience symptoms or issues that may cause use drop-off. Each of the follow-up calls generally includes a brief questionnaire to confirm the program participant is still using the product. Each call generally has a defined educational purpose and the call scripting is developed to meet those needs. All calls also allow for the program participant to ask questions based on his/her experience with the product. The programs include a list of frequently asked questions (FAQ) that allow the health assistant or health care professional to respond to individual program participant needs, as applicable. When a program participant asks a question not included on the list of frequently asked questions, the staff must refer the program participant to his/her practitioner. Program staffers are not permitted to respond in an ad hoc manner; they must respond only within the scripts provided by the client.

Training and specialized product training
Health care professionals who provide services in the pharmaceutical support programs are hired and employed by Alere Health to support specific clients. Clients have the right to review resumes and interview potential program staff prior to final hiring decisions. Health care professionals must complete the Alere Health New Hire Orientation in addition to client-specific education. The Alere Health Learning and Performance team provides training for specific product support program administration.

Practitioner services
Services provided to practitioners are defined by the pharmaceutical client and may include use of the frequently asked questions or mailed information, or may require call transfer activities to product resources within the client's product support framework.

Monitoring and evaluation of outcomes
Alere Health tracks multiple operational, clinical and quality metrics and reports measurable results to demonstrate program impact to our clients. Examples of measurements include enrollment/disenrollment rates, program participants by program levels, program participant program completion, communication with providers, fulfillment reports, and program satisfaction.

BioPharma 2016 goals
- Continue increasing the number of program participants
- Implementation of the outbound call program
- Implementation of the live chat program
- Implementation of the automatic file feed from Covance to Alere Health to increase enrollments in the program.
- Expand the 2016 work plan to include measures for the implemented products that can be tracked and trended.

Confidential property of Optum. © 2016 Optum, Inc.

Appendix A – 2016 quality improvement work plan summary

The measures listed below are some of the key program indicators that will be reported to the division/program-specific quality subcommittee for review, analysis, identification of opportunities, and recommendations for interventions to improve performance results. The quality improvement committee will then review the performance measures and subcommittee analysis, and make decisions about future actions and interventions to be developed and implemented.

The 2016 quality improvement work plan report is a working document that will be clarified and modified as needed. The report will include data from calendar year (CY) 2015, if available, and 2016. Goals will be set based on analysis of industry benchmarks and research documents, past Alere Health performance, and client requirements.

Alere Health is also monitoring Stars measures that are key to our programs and program participants. In an effort to support client Star ratings, 2016 initiatives will focus on reducing readmissions, and improving clinical indicators in our program participants with diabetes and CAD. (Star measures are marked with an asterisk "*")

Measure	Program	Committee Review
Annual Reporting • 2016 quality program and work plan • 2015 quality program evaluation • 2016 population assessment • Program guidelines review/approval • Program content, printed materials, staff scripting • Cultural and diversity training • HIPAA training	DM, CCM, maternity CM, wellness, oncology CM and NICU CM and UM, Nurse24, BioPharma	annual
Safety Events	all	annual
Access Telephone: Calls answered <30 seconds, ASA, abandonment rate	DM, wellness, maternity NICU CM/UM, Nurse24	quarterly
Performance Monitoring: Call auditing/documentation auditing	all	quarterly
Complaints Participants, practitioners, clients volume and closure in less than 28 days from receipt	all	quarterly
Satisfaction Survey Participant	all	quarterly
Satisfaction Survey Client	DM, wellness, CCM, maternity, oncology, NICU CM/UM, Nurse24, BP	annual
Satisfaction Survey Practitioner	DM (each), UM	annual
Wellness Programs		
Health assessment content review	wellness	annual
Self-management tools/virtual coach review	wellness	annual
Coaching: Initial enrollment timeliness	wellness/coaching	quarterly
NCQA Technical Specifications	wellness	annual
Disease Management Programs		
Post processing referral	DM (aggregate)	annual
Enrollment - qualified accept rate	DM (aggregate)	quarterly
Clinical engagement - initial assessment	DM (aggregate)	quarterly
Active participation rate	DM (each)	quarterly
Access: Telephone ASA and CAR	DM (aggregate)	quarterly

Confidential property of Optum. © 2016 Optum, Inc.

Measure	Program	Committee Review
Utilization: Admissions, *readmits, ER visits	COPD, CAD, diabetes, HF, asthma	quarterly
Eligible outcome rate	maternity	quarterly
Clinical performance indicators - *flu, pneumococcal vaccinations	asthma, COPD. CAD, diabetes, HF	quarterly
• Asthma: Controller meds, short-acting beta agonist usage	asthma	quarterly
• COPD: Bronchodilator usage, controller meds,	COPD	quarterly
• CAD: BB post heart attack, *LDL screen and control, daily antithrombotic medication, *hypertension (ACE or ARB), *medication adherence for cholesterol	CAD	quarterly
• Diabetes: *Annual A1C test, *LDL test, *LDL control, *retinal exam, *microalbumin, *A1C control, *medication adherence	diabetes	quarterly
• Heart failure: ACE or ARB, beta blocker usage	heart failure	quarterly
• MSP: Rheumatoid arthritis DMARDs, migraine therapy	MSP	quarterly
• Depression: Antidepressant compliance, continuation phase - psychiatric visits	depression	quarterly
• Maternity: First prenatal visit, postpartum depression rate	maternity	quarterly
• All programs - smoking/tobacco use, seasonal flu		
• Maternity: NICU admissions and NICU days/1000	maternity	annual
• FYOL - well-being visits and immunization rates		
• Quality improvement projects	DM (each)	quarterly
Nurse24 - Health Information Line/Health Call Center		
Access - telephonic ASA and CAR, utilization patterns, chat line, secure messages and response timeliness	N24	quarterly
Health information activities	N24	quarterly
Triaged activities, dispositions	N24	quarterly
Two quality improvement projects	N24	quarterly
Case Management Programs		
Clinical enrollment		
Active participation rates	all	quarterly
TEN's prequalification accept rate	CCM	quarterly
Average calls per month	CCM, NICU	quarterly
Individuals refused CM services: URAC measure 5	all	quarterly
Clinical engagement		
Care transitions – identification of participants who are at risk	all	monthly
Care transitions – rates of admissions to facilities and ED	all	annually
Percent of participants say yes to AD discussion at IA and subsequent assessments	CCM, ONC	quarterly
Percent of participants with any AD at case closure	CCM, ONC	quarterly
Number of successful contacts with participant/CG per month	CCM, ONC	quarterly
Number of successful contacts with internal and external providers per month	CCM	quarterly

Confidential property of Optum. © 2016 Optum, Inc.

Measure	Program	Committee Review
Hospice participation	CCM, ONC	quarterly
Relevant subpopulation assessment	all	annually
3 performance improvement indicators/quality improvement projects	all	quarterly
Utilization Management Programs		
Initial review completion timeliness	NICU	quarterly
Concurrent review completion timeliness	NICU	quarterly
Annual review of guidelines	NICU	annually
Maintain UM state licenses	NICU	annually
Inter rater results	NICU	quarterly
2 quality improvement projects	NICU	quarterly
BioPharma		
Offers to mail program information to caller	Biopharma	quarterly
Reminder to participant that MD is the primary source for condition and treatment info	Biopharma	quarterly
Appropriate documentation of adverse events	Biopharma	quarterly
Accurately provides program information and/or education per program specific protocol	Biopharma	quarterly
Provides approved program scripts in addressing callers without use of generalizations or personal interpretation	Biopharma	quarterly
Appropriate fulfillment provided (appropriate to the call needs identified and was not duplicative)	Biopharma	quarterly
Appropriate referrals made to client specific resources	Biopharma	quarterly

Confidential property of Optum. © 2016 Optum, Inc.

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: February 1, 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	7	
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 1/31/17	177	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	42	47	9	6	8	0
Total # of Recreds	0	0	11	0	0	0
(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	805	671	641	669	343	104

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: Monitoring or Meeting Period:

Credentialing Committee April 5, 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	15	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	13	
Number practitioners recredentialed within 36-month timeline	13	
% 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	200	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	1	23		53	11	4
Total # of Recreds	267	158		280	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	803	616	699	679	371	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
Pharmaceutical and Therapeutics Committee
December 15, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD	Internist	Y
Hao Bui, BS, PharmD	Walgreens	Y
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	N
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, Pharm D	SCVMC Pharmacy Director	Y
Ali Alkoraishi, MD	Psychiatry	Y
Johanna Liu, PharmD	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	N

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	Y
Christine Tomcala	Chief Executive Officer	N
Tami Ogino, PharmD	Clinical Pharmacist	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Dang Huynh, PharmD	Pharmacy Manager	Y

Item	Discussion	Follow-Up Action
	The meeting convened at 6:15 PM.	
I.	**REVIEW, REVISE, AND APPROVE MEETING MINUTES of September 15, 2016.** The minutes were reviewed by Committee as submitted.	Upon motion duly made and seconded, the P&T Committee minutes of **September 15, 2016** were approved as submitted and will be forwarded to the QI Committee and Board of Directors.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
II.	**REPORTS** **a. Health Plan Updates** Dr. Liu presented the update on behalf of Dr. Robertson. Membership growth has stabilized. For contracting, update recently with specialty pharmacy. Were providing specialty pharmacy services through Valley Medical Center and Diplomat. Diplomat relationship was through Medi-Impact. Diplomat and Med-Impact split so no more preferred pricing relationship. RFP was performed. Decided to use Alpha Script Pharmacy based in Peninsula. Working on implementation plan to bring on Alpha Script and taper off Diplomat with as little disruption as possible to members and providers. **b. Appeals and Grievances** Dr. Liu presented the 3rd Quarter 2016 Pharmacy Appeals. Increase in Part D appeals during month of August. 11 were upheld, 12 overturned for CMC line of business. Top two medications appealed during third quarter were Ambien and Vistaril. These are both high risk medications. Lidocaine patches also a top drug for appeals in the third quarter. **c. Membership** Dr. Liu presented the membership update. Medi-Cal is currently at 272, 581 and Cal MediConnect is 7,546. Total membership is 280, 127. **d. Pharmacy Dashboard** Dr. Otomo presented the Pharmacy Dashboard for Medi-Cal and Cal MediCconnect. 100% for Medi-Cal one day turnaround time for prior authorizations. Cal MediConnect turnaround time is at 91% for 24 hour turnaround time (only one fallout). For MTM CMR Completion Rate, reached goal of 22% for the year.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
III.	**OLD BUSINESS/ DISCUSSION ITEMS** **a. Medical PA Grid for Medi-Cal and Cal MediConnect** Dr. Otomo presented the update on the Medicare and Medi-Cal Prior Authorization List. Cover all the same drugs except for one. For Medi-Cal, Synagis requires prior authorization. On Cal MediConnect it is not included. **b. Total Claims data for Medi-Cal** Dr. Huynh presented the 3rd Quarter claims data for Medi-Cal and Cal MediConnect. Medi-Cal: total of 502,304 claims: 89% Generic; 11% Brand. Healthy Kids: total of 1,043 claims: 88% Generic, 12% Brand. Cal MediConnect: total of 80,756 claims: 83.1% Generic, 16.9% Brand. Increase in Medi-Cal claims from 2nd Quarter to 3rd Quarter. Decrease in Healthy Kids claims from 2nd Quarter to 3rd Quarter. Increase in Cal MediConnect claims from 2nd Quarter to 3rd Quarter.	Upon motion duly made and seconded, the Prior Authorization Grids were approved as presented. Present update at next P&T Committee meeting March 16, 2017.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
IV.	**NEW BUSINESS**	
	a. Formulary Modifications Dr. Otomo presented Formulary Modifications made since interim from last Pharmacy and Therapeutics Committee meeting: • Added quantity limits as Santa Clara Family Health Plan was an outlier in this area • Removed OTC cough and cold products (not covered under Medi-Cal) Decision was made and implemented as a safety decision back in 2011. $5 copay for OTC cough and cold products, and patients were given option of products such as Guaifenesin with Codeine at no cost. Patients were choosing the no cost product, thus risk of prescribing narcotics. Presented as a formulary change. Change was due to Federal law. Noted: Opinion of the committee that this formulary change is not in the best interest of the patients. • Added Enbrel with prior authorization to formulary • Removed age limits on Celebrex • Removed all chemicals from formulary: powders	Update Levothyroxine to 1.5 tablets per day per recommendation of Dr. Parashar-Rokicki. Motion to accept formulary changes as presented, with Levothyroxine change to 1.5 tablets per day. With exception committee does not approve removal of OTC cough and cold products. Motion made, seconded and approved Dr. Liu to seek DHCS guidance. Run impact report. Share findings with CEO and CMO. If approved, add select OTC cough and cold medications back to formulary and retro-date.
	b. PA Guideline Review Project Dr. Huynh presented Brand Name Criteria for prior authorization request. Changed to approve for 4 months or as clinically appropriate. (Formerly approve for 12 months). Also presented Compounded Medications Criteria for prior authorization request. Presented Off Label Non-FDA Approved Medications Criteria. Dr. Otomo presented General Criteria for Utilization Management. Covers medications with no specific criteria for coverage.	Upon motion duly made and seconded, prior authorization criteria were accepted as presented.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
IV.	**c. MedImpact P & T Minutes** Dr. Huynh reviewed the MedImpact P&T Minutes and approved as written.	Upon motion duly made and seconded, MedImpact minutes were approved as written.
	d. New Drugs Dr. McCarty presented new drugs. i. Basaglar-Propose add to formulary with quantity limit, and remove Lantus from formulary. Grandfather existing members. ii. Sarilumab & Baricitinib-Informational only. iii. Stelara (ustekinumab)-Presented as informational only	Upon motion duly made and seconded, recommendation was approved as presented.
	e. Class Reviews Dr. McCarty presented class updates and recommendations. i. Growth Hormones Multiple Somatropin Agents. Discussed top seven products. Norditropin least costly of all products. Propose keep on formulary with prior authorization required for FDA approved labeling. Remove Competitor products from formulary. Review by exception request with prior authorization. Prior authorization criteria to include required use of Norditropin first. ii. HIV Update No discussion at this time. iii. Fertility Agents No discussion at this time.	Upon motion duly made and seconded, recommendations were approved as presented.
	f. 4Q2016 Drug Trend and Utilization Review **g. Medi-Cal Formulary Drug Updates** **h. Generic Pipeline-Presented as informational only**	Informational only. No action required.
V.	**ADJOURNMENT** The meeting was adjourned at 7:45 PM.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Submitted by:

Caroline Alexander Date: 3/16/17
Caroline Alexander
Administrative Assistant, SCFHP

Internal Approved By:

Date: 3/16/17
Johanna Liu, PharmD
Director of Quality & Pharmacy, SCFHP

External Approved by:

Date: 3/16/2017
Jimmy Lin, MD
Pharmacy & Therapeutics Chair

Santa Clara Family Health Plan

The Spirit of Care

MINUTES

UTILIZATION MANAGEMENT COMMITTEE

January 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	N
Indira Vemuri, MD	Pediatrics	N
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	N
Lily Boris, MD	Medical Director	Y
Jana Alegre	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	N
Sherry Holm	Behavioral Health Manager	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:05 p.m. The minutes of the October 19, 2016 meeting were approved as presented.	
II. CEO Update	Dr. Robertson presented the CEO update on behalf of Christine Tomcala, CEO. State is dissolving Coordinated Care Initiative (CCI) and reinstating as Cal MediConnect without IHSS. Extended to end of 2019. Expect decrease in growth of MediCal expansion.	
III. Old Business	Dr. Boris presented an update on readmission analysis as a follow up from the October 19th UM committee meeting. Looked at 30 day readmission rate by network. Medi-Cal Non SPD rate was 18.62%, with Network 10 having the highest readmission rate. SPD readmission rate average was 24.99%, with Network 10 and Network 60 having the highest readmission rate. Medi-Cal Overall	

ITEM	DISCUSSION	ACTION REQUIRED
	readmission rate was 20.79%. MCDS 30 day readmission rate (duals patients without Medicare part A) averaged 24.61% readmission rate. Cal MediConnect readmission rate was 13.80% which we are trending.	
IV. Action Items	a. Review of Policies Ms. Alegre presented a summary of changes to the UM Policies. Twelve policies were presented for review and approval. Edited HS.01 to HS.05 with NCQA verbiage. Added HS.09 Interrater Reliability. After motion duly made, seconded, all policies were approved as presented. b. Adopt Hierarchy of UM Criteria-HS.02 Ms. Alegre presented HS.02 Hierarchy of UM Criteria to the committee. Procedure adopted from this policy. Using Noridian for CMC line of business. For Medi-Cal line of business using MCG criteria and Medi-Cal guidelines as well as MD review. More specific in procedure and in policy more generalized. c. UM Program Description 2017 Dr. Boris presented a summary of the changes to the UM Program Description. Manages our UM processes. Only updates added were new NCQA requirements in 2017. Recommendation by Dr. Alkoraishi to look at Section M on Confidentiality in regards to 42 CFR Part 2 (release of information regarding substance abuse). After motion duly made, seconded, UM Program Description 2017 approved as presented.	Lily Boris and Jeff Robertson to look into this. If edited, will bring UM Program Description back to April UM Committee meeting.

ITEM	DISCUSSION	ACTION REQUIRED
V. Standing Reports	a. Membership Dr. Robertson presented an update on membership. Steady growth throughout the year of 2016. Ended the year at 280,000 overall membership. Common to have a dip in membership in January because members lose eligibility and reapply to get coverage retroactively applied. Most of loss occurred in Net 20. b. UM Reports 2016 i. Turn Around Time (Cal MediConnect/Medi-Cal) Dr. Boris presented Cal MediConnect and Medi-Cal dashboard for turnaround time on authorization requests. For Cal MediConnect, the goal is 95% in all areas. For Pre-Service Organization Determinations, the percentage of timely decisions made within 14 days is 94.8% as of December 2016. The percentage of timely decisions made within 72 hours is 93.7%. For Concurrent Organization Determinations, the percentage of timely decisions made within 24 hours is 72.4%. The percentage of timely decisions made within 30 days is 96.7%. For Medi-Cal, the goal is 95% in all areas. For Routine Authorizations, the percentage of timely decisions made within 5 business days of request is 96.8% as of December 2016. The percentage of timely decisions made within 72 hours of request is 96.4%. Data on the percentage of timely decisions made within 24 hours of request is unavailable at this time. Percentage of retrospective reviews completed within 30 calendar days of request is 96.8%. ii. Standard Utilization Metrics Dr. Boris presented the Standard Utilization Metrics. Medi-Cal non SPD average length of stay has remained at about 4, discharges per thousand 3.44. Medi-Cal SPD average length of stay increased from 4 to 5.26 days, discharges per thousand 12.93. CMC average length of stay is 6 days, discharges per thousand 271.3. For NCQA Medicaid Benchmark Comparisons, non SPD 90% are higher than us, average length of stay 4.03 days. For SPD we are in top 10%, average length of stay is 5.26. CMC population at 271.32 discharges per thousand, Medi-Cal SPD 155.13 discharges per thousand. Above NCQA mean by about 30 days for well managed. Every procedure down or flat for frequency of selected procedures with exception of Male age 45-64 Bariatric Surgery which increased (4 cases). Medi-Cal Behavioral Health Metrics ADHD Medicaid Percentile Rank is 25 to 50th percent.	Jana Alegre to check on language of CMC and NCQA on timeliness of Concurrent Review (Business Days for 24 hour turnaround time)

ITEM	DISCUSSION	ACTION REQUIRED
	iii. Specialty Referral Tracking Dr. Boris presented an update on Specialty Referral Tracking. SCFHP received a CAP in the last DHCS audit, of April 2016 due to not having a referral tracking system in place. The UMC adopted HS.01.02 Referral Tracking Procedure. On an annual basis UMC would look at 3 months of prior authorizations,in accordance with the procedure. The patient selection will review any member that has not had a claim in the system by the time of the calls. .. Outbound calls are made to patients to see if they received service. 42 of 62 (74% of authorizations had paid claim). 16 of 62 (25% had no matching claim). After calls, members stated they had procedure but received no claim (51 of 62 had procedure). We looked at 11 that had no matching claims: one was PMG delegate, so no access to claim. One member unsure if they got procedure done. Four members unable to reach, Four auths cancelled or denied, one procedure cancelled by physician (for cardiac concerns). The study shows that 90% either received services or had an auth cancelled/denied. This first study was to determine if there was a problem (barriers to getting procedure such as transportation, language barrier). Barrier analysis done to determine reason why 10% did not get procedure. UMC Recommends that the study be repeated study annually. Please see attachment for the details of the findings. c. Mental Health Update (Behavioral Health Utilization Data/ABA Utilization Data) Ms. Holm presented the Behavioral Health Utilization Data update. All Behavioral Health Treatment except for Kaiser and Valley Health Plan transition from San Andreas Regional Center for all diagnosed children with autism (over 3 years old). Members served ranged from 69 in January 2016 to 162 in December 2016. For Behavioral Health Utilization, 209 members with outreach activities (served in County & Community based clinics), 90 hospitalized members, 109 Health Risk Assessments, and 60 per month intensive case management. Medi-Cal members served in FQHC and Central Wellness ranged from 98 in January 2016 to 127 in December 2016. Cal MediConnect members served in FQHC and Central Wellness ranged from 210 in January 2016 to 160 in September 2016. Data was not yet available for the 4th Quarter of 2016 on Cal MediConnect members served d. Committee Membership/Charter Dr. Robertson reviewed the UM Committee charter. All current committee members have agreed to remain on committee.	UMC recommended that the Specialty Tracking policy be completed annually.
VI. Adjournment	Meeting adjourned at 6:55 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, April 19, 2017, 6:00 PM	

ITEM	DISCUSSION	ACTION REQUIRED

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
March 22, 2017

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Yes
Ngon Hoang Dinh, DO	Head and Neck Surgery	No
Indira Vemuri, MD	Pediatrics	Yes
Dung Van Cai, MD	OB/GYN	Yes
Habib Tobaggi, MD	Nephrology	Yes
Jeff Robertson, MD, CMO	Managed Care	Yes
Ali Alkoraishi, MD	Adult and Child Psychiatry	Yes

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	No
Lily Boris, MD	Medical Director	Yes
Jana Castillo	Utilization Management Manager	No
Sandra Carlson	Health Services Director	No
Sherry Holm	Behavioral Health Manager	No
Caroline Alexander	Administrative Assistant	No

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	The meeting was started with a quorum at 5:30 PM.	None
II. CEO Update	N/A	None
III. Old Business	None	None

ITEM	DISCUSSION	ACTION REQUIRED
IV. Review Items a. Exhibit: 1. Procedure HS.04.01 is reviewed with committee members b. Exhibit: 2. 4th Quarter 2016 plan Quality Monitoring and findings are submitted to UMC in accordance to the stated procedure.	• Dr. Boris reviewed the recent DMHC audit findings on behalf of DHCS for CMC. The findings included: that Finding #1: For decisions to deny service authorization requests, notices to enrollees are not produced in a manner, format, and language that can be easily understood. As a response, the plan updated the Procedure HS.04.01 to include CMC. The UM activities will be conducted in accordance to the procedure quarterly. Therefore, a CMC Quarterly Quality report was completed for 4th quarter 2016 and the results presented to UMC. The findings of review of 30 authorizations for multiple elements are summarized: o 30 unique authorizations were pulled with a random sampling. ▪ Of the sample 27% or 8/30 were expedited • 100% of the expedited authorizations were processed within 72 calendar hours • 95% or 21/22 of the standard authorizations met timeliness factors ▪ 70% or 21/30 of the denials were medical necessity denials ▪ 100% of denials received physician review ▪ 100% of the files had the correct letter template	The committee reviewed the attached information on Quarterly Quality monitoring of SCFHP QA process for denial notifications and is in agreement with quarterly updates to UMC. This is the first report and the UMC will follow the reports and agrees that a template for common denials and staff training is appropriate.

ITEM	DISCUSSION	ACTION REQUIRED
	o Review of the letter content shows that 60% or 18/30 of the letters had clear denial language. o However, 40% or 12/30 did not have evidence of clear denial language. ▪ Most common errors were: • MCG guideline not clearly identified. • If non contracted practitioner was denied, an appropriate alternative contracted practitioner was not provided to the member. • Denial verbiage is not stated in a member friendly language. • **Follow-Up** The Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows: o Created a template for denial letter verbiage that is member centric. ▪ Start with the common denial reason. • For non-contracted provider denials and redirection to in network, work with customer service to include in network	

ITEM	DISCUSSION	ACTION REQUIRED
	alternatives. o Train staff on denial process and notifications regulatory requirements (verbiage and TAT)	
Item 2. a. Exhibit: 3 Plan has updated Procedure HS.01.02 to include CMC (see attached) b. Exhibit: 4 Plan is presenting the follow up of : Update on Specialty Referral Tracking for CMC (see attached report for discussion)	Dr. Boris reviewed the recent DMHC audit findings on behalf of DHCS for CMC. The Plan does not have an established system to track and monitor specialty referrals requiring prior authorization for CMC. As such, the procedure HS.01.02 was updated to include CMC line of business. To complete the Santa Clara Family Health Plan's (SCFHP) process for tracking referrals and meet the guidance of HS.01.02 (Referral Tracking) to their completion and drive improvements through the monitoring of provider referral and specialist care patterns of practice. These were randomly selected with Cal MediConnect members. Please see attachment for complete information. • The findings of review authorizations for are summarized: o 19/35 or 54% had the procedure requested	The committee agrees with adding CMC LOB. They reviewed the report and acknowledged that the CMC members are difficult to contact. The UMC will continue to monitor.

ITEM	DISCUSSION	ACTION REQUIRED
	• Of the 16 left in the sample without matching claims: o 1 deceased o 1 member's daughter was unsure (DME) o 1 member went to SNF instead (Empress Care) o 1 member still waiting (DME – Commode Chair and Cane) o 12 unable to reach • **Recommendation based on this review is for annual follow up.** o Match pharmacy data with our auth data for the next annual follow up. o UM: Referred one member to DME vendor to resolve outstanding DME item	
VI. Adjournment		
NEXT MEETING	The next meeting is scheduled for Wednesday, April 19, 2017, 6:00 PM	

Prepared by:

_____ Date _____

Lily Boris, MD
Med Director

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

Santa Clara
Family Health Plan
The Spirit of Care

Quality Improvement Committee
Consumer Advisory Board – Cal MediConnect Member Feedback
2016 & Q1 - 2017

The following are issues of Cal MediConnect (CMC) program management and enrollee care identified by CMC members during the monthly Consumer Advisory Board meetings. SCFHP is required to share this member input with the QI Committee quarterly.

Summary of Issues:

Phone

1. The Valley Medical Center (VMC) Call Reminder Line has a "click-click" then hangs up. Issue is several years old. Members have complained about it but nothing has happened.

   Action Taken: Unable to recreate concern. Determined this issue is outside of the scope of the Cal MediConnect program. Complaints have been previously submitted by member to Valley Medical Center (Hospital).

2. Members are bothered by the number of calls from SCFHP (and/or Delegate) weekly; at times are overwhelmed with the volume.

3. Members struggle to understand some staff with strong accents

4. Delays with Customer Service line after hours. Member was on hold for 20 minutes before prompted to leave a message. SCFHP

   Action Taken: Customer Services Rep followed-up with member to get more specifics.

SCFHP After-Hours Nurse Line – Support and Customer Service issue. Nurse line placed caller on hold for 20 minutes only to then be prompted for leaving a voice mail message. Caller was frustrated for time spent on hold.

Action Taken: Unable to establish systemic issue. Continue to track other future complaints and monitor for recurrence.

Customer Service/Case Management Support for Member– With an Authorization for DME supplies ending, along with problems related to a wrong physician and diagnosis for auth, a CMC Member contacted Case Management (CM) for help and Customer Service, but didn't get a call back. Crescent Provider told member they had to see doctor before auth could be approved, but they couldn't schedule and were almost hospitalized.

Action Taken: Nurse Case Manager notified and successfully resolved the case/issue.

Pharmacy Co-Pay - Member was surprised by new Pharmacy co-pays and expressed difficulty with paying them at times.

Additional Input on CMC Program Management and Enrollee Care

- Case Management/Care Coordination
  - Satisfied working with their case managers and getting the help that they need.
  - Linking with the case manager helped member access IHSS services.
  - Value the combination of medical and social services provided to meet member needs.
  - Appreciation for case manager "check-in" call, particularly in her own language (Spanish).
- Providers
  - Excellent service received from the nursing staff and doctors at a Specialty Clinic at Stanford and Fair Oaks (Valley Health Plan) clinics.
- Pharmacy
  - Received excellent service from SCFHP and Pharmacy for prescriptions not typically covered.
- Other
  - Suggestion: provide members with a written summary of how transportation benefit can be arranged including what's different, if after hours
  - Health plan resolution of member billing issue
  - Acupuncture coverage has been beneficial to a member.

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the Santa Clara County Health Authority Provider Advisory Council (PAC)

Thursday, May 4, 2017
12:15 PM – 1:45 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes

Members Present:
Thad Padua, M.D., Chair
Steve Church
Bridget Harrision, M.D.
Peter Nguyen, D.O.
Jimmy Lin, M.D.
Sherri Sager

Staff Present:
Christine Tomcala, Chief Executive Officer
Jeff Robertson, M.D., Chief Medical Officer
Chris Turner, Interim Chief Operating Officer
Sherry Holm, Behavioral Health Program Manager
Johanna Liu, Director of QI & RX
Lori Andersen, Operations Director, LTSS
Abby Baldovinos, Sr. Provider Services Representative
Art Shaffer, Sr. Provider Services Representative
Claudia Graciano, Sr. Provider Services Representative
Robyn Esparza, Administrative Assistant

Members Not Present:
Kingston Lum
Dolly Goel, M.D.
Dave Mineta

Staff Not Present:
Jennifer Clements, Director of PNM
Irene Walsh, MLTSS Provider Services Representative
Lily Boris, MD, Medical Director
Lori Anderson, Operations Director, LTSS

Guest Present:
Peter Goll, CEO, PMG, San Jose

1. **Roll Call**

Thad Padua, MD, Chairperson, called the meeting to order at 12:30 pm.
Roll call was taken and a quorum was established.

2. **MINUTES REVIEW AND APPROVAL**

Meeting minutes were reviewed. Dr. Padua asked the Committee if there were any additional questions or comments regarding the February 2, 2017 meeting minutes.

- ✓ It was moved, seconded that the February 2, 2017 minutes be approved.

3. **PUBLIC COMMENT**

- ✓ There were no public comments.

4. **COMMITTEE MEMBERSHIP**

a) **Resignation of Dr. Tuyen Ngo, President, Premier Care**

Dr. Padua, Chair, advised the Committee that Dr. Tuyen Ngo, President, Premier Care, is moving on to other roles within the Premier Care organization and that Dr. Chung Vu, President of Premier Care, will be his successor and taking his place as a PAC Committee representative.

b) **Introduction of New Committee Member**

Dr. Padua, Chair, introduced and welcomed Dr. Chung Vu, President, and Premier Care, who is replacing the vacating member Dr. Tuyen Ngo, to the Committee. Dr. Vu's CV was presented and reviewed by the Committee.

- ✓ Dr. Vu's Committee membership approved.

c) **Committee Membership Roster**

Per last month's meeting, the Committee Membership Roster was presented for the Committee reference.

5. **CHIEF EXECUTIVE OFFICER UPDATE**

Ms. Tomcala presented the April 2017 Membership Summary, noting the current enrollment is 277,665, with the majority of our membership in Medi-Cal, down 1000 members since January

- Healthy Kids: 2,794
- Cal MediConnect: 7,567
- Medi-Cal: 267,304

With regard to Medi-Cal Membership by Age Group and Network, Ms. Tomcala presented the following:

- Pediatrics: 41%
- Adults: 59%

Ms. Tomcala discussed the following current events:

a) **Affordable Care Acts House Vote**

Ms. Tomcala advised the Committee that the House vote on the Affordable Care Act (ACA) passed today with 217 in favor and 212 opposed.

b) **DHCS Audit**

Ms. Tomcala advised the Committee that the Plan was audited by the Department of Health Care Services (DHCS) in April of this year. The audit was the annual medical audit and that it went quite well. The Plan has been working diligently to identify any areas that needed improvement in regards to compliance and implement required policies and procedures. She noted that the auditors appreciated all the work the Health Plan has done to accomplish this task since the last Corrective Action Plan (CAP). The remaining compliance gap involves Provider Dispute Resolutions (PDRs). The Plan continues to work diligently and it will be completed by end of year.

c) Claims System Upgrade

Ms. Tomcala advised Committee The Plan has been using two systems to process claims: Cal MediConnect (CMC) claims processed by the QNXT system and Medi-Cal (MC) claims processed by XPRESS, a much older system. The Plan is in the process of converting our MC system over to QNXT, so we will now have a single platform processing all claims for all lines of business. The go live date for QNXT is July 1, 2017.

6. **Chief Medical Officer**

Dr. Robertson discussed the following items:

a) SCFHP 20th Anniversary

Dr. Robertson, CMO, informed the Committee that in honor of SCFHP's 20th Anniversary the Marketing Department asked a photographer to attend today's meeting to take photographs throughout the meeting. These pictures will be included in an album of events which is being created in celebration of our anniversary.

b) Technology Upgrade

Dr. Robertson informed the Committee that The Plan is implementing a lot of new technology that would be expected from a 21st century Silicon Valley company. A total of four systems are being implemented:

1) **Credentialing System:** Upgrading to Vistar, which will be more automated, replacing our current paper process and help reduce our current application cycle. Currently, we get about 90% done in 60 days. We expect to shorten that even further with bringing new providers on board and credentialing.
2) **Provider & Member Portal:** Will allow providers to check eligibility, prior authorization and interact electronically with the Plan. Our current portal is very primitive and many providers only use it to check eligibility. Providers will receive notices from the Plan with instructions on how to register. Our goal is to reduce the need to call the Plan and provide more self-service opportunities for the provider office staff.
3) **Case Management System:** The new system, Esset, will allow more interaction for providers in regards to their patients who are on case management.
4) **Claims & Membership System:** QNXT is not a new system, the Plan has been using it for two years for Cal MediConnect, so we know it works well. However, it is a new system for Medi-Cal, which is the vast majority of our membership. Dr. Robertson educated the Committee on bundling and unbundling, for the purpose of soliciting their feedback on any issues they see arising. He noted unbundling is when you take one procedure, break it down to as many parts as possible and then individually charge for each component. He advised that for the last 20 years, there has been an industry standard called CCI (Correct Coding Initiative) thru Medicare and it takes these unbundled elements and puts them back into the parent charge. So, QNXT will reject unbundled claims and rundle them. The Plan is prepared for questions form the providers.

7. **Behavioral Health**

Ms. Sherry Holm, Director of Behavioral Health, provided a presentation on of Behavioral Health. Ms. Holm directs the Autism Program and is liaison between the Plan and County partners.

- ✓ Ms. Holm will develop a workflow to present at a future meeting.

8. **Quality and Pharmacy**

Ms. Johanna Liu, Director of QI and Pharmacy, presented the drug reports on the Top 10 Drugs by Total Cost and by Prior Authorization for the date range of 01/01/17 – 03/31/17.

9. **ADJOURNMENT**

It was moved, seconded, and approved to adjourn the meeting at 1:40pm. The next meeting is scheduled for August 3, 2017.

Dr. Thad Padua, PAC Committee Chair **Date**

DRAFT

BYLAWS OF
SANTA CLARA COUNTY HEALTH AUTHORITY
(Adopted as amended May 15, 2014)

ARTICLE I
AUTHORITY, PURPOSES, STATUS AND POWERS

Section 1.1 **Authority.** These Bylaws are adopted by the Santa Clara County Health Authority ("Authority") to establish rules for its proceedings, as authorized by Welfare and Institutions Code 14087.38 ("Section 14087.38") and Ordinance No.300.576 ("Ordinance"), as amended from time to time. The Authority is a public agency created by the Board of Supervisors of Santa Clara County ("County") pursuant to authority conferred by Section 14087.38.

Section 1.2 **Purposes.** The purposes of the Authority are to meet the problems of delivery of publicly assisted medical care in the County, to demonstrate ways of promoting quality care and cost efficiency, and to further such other purposes as are contemplated by Section 14087.38 and described in the Ordinance.

Section 1.3 **Status.** The Authority is an entity separate from the County. Obligations, acts, omissions or liabilities of the Authority shall be obligations, acts omissions or liabilities solely of the Authority, and shall not, directly or indirectly, be obligations, acts, omissions or liabilities of the County or any officials, employees or agents of the County.

Section 1.4 **Powers.** The Authority shall have the power to negotiate and enter into contracts with the Department of Health Care Services and to arrange for the provision of health care services for Medi-Cal beneficiaries as authorized by Section 14087.38. To the extent authorized by Section 14087.38, the Authority may also enter into contracts to arrange for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured, indigent, or underinsured individuals. The Authority shall have all rights, powers, duties, privileges and immunities expressed, either directly or implicitly, in Section 14087.38. Chapter 1 of Division A6 of the Ordinance Code of the County, containing general rules and procedural requirements applicable to boards and commissions of the county, as they may apply now.

Deleted: or

ARTICLE II
GOVERNING BOARD

Section 2.1 **Governance.** Responsibility for governing and managing the affairs of the Authority shall be vested in a governing board ("Governing Board").

Section 2.2 **Number.** The Governing Board shall consist of thirteen (13) members ("Board Members"), each of whom shall have a fiduciary duty to act in the best interest of the Authority.

Deleted: May 15

Deleted: 4

Section 2.3 **Qualifications.** Board Members shall be chosen for their willingness and ability to effectively contribute to and support the objectives of the Authority, shall have a commitment to a health care system that seeks to improve access to quality health care for persons served by the Authority and shall have a commitment to maintaining and preserving a health care safety net for the medically indigent, uninsured, and underinsured populations of the County. Board Members shall either reside, be employed, or provide services in the county, and shall be generally representative of the diverse backgrounds, interests and demography of persons residing in the County. When nominating members to the Governing Board candidates possessing the following backgrounds should be considered: expertise in business, finance, managed care, hospital administration, information technology, medicine, health care policy, or law.

Section 2.4 **Nominations.** Nominations shall be made as follows: Board members shall be nominated by the County Board of Supervisors.

Section 2.5 **Appointment**. Appointments shall be made upon a majority vote by the County Board of Supervisors.

Section 2.6 **Term.** The terms for all Board Members shall be two years. No Board Member may serve more than four (4) consecutive terms without a break in service from the Board of at least one year.

Section 2.7 **Resignation.** Any Board Member may resign at any time by giving written notice of such resignation to the Chairperson of the Governing Board. Such resignation shall take effect at the time specified in the notice; provided, however, that if the resignation is not to be effective immediately upon receipt of the notice by the Chairperson, the Governing Board must affirmatively vote to accept the effective date specified, and if the Governing Board does not approve such later date, the resignation shall be effective immediately.

Section 2.8 **Removal.** A Board Member may be removed from the Governing Board by either of the following methods:

2.8.1 The Governing Board, by an affirmative vote of no less than six Governing Board Members, may remove a Board member. The reasons for removal may include:

2.8.1.1 The Board Member fails to meet the qualifications as a Board Member;

2.8.1.2 The Board Member fails to attend three (3) consecutive regular meetings of the Governing Board;

2.8.1.3 The Board Member fails during any twelve (12) month period to attend a minimum of 50% of (a) the regular and special meetings of the Governing Board, or (b) the meetings of the committees of which the Board Member is a member;

Deleted: and

Deleted: May 15

Deleted: 4

2.8.1.4 The Board Member fails to discharge legal obligations as a member of a public agency;

2.8.1.5 The Board Member is convicted of a crime involving corruption or any felony; or the Board Member is barred, suspended or excluded from participation in federal programs or has been barred from serving as a Board Member pursuant to the Knox-Keene Act;

2.8.1.6 A request for removal has been submitted by the Board of Supervisors.

2.8.1.7 Other good cause, as reasonably determined by the Governing Board.

2.8.2 A Board Member shall be given reasonable notice and an opportunity to respond before the Governing Board prior to any vote by the Governing Board regarding potential removal of that Board Member.

Section 2.9 Vacancies. Any vacancy in the Board, however created, shall be filled by the County Board of Supervisors.

Deleted: Section 2.10 . Reimbursement Of Expenses.¶
¶
. . 2.10.1 . Board Members, other than County employees, may be reimbursed for services and out-of-pocket expenses at a rate to be determined by the Board for each Board meeting attended. ¶

ARTICLE III
OFFICERS

Section 3.1 Designation. The Officers of the Authority shall be:

3.1.1 A Chairperson, who shall be a Board Member, and who shall preside at all meetings of the Governing Board.

3.1.2 A Vice-Chairperson who shall be a Board Member, and who in the Chairperson's absence, or inability to act, shall preside at the meetings of the Governing Board.

If both the Chairperson and the Vice-Chairperson are absent or unable to act, the Board Members present shall by action of the Board Members select one of the Board Members present to act as chairperson pro tempore, who, while so acting, shall have all of the authority of the Chairperson.

Deleted: resolution

3.1.3 A Treasurer, shall be a Board Member or such other person as appointed by the Governing Board, including but not limited to the Chief Financial Officer, who is employed by the Authority, and who shall have custody of and disburse the Authority's funds. The Treasurer shall have the authority to delegate the signatory function of the Treasurer to such persons as authorized by the Governing Board.

3.1.4 A Secretary, who shall be a Board Member or other person appointed by the Governing Board, including a person employed by the Authority, and who shall be responsible for preparing and keeping the minutes of the Governing Board; shall attest to the

Deleted: May 15

Deleted: 4

signature of the Chairperson, Vice-Chairperson, Treasurer, Chief Executive Officer or other authorized signatory on documents executed on behalf of the Authority; shall give, or cause to be given, notice of all meetings of the Governing Board and committees of the Authority as required by law; shall keep the seal of the Authority, if one be adopted, in safe custody; and shall have such other duties as may be prescribed by resolution of the Governing Board or these Bylaws.

Section 3.2 Election. The Governing Board shall elect officers for a two-year term. Officers may be elected for consecutive two-year terms.

Deleted: , at its first meeting of each calendar year, or as soon thereafter as possible,

Deleted: one

Section 3.3 Resignation. Any officer may resign effective on giving written notice to the Secretary or the Chairperson, unless the notice specifies a later time for his or her resignation to become effective. Upon receipt of such notice by the Secretary or the Chairperson, as applicable, the Secretary shall notify (or, if applicable, the Chairperson shall direct the Secretary to notify and the Secretary shall then notify) all the other officers of the Authority and shall enter the notice in the proceedings of the Governing Board. The acceptance of a resignation shall not be necessary to make it effective.

Section 3.4 Vacancies. A vacancy in any of the officer positions for any cause shall be filled by a special election of the Governing Board at the next regular or special meeting of the Governing Board.

Deleted: office

ARTICLE IV
MEETINGS

Section 4.1 Regular And Special Meetings. The date, time and place of regular meetings of the Governing Board shall be established by resolution of the Governing Board. The Governing Board shall hold regular meetings during at least each of four (4) months of each calendar year, at least one of which may include a strategic planning session. Special meetings may be held upon the call and the discretion of the Chairperson. However, upon the request of any three (3) or more Board Members, the Chairperson shall call a special meeting. Special meetings shall be subject to the rules otherwise set forth in these Bylaws.

Deleted: shall be

Section 4.2 Open And Public. Meeting shall be open and public and all persons shall be permitted to attend, except for closed sessions, all as required and permitted by applicable law, including the Ralph M. Brown Act (Gov. Code 54950 *et. seq.*) and Section 14087.38.

Section 4.3 Notice.

4.3.1 Notice of every regular meeting, and any special meeting which is called at least one (1) week prior to the date set for the meeting, shall be given to each member of the Governing Board and to any person who has filed a written request for notice with the Authority. Any such mailed notice shall be mailed at least one (1) week prior to the date set for the meeting to which it applies, except that the Governing Board may give the notice as it deems practical of special meetings called less than seven (7) days prior to the date set for the meeting. Any request for notice filed pursuant to this section shall be valid for one (1) year from the date on which it is

Deleted: May 15

Deleted: 4

filed unless a renewal request is filed. All requests for notice shall be filed with the Secretary of the Authority. Renewal requests for notice shall be filed within ninety (90) days after January 1 of each year.

4.3.2 Written notice of each special meeting shall be delivered personally, electronically, or by mail to each Board Member and, to each local newspaper of general circulation, radio and television station, requesting such written notice in writing. Such notice shall be received at least twenty-four (24) hours before the time of such meeting as specified in the notice. The notice shall specify the time and place of the special meeting and the agenda for the meeting. No other business shall be considered at such meeting. Notice shall be required pursuant to this section regardless of whether any action is taken at the special meeting. In cases of emergency, notice of special meetings may be dispensed with only to the extent permitted by applicable law.

Section 4.4 Waiver Of Notice. Written notice may be dispensed with as to any Board Member who, at or prior to the time the meeting convenes, files with the Secretary a written waiver of notice. Such waiver may be given by any means that allows for a permanent record and may be authorized by law. Such written notice also may be dispensed with as to any Board Member who is actually present at the meeting at the time it convenes.

Section 4.5 Attendance And Participation. Board Members must attend the regular meetings of the Governing Board and of committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of the Authority.

Section 4.6 Quorum. A quorum is a majority of the Board Members (i.e. seven members). A quorum must be present to initiate and conduct the transaction of business at any regular or special meeting of the Governing Board.

Section 4.7 Meeting Agendas. For all meetings that are open and public pursuant to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), the provisions of Sections 4.7.1 through 4.7.3 shall apply.

4.7.1 The Chief Executive Officer of the Authority shall prepare an agenda for every meeting of the Governing Board setting forth a brief general description of each item of business to be transacted or discussed at the meeting and the time and location of the meeting. Each agenda for a regular meeting shall provide an opportunity for members of the public to address the Governing Board directly on items of interest to the public that are within the subject matter jurisdiction of the Authority. At least seventy-two (72) hours before a regular meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted at the main entrance of the Authority's executive offices and online on the Health Authority's website, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public.

4.7.2 No action shall be taken at a regular meeting on any item not appearing on the posted agenda; provided, however, that the Board Members may take action on items of business not appearing on the posted agenda under the following conditions:

Deleted: May 15

Deleted: 4

4.7.2.1 The Governing Board determines by a majority vote of the Board Members present that an emergency situation exists under Government Code 54956.5; or

4.7.2.2 The Governing Board determines by a two-thirds vote of the Governing Board, or, if less than two-thirds of the Board Member are present, by a unanimous vote of those Board Members present, that the need to take the action arose subsequent to the posting of the agenda; or

4.7.2.3 The item was included in the posted agenda for a meeting of the Governing Board occurring not more than five (5) calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

4.7.3 At least twenty-four (24) hours before a special meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted with the call and notice of the meeting at the main entrance of the Authority executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public. No business not set forth in the posted agenda shall be considered by the Governing Board at such special meeting.

Section 4.8 Conduct Of Business. The items on the agenda shall be considered in order unless the Chairperson shall announce a change in the order of consideration. Unless an agenda item identifies a particular source for a report, the Chief Executive Officer, the Board Members, the Authority staff and consultants shall report first on the item, after which the item shall then be open to public comment upon recognition of the speaker by the Chairperson. The proceedings of the Governing Board shall be guided by the provisions of the law applicable thereto and, except as herein otherwise provided, by Robert's Rules of Order, newly revised. Provided, further, that the failure to follow Robert's Rules of Order shall not invalidate any action taken.

Deleted: To the extent that conduct of the meeting is not governed by these bylaws or the Ralph M. Brown Act, the current edition of Robert's Rules of Order shall apply.

Section 4.9 Resolutions and Motions. All official acts of the Authority shall be taken either by resolution or a motion, duly made, seconded and adopted by vote of the Board Members.

Section 4.10 Voting. Except as otherwise provided by these Bylaws, when a quorum is present all official acts of the Governing Board shall require the affirmative vote of a majority of the Board Members present and eligible to vote.

Section 4.11 Disqualification From Voting. A Board Member shall be disqualified from voting on any motion or resolution relating to a transaction in which he or she has a financial interest, as required by law or by the Conflicts of Interest Policy of the Authority, as described in Article IX. Except as required by law or by the Conflict of Interest Policy of the Authority, no Board Member shall be disqualified from serving as a Board Member or taking part in any proceedings of the Governing Board because of any financial interest of a Board Member.

Deleted: May 15

Deleted: 4

Section 4.12 Minutes. The Secretary shall cause to have prepared the minutes of each meeting of the Governing Board. The minutes shall be an accurate summary of the Governing Board. The minutes shall be an accurate summary of the Governing Board's consideration of each item on the agenda and an accurate record of each action of the Governing Board. At a subsequent meeting, the Secretary shall submit the minutes to the Governing Board for approval by a majority vote of Board Members in attendance at the meeting covered by the minutes. When approved, the minutes shall be signed by the Secretary and kept with the proceedings of the Governing Board.

Section 4.13 Closed Sessions. The Governing Board shall meet in closed session only as permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and Section 14087.38. The Governing Board shall post an agenda and report the actions taken at a closed session to the public to the extent required by applicable law. A closed session minute book may be established and maintained for minutes of closed sessions, which shall reflect only the topics of discussion and decisions made at the session. The closed session minute book shall be kept confidential, shall not be a public record, and shall be available to the Board Members, the Chief Executive Officer, and the Governing Board's legal counsel, except as otherwise required by applicable law.

Deleted: shall

Deleted: all

Section 4.14 Public Records. All documents and records of the Authority, not exempt from disclosure under applicable law, shall be public records under the California Public Records Act (Government Code 6250 *et seq.*). The Governing Board and the Chief Executive Officer shall take appropriate steps to maintain the confidentiality of all documents and records of the Governing Board for which exemptions from disclosure are available under applicable statutes.

Section 4.15 Adjournment. The Governing Board may adjourn any meeting to a time and place specified in the resolution of adjournment, notwithstanding less than a quorum may be present and voting. If no member of the Governing Board is present at a regular or adjourned meeting, the Chief Executive Officer or his or her designee may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in Section 4.3 of the Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

ARTICLE V
COMMITTEES OF THE GOVERNING BOARD

Section 5.1 Bylaws Committee. The Governing Board shall appoint a three (3) member Bylaws Committee, all of whom shall be Board Members. Proposed amendments to these Bylaws shall not be effective unless approved by a majority vote of the Bylaws Committee, and by the affirmative vote of no less than a majority of Board Members, as set forth in Article XII.

Section 5.2 Executive/Finance Committee. The Governing Board shall appoint a five (5) member Executive/Finance Committee. One Alternate may be appointed by the Governing Board. The Alternate shall be entitled to vote as an Executive/Finance Committee member when

Deleted: May 15

Deleted: 4

an Executive/Finance Committee member is absent from the Executive/Finance Committee meeting.

5.2.1 The Executive/Finance Committee shall consist of its Chair and Vice Chair, plus three (3) other Board members. The Alternate shall be a Board member. At least one of the members of the Executive Committee shall have financial expertise. The Chief Executive Officer and Chief Financial Officer of the Health Authority shall serve as ex officio members of the Executive/Finance Committee, without vote.

5.2.2 In the event of a financial, operational, legal, personnel or public relations emergency, which the Chief Executive Officer or the Executive/Finance Committee reasonably determines requires handling before the next scheduled meeting of the Governing Board or before a special meeting of the Governing Board can be called, the Executive/Finance Committee shall have all of the powers and authority of the Board of Directors to act in the intervals between meetings of the Board of Directors.

5.2.3 Notwithstanding the above, the Executive/Finance Committee shall not have authority to: amend or repeal the Bylaws or adopt new Bylaws; fill vacancies on the Governing Board; or fix compensation of Directors. By majority vote of the Governing Board, the Board may at any time revoke or modify the authority delegated to the Executive/Finance Committee.

5.2.4 Any action taken by the Executive/Finance Committee must be reported to the Governing Board at the next meeting.

5.2.5 The Executive/Finance Committee shall also serve as the Audit Committee of the Governing Board. The Governing Board must approve the budget. Any major change in the budget must be approved by the Governing Board or the Executive/Finance Committee. Annual and periodic financial reports shall be submitted to the Governing Board.

5.2.6 The Executive/Finance Committee Charter, as amended from time to time, is attached hereto and incorporated herein.

Section 5.3 Quality Improvement Committee. The Governing Board shall establish a Quality Improvement Committee to oversee the Authority's Quality Improvement Program. The charter of the Quality Improvement Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.4 Compliance Committee. The Governing Board shall establish the Compliance Committee to assist the Governing Board in its oversight of the implementation and effectiveness of the Authority's Compliance Program. The charter of the Compliance Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.5 Provider Advisory Council. The Governing Board shall establish a Provider Advisory Council, composed of participating providers, to provide expertise to the Authority relative to their respective specialties. The Provider Advisory Council shall have a sufficient

Deleted: an

Deleted: for discussion

Deleted: Finance Committee

Deleted: , responsible for: developing and reviewing fiscal policy; monitoring investment activity and financial performance; reviewing and making recommendations regarding financial statements, audits, financial management and business plan objectives; and reviewing with, and making recommendations to the Governing Board, regarding the annual budget and variations from the budget

Deleted: and all expenditures must be within budget

Formatted: Font: Bold

Formatted: Highlight

Formatted: Indent: First line: 0"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Highlight

Formatted: Highlight

Formatted: Underline

Deleted: May 15

Deleted: 4

number of members to provide the necessary expertise and to work effectively as a group. The charter of the Provider Advisory Council, as amended from time to time, is attached hereto and incorporated herein.

Section 5.6 Consumer Advisory Committee. The Governing Board shall establish a Consumer Advisory Committee, which shall provide input and feedback on the services provided by the Authority. The Consumer Advisory Committee shall constitute the "Community Advisory Committee," referenced in Section A-18-334 of the Ordinance. The charter of the Consumer Advisory Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.7 Additional Committees. The Governing Board may, from time to time, adopt charters creating such additional committees and subcommittees of the Governing Board as it deems necessary to carry out its purposes. The charter shall specify the number and qualifications of members, scope of matters on which such committee or subcommittee will provide review and recommendations, and parameters for the conduct of proceedings. No committee or subcommittee may be composed of a number of Board Members constituting a quorum of voting Board Members.

Section 5.8 Authority. All such other committees and subcommittees shall be advisory only, unless otherwise specified by the Governing Board.

Section 5.9 Meetings. Regular meetings of the committees and subcommittees shall be held at such times and places as are determined by the chairperson of the committee or subcommittee. Special meetings may be held at any time and place as may be designated by the Chairperson, the chairperson of the committee or subcommittee, the Chief Executive Officer or a majority of the members of the committee or subcommittee.

Section 5.10 Open and Public. Meetings of committees and subcommittees shall be open and public, except such meetings that may be held in closed session to the extent permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and Section 14087.38.

Section 5.11 Notice and Agenda Posting. To the extent that meetings of committees and subcommittees are subject to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), notice and agenda posting regarding such regular and special meetings shall be carried in the same manner as that applicable to regular and special meetings of the Governing Board as set forth in Article IV of these Bylaws.

Section 5.12 Minutes. The Secretary or his or her designee shall prepare minutes of each meeting of every committee and subcommittee. The minutes shall be an accurate summary of the committee's or subcommittee's consideration of the matters before it and an accurate record of each action of the committee or subcommittee. At a subsequent meeting, the Secretary or designee shall submit the minutes to the committee or subcommittee for approval by a majority vote of members in attendance at the meeting covered by the minutes. When approved, copies of

Formatted: Underline

Formatted: Font: Not Bold

Deleted: 3

Deleted: by resolution

Deleted: e

Deleted: and appoint the members of

Deleted: Except as provided in Article VI, only Board Members shall serve on committees and subcommittees, but n

Deleted: The Governing Board may designate one (1) or more Board Members as alternate members of any committee or subcommittee to stand in for any absent member at any meeting of the committee or subcommittee.

Formatted: Highlight

Deleted: 4

Deleted: 5

Deleted: Except for the Executive Committee, at least one third of the authorized number of members of the committee or subcommittee shall constitute a quorum for the transaction of business. In the case of the Executive Committee, a majority of the seated members of the committee shall constitute a quorum for the transaction of business.

Deleted: 6

Deleted: 7

Deleted: 8

Deleted: May 15

Deleted: 4

minutes shall be forwarded by the Secretary or designee to the Board Members and to the Chief Executive Officer.

ARTICLE VI
[RESERVED]

ARTICLE VII
EXECUTION OF DOCUMENTS

Section 7.1 Contracts and Instruments.

7.1.1 The Governing Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Authority, and this authority may be general or confined to specific instances; and, unless so authorized or ratified by the Governing Board, no officer, agent or employee shall have any power or authority to bind the Authority by any contract or engagement or to render it liable for any purpose or for any amount.

7.1.2 The Secretary shall have the authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of the Authority and to certify the incumbency of those signatories.

7.1.3 Each and every contract, indenture, mortgage, loan or credit document, lease, or other instrument or obligation of the Authority shall contain a statement to the effect that the Authority is a separate legal entity from the County, that the County, and its officials, employees and agents, are not responsible for the obligations of the Authority, and that (except if the county is a direct party to the particular document or instrument) the parties to the particular document or instrument do not intend to, or have the power to, confer on any person or entity any rights or remedies against the County or any officials, employees or agents of the County.

Section 7.2 Checks, Drafts, Evidences of Indebtedness. All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of the Authority or payable to the order of the Authority, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by resolution of the Governing Board.

ARTICLE VIII
CHIEF EXECUTIVE OFFICER

Section 8.1 Appointment and Tenure. The Governing Board shall select and appoint a Chief Executive Officer who shall be its direct executive representative in the management of the affairs and activities of the Authority. The Chief Executive Officer shall serve at the pleasure of the Governing Board, subject to the provisions of any contract of employment between the

Deleted: ADVISORY AND STANDING COMMITTEES¶

Deleted: Section 6.1 . Provider Advisory Council.¶
¶
. . 6.1.1 . The Governing Board shall establish one or more Provider Advisory Council, composed of participating providers, to provide expertise to the Authority relative to their respective specialties. Each Provider Advisory Council shall have a sufficient number of members to provide the necessary expertise and to work effectively as a group. The Governing Board shall determine the number and composition of each Council with the assistance of recommendations made by the Chief Executive Officer. Provider Advisory Council members shall serve for a maximum of three two-year terms.¶
¶
. . 6.1.2 . Each Provider Advisory Council shall have a chairperson and a vice chairperson appointed by the Governing Body. The Chief Executive Officer shall designate a staff person to serve as secretary and to be responsible for notifying members of the dates and times of meetings and preparing a record of the Council's meetings.¶
¶
. . 6.1.3 . Each Provider Advisory Council shall meet on a regular basis, and shall make recommendations and reports to the Governing Board. Meetings of the Provider Advisory Council shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 *et seq.*).¶

Deleted: Section 6.2 . Consumer Affairs Committee.¶
¶
. . 6.2.1 . The Governing Board shall establish a standing Committee of the Board to be called the Consumer Affairs Committee, which shall be responsible for participating in establishing public policy of the health care service plan ("the Plan") established by the Authority. Public policy includes, but is not necessarily limited to, policies to assure the comfort, dignity, and convenience of the members, as described in the Knox-Keene Act, Section 1369 of the Health and Safety Code. The Consumer Affairs Committee shall constitute the "Community Advisory Committee," referenced in Section A-18-334 of the Ordinance. The Consumer Affairs Committee shall have a sufficient number of members to provide community involvement and an appropriate representation of the interests of enrolled Plan members. The Governing Board shall determine the number and composition of the Committee with the assistance of recommendations made by the Chief Executive Officer. Committee members shall serve for a maximum of three two-year terms, unless the committee member who is appointed to represent plan members is no longer qualified for Plan enrollment or otherwise loses eligibility for Plan membership.¶
¶
. . 6.2.2 . The Consumer Affairs Committee shall have a chairperson and a vice-chairperson appointed by the Governing Board. The Chief Executive Officer shall designate an employee of the Authority to serve as secretary and to be responsible for notifying members of the dates and times of meetings and preparing a record of the Committee's meetings. ¶
¶
. . 6.2.3 . The Consumer Affairs Committee shall meet not less than two times per year, and shall make recommendations and reports to the Governing Board. Meetings of the Consumer Affairs Commi ...

Deleted: Section 6.8 . Additional Advisory Committees. The Governing Board may, as it deems necessary, establish advisory committees. A resolution of the Governing Board establishing any additional advisory committee shall specify the number and qualifications of members, scope of matters on which such group or committee will provide review and recommendations, parameters for the conduct of proceedings, and conditions and procedures for dissolution for the advisory committee.¶

Deleted: May 15

Deleted: 4

Authority and the Chief Executive Officer. The Governing Board shall at least annually evaluate the performance of the Chief Executive Officer.

Section 8.2 Duties.

8.2.1 The Chief Executive Officer shall have the necessary authority and responsibility to conduct the Authority's activities, subject to the oversight and authority of the Governing Board and the Chairperson. The Chief Executive Officer shall be responsible to carry out the formal and informal policies, procedures and practices of the Authority.

8.2.2 The Chief Executive Officer shall act as the duly authorized representative of the Authority in all matters in which the Authority has not formally designated some other person to act.

8.2.3 The Chief Executive Officer shall designate a Chief Financial Officer and a Chief Medical Officer of the Authority both of whom shall be employees of the Authority. The Chief Executive Officer may also appoint and engage individuals to fill such other executive, administrative and management positions for the Authority as the Governing Board shall authorize by resolution. All personnel shall serve at the pleasure of the Chief Executive Officer, subject to any contract of employment between the Authority and any such employee and the personnel policies adopted by the Governing Board.

ARTICLE IX
CONFLICT OF INTEREST POLICY

Section 9.1 Adoption. The Governing Board shall by resolution adopt and from time to time may amend a Conflict of Interest Code for the Authority as required by applicable law.

Section 9.2 Board Member Statements. Each Board Member shall file statements disclosing reportable investments, business positions, interests in real property and income in accordance with the Political Reform Act of 1974 (Government Code 81000 *et seq.*) and the regulations of the Fair Political Practices Authority.

Section 9.3 Prohibition On Board Members With Financial Interest. Except as may be permitted by Section 9.4, a Board Member shall not make, participate in making, or in any way attempt to influence a Governing Board decision in which the Board Member knows, or has reason to know, that he or she has a financial interest as defined by California law or as set forth in the Authority's Conflict of Interest Code.

Section 9.4 Conflict of Interest Exemption. In accordance with Welfare & Institutions Code § 14087,38(h), a Board Member shall not be deemed to be interested in a contract entered into by the Authority within the meaning of Government Code 1090, *et. seq.* if all of the following apply:

Deleted: adopt by resolution a program (including timing and method) for evaluating the Chief Executive Officer.

Formatted: Highlight

Formatted: Highlight

Deleted: Director

Deleted: May 15

Deleted: 4

(a) The Board of Supervisors appointed the Board Member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.

(b) The contract authorizes the Board Member or the organization the Board Member represents to provide services to beneficiaries under the Authority's programs.

(c) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Board Member was appointed to represent.

(d) The Board Member does not influence or attempt to influence the Governing Board or another Board Member to enter into the contract in which the Board Member is interested.

(e) The Board Member discloses the interest to the Governing Board and abstains from voting on the contract.

(f) The Governing Board notes the Board Member's disclosures and abstention in its official records and authorizes the contract in good faith by a vote of the Governing Board sufficient for the purpose without counting the vote of the interested Board Member.

ARTICLE X
PROCEDURES, PRACTICES AND POLICIES RELATING TO IMPLEMENTATION OF THE TWO-PLAN MODEL

Section 10.1 Compliance With Two-Plan Model. The Authority shall, in connection with the conduct of its business and the discharge of its responsibilities, comply fully with the concepts and philosophy of the Medi-Cal Two-Plan Model for Managed Care ("Two-Plan Model"), as issued by the State Department of Health Care Services ("DHCS"). In conducting its business and discharging its responsibilities, the Authority shall meet the particulars set forth in this Article X.

Section 10.2 Contract Negotiation and Renegotiation. The Authority shall, in negotiating and renegotiating contracts, give preference to providers (sometimes referred to herein as "preferred providers"): (1) based on (a) the number of Section 10.2.1 categories a provider is within, and (b) the number of and extent to which the factors set forth in each Section 10.2.1 category apply to the provider; (2) in the manner prescribed in Section 10.2.2; and (3) in accordance with the standards set forth in Section 10.3.

10.2.1 The following are the preference categories that shall be applicable for the Authority in negotiating and renegotiating contracts:

(a) Disproportionate Share Hospitals. The Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program. For purposes of the Section 10.2.1(a), "regularly and repeatedly"

Deleted: May 15

Deleted: 4

means that, at any particular time, the hospital has been recognized as a disproportionate share hospital under the Medi-Cal program for no less than three (3) of the most recent four (4) years. Among hospitals that have regular and repeatedly qualified for disproportionate share status, the Authority shall giver greater preference to those hospitals that historically have had the highest levels of disproportionality, as measured on both a relative and absolute basis, over the most recent four (4) years.

(b) Safety Net Providers. The Authority shall give preference to FQHCs and any other providers that DHCS has defined as safety net providers in the general policies relating to the Two-Plan Model.

(c) Traditional Medi-Cal Providers. The Authority may give preference to community-based clinics and private providers with a history of serving a substantial proportion of Medi-Cal patients.

(d) Medically Indigent, Uninsured, and Underinsured Care Providers. The Authority shall give substantial preference to providers that have regularly and repeatedly provided the highest levels of ratios of care to the medically indigent, uninsured, and underinsured.

10.2.2 The following prescribes the manner in which the Authority shall give preference to providers in negotiating and renegotiating contracts:

(a) Generally. Preference shall be given in a fashion to preserve the health care safety net in the County, including public health services, as envisioned by the Two-Plan Model and in accordance with the standards set forth in Section 10.3.

(b) Disproportionate Share Hospitals. The Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program in a fashion to ensure that these hospitals have sufficient Medi-Cal patient participation so that: (1) all available federal funding is retained for the geographic area of the county; and (2) among these hospitals, the hospitals that historically have had the highest levels of disproportionality receive federal funding commensurate with their higher levels of disproportionality. The most recent four (4) years shall be the "historical" period for purposes of this provision.

(c) All Preferred Providers. Subject to provider capacity and patients' medical interests, the Authority may take one or more of the following measures, as necessary or appropriate to meet the requirements of the Section 10.2.2: (1) assign patients to preferred providers, especially to those providers entitled to substantial preference under Section 10.2.1(a) and 10.2.1(d); (2) give preferential pricing terms to preferred providers; (3) give rights of first refusal on negotiating and renegotiating contracts to preferred providers; and (4) furnish preferred providers with such special or additional administrative or clinical support services as may be necessary or appropriate to assist such providers in transitioning to a managed care environment.

Deleted: For purposes of this Section 10.2.1(c), "substantial proportion" means that in each of two (2) of the most recent four (4) years, a community-based clinic or private provider has received at least $25,000 in payments per year from serving Medi-Cal patients.

Deleted: and

Deleted: and

Deleted: May 15

Deleted: 4

(d) Impact of Preferences. As among preferred providers, it is expected that higher levels of funding may be given by the Authority to those entitled to substantial preference, as compared to other preferred providers. The Authority shall fulfill its obligations under this Section 10.2 notwithstanding any detriment or adverse impact to non-preferred providers that may be caused by the fulfillment of such obligations, and notwithstanding that certain special or additional administrative clinical support services may be unavailable to non-preferred providers.

Section 10.3 Establishment and Maintenance of Provider Network. The Authority shall meet the standards set forth in this Section 10.3 in establishing and maintaining the provider network and in implementing the preferences described in Section 10.2.

10.3.1 The Authority shall foster and maintain the clinical relationships between Medi-Cal, medically indigent, uninsured, and underinsured patients and their health care providers.

10.3.2 The Authority shall, in establishing and maintaining the provider network, recognize and accommodate the cultural and linguistic diversity of Medi-Cal, medically indigent,uninsured, and underinsured patients.

10.3.3 The Authority shall, in establishing and maintaining the provider network, recognize, accommodate and support those special programs and activities of providers that have been regularly and repeatedly successful in addressing the medical and social needs of Medi-Cal, medically indigent, uninsured, and underinsured patients.

ARTICLE XI
MISCELLANEOUS, PROCEDURES, PRACTICES AND POLICIES, INSURANCE, BONDS

Section 11.1 Purchasing, Hiring, Personnel, Etc. The Governing Board shall by resolution adopt and, from time to time may amend, policies necessary and appropriate for the proper conduct of the Authority's activities and affairs and in the furtherance of the Authority's authorized purposes. Copies of all such policies shall be maintained with the minutes of proceedings of the Governing Board.

Section 11.2 Enforcement. Subject to the ultimate authority of the Governing Board, the Chief Executive Officer shall be responsible to implement all procedures, practices and policies adopted by the Governing Board.

Section 11.3 Insurance. The Chief Executive Officer shall procure, at the Governing Board's direction, such liability, property, casualty, workers' compensation, and such other insurance (including, without limitation, directors' and officers' liability, professional liability, and health plan re-insurance) in such amounts and with such carriers as the Governing Board shall from time to time determine is prudent in the conduct of its activities; provided, the Governing Board may in its discretion provide self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

Deleted: and

Deleted: and

Deleted: and

Deleted: , procedures, practices and

Deleted: for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property and improvements, hiring employees, managing its personnel and for all other matters, in the determination of the Governing Board, as are necessary and appropriate for the proper conduct of the Authority's activities and affairs and

Deleted: its

Deleted: procedures, practices and

Deleted: May 15

Deleted: 4

Section 11.4 Bonds. The Authority shall require all of the Board Members, as well as the Authority's officers, employees and agents, to be covered by fidelity bonds to the extent required by law, and otherwise to the extent the Governing Board determines prudent in the conduct of its activities. The cost of such bonds shall be paid for by the Authority.

Section 11.5 Defense and Indemnification. So long as such individual was acting within the scope of his or her employment or official capacity, the Authority shall defend and hold harmless its current and former members, officers, employees, and other agents to the full extent set forth by the California Tort Claims Act (Gov. Code 810 *et seq.*) and Section 14087.38(j).

Section 11.6 Immunities. The Authority, all Board Members, and all officers, employees, and agents of the Authority shall, to the full extent set forth by law, be protected by the Immunities applicable to public entities and individuals as provided by the California Tort Claims Act (Gov. Code 810 *et seq.* and Section 14087.38(j)).

Section 11.7 Reports to County Board of Supervisors. The Governing Board shall prepare and deliver to the County Board of Supervisors an annual written report describing the activities of the Authority during the preceding year, and outlining, in general terms, the anticipated nature of the Authority's activities for the forthcoming year.

ARTICLE XII
AMENDMENT OF BYLAWS

The Bylaws may be amended or repealed. Proposed changes to amend or repeal the Bylaws may be forwarded in writing by any Governing Board member to the Chairperson of the Bylaws Committee. The Bylaws Committee by a majority vote must approve proposed changes in advance of submitting proposed Bylaws changes to the governing Board. If approved by the Bylaws committees, the proposed Bylaws changes shall be placed on the agenda and provided to the Governing Board members at least 3 (three) days prior to the Board meeting at which the proposed Bylaw changes shall be considered. The Governing board shall adopt the proposed changes by the voting approval of at least a majority of members of the Governing Board. The Bylaws Committee shall also nominate Officers of the Authority to the Governing Board for consideration.

Attachments—

- Executive/Finance Committee Charter
- Compliance Committee Charter
- Quality Improvement Committee Charter
- Consumer Advisory Committee Charter
- Provider Advisory Council Committee Charter

Deleted: 7

Deleted: seven

Formatted: Left

Formatted: Left, Indent: Left: 0.75"

Formatted: Highlight

Deleted: May 15

Deleted: 4

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

That I am the duly elected and acting Secretary of the Santa Clara County Health Authority, a local public agency; and

The foregoing Bylaws, comprising 22 pages, including this page, constitute the Bylaws of the Authority, as duly adopted by the Authority at a regular meeting, duly called and held on January 18, 1996, at San Jose, California, and subsequently amended on January 20, 2000, May 23, 2002, January 23, 2003, November 18, 2004,September 22, 2005, April 21, 2011, May 15, 2014, and _____, 2017.

Deleted: and

Formatted: Highlight

Formatted: Highlight

_____

Elizabeth G. Pianca
Secretary of the Authority

Deleted: May 15

Deleted: 4

BYLAWS OF
SANTA CLARA COUNTY HEALTH AUTHORITY
(Adopted as amended May 15, 2014)

ARTICLE I
AUTHORITY, PURPOSES, STATUS AND POWERS

Section 1.1 Authority. These Bylaws are adopted by the Santa Clara County Health Authority ("Authority") to establish rules for its proceedings, as authorized by Welfare and Institutions Code 14087.38 ("Section 14087.38") and Ordinance No.300.576 ("Ordinance"), as amended from time to time. The Authority is a public agency created by the Board of Supervisors of Santa Clara County ("County") pursuant to authority conferred by Section 14087.38.

Section 1.2 Purposes. The purposes of the Authority are to meet the problems of delivery of publicly assisted medical care in the County, to demonstrate ways of promoting quality care and cost efficiency, and to further such other purposes as are contemplated by Section 14087.38 and described in the Ordinance.

Section 1.3 Status. The Authority is an entity separate from the County. Obligations, acts, omissions or liabilities of the Authority shall be obligations, acts omissions or liabilities solely of the Authority, and shall not, directly or indirectly, be obligations, acts, omissions or liabilities of the County or any officials, employees or agents of the County.

Section 1.4 Powers. The Authority shall have the power to negotiate and enter into contracts with the Department of Health Care Services and to arrange for the provision of health care services for Medi-Cal beneficiaries as authorized by Section 14087.38. To the extent authorized by Section 14087.38, the Authority may also enter into contracts to arrange for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured, indigent, or underinsured individuals. The Authority shall have all rights, powers, duties, privileges and immunities expressed, either directly or implicitly, in Section 14087.38. Chapter 1 of Division A6 of the Ordinance Code of the County, containing general rules and procedural requirements applicable to boards and commissions of the county, as they may apply now.

ARTICLE II
GOVERNING BOARD

Section 2.1 Governance. Responsibility for governing and managing the affairs of the Authority shall be vested in a governing board ("Governing Board").

Section 2.2 Number. The Governing Board shall consist of thirteen (13) members ("Board Members"), each of whom shall have a fiduciary duty to act in the best interest of the Authority.

Section 2.3 Qualifications. Board Members shall be chosen for their willingness and ability to effectively contribute to and support the objectives of the Authority, shall have a commitment to a health care system that seeks to improve access to quality health care for persons served by the Authority and shall have a commitment to maintaining and preserving a health care safety net for the medically indigent, uninsured, and underinsured populations of the County. Board Members shall either reside, be employed, or provide services in the county, and shall be generally representative of the diverse backgrounds, interests and demography of persons residing in the County. When nominating members to the Governing Board candidates possessing the following backgrounds should be considered: expertise in business, finance, managed care, hospital administration, information technology, medicine, health care policy, or law.

Section 2.4 Nominations. Nominations shall be made as follows: Board members shall be nominated by the County Board of Supervisors.

Section 2.5 Appointment. Appointments shall be made upon a majority vote by the County Board of Supervisors.

Section 2.6 Term. The terms for all Board Members shall be two years. No Board Member may serve more than four (4) consecutive terms without a break in service from the Board of at least one year.

Section 2.7 Resignation. Any Board Member may resign at any time by giving written notice of such resignation to the Chairperson of the Governing Board. Such resignation shall take effect at the time specified in the notice; provided, however, that if the resignation is not to be effective immediately upon receipt of the notice by the Chairperson, the Governing Board must affirmatively vote to accept the effective date specified, and if the Governing Board does not approve such later date, the resignation shall be effective immediately.

Section 2.8 Removal. A Board Member may be removed from the Governing Board by either of the following methods:

2.8.1 The Governing Board, by an affirmative vote of no less than six Governing Board Members, may remove a Board member. The reasons for removal may include:

2.8.1.1 The Board Member fails to meet the qualifications as a Board Member;

2.8.1.2 The Board Member fails to attend three (3) consecutive regular meetings of the Governing Board;

2.8.1.3 The Board Member fails during any twelve (12) month period to attend a minimum of 50% of (a) the regular and special meetings of the Governing Board, or (b) the meetings of the committees of which the Board Member is a member;

2.8.1.4 The Board Member fails to discharge legal obligations as a member of a public agency;

2.8.1.5 The Board Member is convicted of a crime involving corruption or any felony; or the Board Member is barred, suspended or excluded from participation in federal programs or has been barred from serving as a Board Member pursuant to the Knox-Keene Act;

2.8.1.6 A request for removal has been submitted by the Board of Supervisors.

2.8.1.7 Other good cause, as reasonably determined by the Governing Board.

2.8.2 A Board Member shall be given reasonable notice and an opportunity to respond before the Governing Board prior to any vote by the Governing Board regarding potential removal of that Board Member.

Section 2.9 Vacancies. Any vacancy in the Board, however created, shall be filled by the County Board of Supervisors.

ARTICLE III
OFFICERS

Section 3.1 Designation. The Officers of the Authority shall be:

3.1.1 A Chairperson, who shall be a Board Member, and who shall preside at all meetings of the Governing Board.

3.1.2 A Vice-Chairperson who shall be a Board Member, and who in the Chairperson's absence, or inability to act, shall preside at the meetings of the Governing Board.

If both the Chairperson and the Vice-Chairperson are absent or unable to act, the Board Members present shall by action of the Board Members select one of the Board Members present to act as chairperson pro tempore, who, while so acting, shall have all of the authority of the Chairperson.

3.1.3 A Treasurer, shall be a Board Member or such other person as appointed by the Governing Board, including but not limited to the Chief Financial Officer, who is employed by the Authority, and who shall have custody of and disburse the Authority's funds. The Treasurer shall have the authority to delegate the signatory function of the Treasurer to such persons as authorized by the Governing Board.

3.1.4 A Secretary, who shall be a Board Member or other person appointed by the Governing Board, including a person employed by the Authority, and who shall be responsible for preparing and keeping the minutes of the Governing Board; shall attest to the

signature of the Chairperson, Vice-Chairperson, Treasurer, Chief Executive Officer or other authorized signatory on documents executed on behalf of the Authority; shall give, or cause to be given, notice of all meetings of the Governing Board and committees of the Authority as required by law; shall keep the seal of the Authority, if one be adopted, in safe custody; and shall have such other duties as may be prescribed by resolution of the Governing Board or these Bylaws.

Section 3.2 Election. The Governing Board shall elect officers for a two-year term. Officers may be elected for consecutive two-year terms.

Section 3.3 Resignation. Any officer may resign effective on giving written notice to the Secretary or the Chairperson, unless the notice specifies a later time for his or her resignation to become effective. Upon receipt of such notice by the Secretary or the Chairperson, as applicable, the Secretary shall notify (or, if applicable, the Chairperson shall direct the Secretary to notify and the Secretary shall then notify) all the other officers of the Authority and shall enter the notice in the proceedings of the Governing Board. The acceptance of a resignation shall not be necessary to make it effective.

Section 3.4 Vacancies. A vacancy in any of the officer positions for any cause shall be filled by a special election of the Governing Board at the next regular or special meeting of the Governing Board.

ARTICLE IV
MEETINGS

Section 4.1 Regular And Special Meetings. The date, time and place of regular meetings of the Governing Board shall be established by resolution of the Governing Board. The Governing Board shall hold regular meetings during at least each of four (4) months of each calendar year, at least one of which may include a strategic planning session. Special meetings may be held upon the call and the discretion of the Chairperson. However, upon the request of any three (3) or more Board Members, the Chairperson shall call a special meeting. Special meetings shall be subject to the rules otherwise set forth in these Bylaws.

Section 4.2 Open And Public. Meeting shall be open and public and all persons shall be permitted to attend, except for closed sessions, all as required and permitted by applicable law, including the Ralph M. Brown Act (Gov. Code 54950 *et. seq.*) and Section 14087.38.

Section 4.3 Notice.

4.3.1 Notice of every regular meeting, and any special meeting which is called at least one (1) week prior to the date set for the meeting, shall be given to each member of the Governing Board and to any person who has filed a written request for notice with the Authority. Any such mailed notice shall be mailed at least one (1) week prior to the date set for the meeting to which it applies, except that the Governing Board may give the notice as it deems practical of special meetings called less than seven (7) days prior to the date set for the meeting. Any request for notice filed pursuant to this section shall be valid for one (1) year from the date on which it is

filed unless a renewal request is filed. All requests for notice shall be filed with the Secretary of the Authority. Renewal requests for notice shall be filed within ninety (90) days after January 1 of each year.

4.3.2 Written notice of each special meeting shall be delivered personally, electronically, or by mail to each Board Member and, to each local newspaper of general circulation, radio and television station, requesting such written notice in writing. Such notice shall be received at least twenty-four (24) hours before the time of such meeting as specified in the notice. The notice shall specify the time and place of the special meeting and the agenda for the meeting. No other business shall be considered at such meeting. Notice shall be required pursuant to this section regardless of whether any action is taken at the special meeting. In cases of emergency, notice of special meetings may be dispensed with only to the extent permitted by applicable law.

Section 4.4 Waiver Of Notice. Written notice may be dispensed with as to any Board Member who, at or prior to the time the meeting convenes, files with the Secretary a written waiver of notice. Such waiver may be given by any means that allows for a permanent record and may be authorized by law. Such written notice also may be dispensed with as to any Board Member who is actually present at the meeting at the time it convenes.

Section 4.5 Attendance And Participation. Board Members must attend the regular meetings of the Governing Board and of committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of the Authority.

Section 4.6 Quorum. A quorum is a majority of the Board Members (i.e. seven members). A quorum must be present to initiate and conduct the transaction of business at any regular or special meeting of the Governing Board.

Section 4.7 Meeting Agendas. For all meetings that are open and public pursuant to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), the provisions of Sections 4.7.1 through 4.7.3 shall apply.

4.7.1 The Chief Executive Officer of the Authority shall prepare an agenda for every meeting of the Governing Board setting forth a brief general description of each item of business to be transacted or discussed at the meeting and the time and location of the meeting. Each agenda for a regular meeting shall provide an opportunity for members of the public to address the Governing Board directly on items of interest to the public that are within the subject matter jurisdiction of the Authority. At least seventy-two (72) hours before a regular meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted at the main entrance of the Authority's executive offices and online on the Health Authority's website, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public.

4.7.2 No action shall be taken at a regular meeting on any item not appearing on the posted agenda; provided, however, that the Board Members may take action on items of business not appearing on the posted agenda under the following conditions:

4.7.2.1 The Governing Board determines by a majority vote of the Board Members present that an emergency situation exists under Government Code 54956.5; or

4.7.2.2 The Governing Board determines by a two-thirds vote of the Governing Board, or, if less than two-thirds of the Board Member are present, by a unanimous vote of those Board Members present, that the need to take the action arose subsequent to the posting of the agenda; or

4.7.2.3 The item was included in the posted agenda for a meeting of the Governing Board occurring not more than five (5) calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

4.7.3 At least twenty-four (24) hours before a special meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted with the call and notice of the meeting at the main entrance of the Authority executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public. No business not set forth in the posted agenda shall be considered by the Governing Board at such special meeting.

Section 4.8 Conduct Of Business. The items on the agenda shall be considered in order unless the Chairperson shall announce a change in the order of consideration. Unless an agenda item identifies a particular source for a report, the Chief Executive Officer, the Board Members, the Authority staff and consultants shall report first on the item, after which the item shall then be open to public comment upon recognition of the speaker by the Chairperson. The proceedings of the Governing Board shall be guided by the provisions of the law applicable thereto and, except as herein otherwise provided, by Robert's Rules of Order, newly revised. Provided, further, that the failure to follow Robert's Rules of Order shall not invalidate any action taken.

Section 4.9 Resolutions and Motions. All official acts of the Authority shall be taken either by resolution or a motion, duly made, seconded and adopted by vote of the Board Members.

Section 4.10 Voting. Except as otherwise provided by these Bylaws, when a quorum is present all official acts of the Governing Board shall require the affirmative vote of a majority of the Board Members present and eligible to vote.

Section 4.11 Disqualification From Voting. A Board Member shall be disqualified from voting on any motion or resolution relating to a transaction in which he or she has a financial interest, as required by law or by the Conflicts of Interest Policy of the Authority, as described in Article IX. Except as required by law or by the Conflict of Interest Policy of the Authority, no Board Member shall be disqualified from serving as a Board Member or taking part in any proceedings of the Governing Board because of any financial interest of a Board Member.

Section 4.12 Minutes. The Secretary shall cause to have prepared the minutes of each meeting of the Governing Board. The minutes shall be an accurate summary of the Governing Board. The minutes shall be an accurate summary of the Governing Board's consideration of each item on the agenda and an accurate record of each action of the Governing Board. At a subsequent meeting, the Secretary shall submit the minutes to the Governing Board for approval by a majority vote of Board Members in attendance at the meeting covered by the minutes. When approved, the minutes shall be signed by the Secretary and kept with the proceedings of the Governing Board.

Section 4.13 Closed Sessions. The Governing Board shall meet in closed session only as permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and Section 14087.38. The Governing Board shall post an agenda and report the actions taken at a closed session to the public to the extent required by applicable law. A closed session minute book may be established and maintained for minutes of closed sessions, which shall reflect only the topics of discussion and decisions made at the session. The closed session minute book shall be kept confidential, shall not be a public record, and shall be available to the Board Members, the Chief Executive Officer, and the Governing Board's legal counsel, except as otherwise required by applicable law.

Section 4.14 Public Records. All documents and records of the Authority, not exempt from disclosure under applicable law, shall be public records under the California Public Records Act (Government Code 6250 *et seq.*). The Governing Board and the Chief Executive Officer shall take appropriate steps to maintain the confidentiality of all documents and records of the Governing Board for which exemptions from disclosure are available under applicable statutes.

Section 4.15 Adjournment. The Governing Board may adjourn any meeting to a time and place specified in the resolution of adjournment, notwithstanding less than a quorum may be present and voting. If no member of the Governing Board is present at a regular or adjourned meeting, the Chief Executive Officer or his or her designee may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in Section 4.3 of the Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

ARTICLE V
COMMITTEES OF THE GOVERNING BOARD

Section 5.1 Bylaws Committee. The Governing Board shall appoint a three (3) member Bylaws Committee, all of whom shall be Board Members. Proposed amendments to these Bylaws shall not be effective unless approved by a majority vote of the Bylaws Committee, and by the affirmative vote of no less than a majority of Board Members, as set forth in Article XII.

Section 5.2 Executive/Finance Committee. The Governing Board shall appoint a five (5) member Executive/Finance Committee. One Alternate may be appointed by the Governing Board. The Alternate shall be entitled to vote as an Executive/Finance Committee member when

an Executive/Finance Committee member is absent from the Executive/Finance Committee meeting.

5.2.1 The Executive/Finance Committee shall consist of its Chair and Vice Chair, plus three (3) other Board members. The Alternate shall be a Board member. At least one of the members of the Executive Committee shall have financial expertise. The Chief Executive Officer and Chief Financial Officer of the Health Authority shall serve as ex officio members of the Executive/Finance Committee, without vote.

5.2.2 In the event of a financial, operational, legal, personnel or public relations emergency, which the Chief Executive Officer or the Executive/Finance Committee reasonably determines requires handling before the next scheduled meeting of the Governing Board or before a special meeting of the Governing Board can be called, the Executive/Finance Committee shall have all of the powers and authority of the Board of Directors to act in the intervals between meetings of the Board of Directors.

5.2.3 Notwithstanding the above, the Executive/Finance Committee shall not have authority to: amend or repeal the Bylaws or adopt new Bylaws; fill vacancies on the Governing Board; or fix compensation of Directors. By majority vote of the Governing Board, the Board may at any time revoke or modify the authority delegated to the Executive/Finance Committee.

5.2.4 Any action taken by the Executive/Finance Committee must be reported to the Governing Board at the next meeting.

5.2.5 The Executive/Finance Committee shall also serve as the Audit Committee of the Governing Board. The Governing Board must approve the budget. Any major change in the budget must be approved by the Governing Board or the Executive/Finance Committee. Annual and periodic financial reports shall be submitted to the Governing Board.

5.2.6 The Executive/Finance Committee Charter, as amended from time to time, is attached hereto and incorporated herein.

Section 5.3 Quality Improvement Committee. The Governing Board shall establish a Quality Improvement Committee to oversee the Authority's Quality Improvement Program. The charter of the Quality Improvement Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.4 Compliance Committee. The Governing Board shall establish the Compliance Committee to assist the Governing Board in its oversight of the implementation and effectiveness of the Authority's Compliance Program. The charter of the Compliance Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.5 Provider Advisory Council. The Governing Board shall establish a Provider Advisory Council, composed of participating providers, to provide expertise to the Authority relative to their respective specialties. The Provider Advisory Council shall have a sufficient

number of members to provide the necessary expertise and to work effectively as a group. The charter of the Provider Advisory Council, as amended from time to time, is attached hereto and incorporated herein.

Section 5.6 Consumer Advisory Committee. The Governing Board shall establish a Consumer Advisory Committee, which shall provide input and feedback on the services provided by the Authority. The Consumer Advisory Committee shall constitute the "Community Advisory Committee," referenced in Section A-18-334 of the Ordinance. The charter of the Consumer Advisory Committee, as amended from time to time, is attached hereto and incorporated herein.

Section 5.7 Additional Committees. The Governing Board may, from time to time, adopt charters creating such additional committees and subcommittees of the Governing Board as it deems necessary to carry out its purposes. The charter shall specify the number and qualifications of members, scope of matters on which such committee or subcommittee will provide review and recommendations, and parameters for the conduct of proceedings. No committee or subcommittee may be composed of a number of Board Members constituting a quorum of voting Board Members.

Section 5.8 Authority. All such other committees and subcommittees shall be advisory only, unless otherwise specified by the Governing Board.

Section 5.9 Meetings. Regular meetings of the committees and subcommittees shall be held at such times and places as are determined by the chairperson of the committee or subcommittee. Special meetings may be held at any time and place as may be designated by the Chairperson, the chairperson of the committee or subcommittee, the Chief Executive Officer or a majority of the members of the committee or subcommittee.

Section 5.10 Open and Public. Meetings of committees and subcommittees shall be open and public, except such meetings that may be held in closed session to the extent permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and Section 14087.38.

Section 5.11 Notice and Agenda Posting. To the extent that meetings of committees and subcommittees are subject to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), notice and agenda posting regarding such regular and special meetings shall be carried in the same manner as that applicable to regular and special meetings of the Governing Board as set forth in Article IV of these Bylaws.

Section 5.12 Minutes. The Secretary or his or her designee shall prepare minutes of each meeting of every committee and subcommittee. The minutes shall be an accurate summary of the committee's or subcommittee's consideration of the matters before it and an accurate record of each action of the committee or subcommittee. At a subsequent meeting, the Secretary or designee shall submit the minutes to the committee or subcommittee for approval by a majority vote of members in attendance at the meeting covered by the minutes. When approved, copies of

minutes shall be forwarded by the Secretary or designee to the Board Members and to the Chief Executive Officer.

ARTICLE VI
[RESERVED]

ARTICLE VII
EXECUTION OF DOCUMENTS

Section 7.1 Contracts and Instruments.

7.1.1 The Governing Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Authority, and this authority may be general or confined to specific instances; and, unless so authorized or ratified by the Governing Board, no officer, agent or employee shall have any power or authority to bind the Authority by any contract or engagement or to render it liable for any purpose or for any amount.

7.1.2 The Secretary shall have the authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of the Authority and to certify the incumbency of those signatories.

7.1.3 Each and every contract, indenture, mortgage, loan or credit document, lease, or other instrument or obligation of the Authority shall contain a statement to the effect that the Authority is a separate legal entity from the County, that the County, and its officials, employees and agents, are not responsible for the obligations of the Authority, and that (except if the county is a direct party to the particular document or instrument) the parties to the particular document or instrument do not intend to, or have the power to, confer on any person or entity any rights or remedies against the County or any officials, employees or agents of the County.

Section 7.2 Checks, Drafts, Evidences of Indebtedness. All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of the Authority or payable to the order of the Authority, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by resolution of the Governing Board.

ARTICLE VIII
CHIEF EXECUTIVE OFFICER

Section 8.1 Appointment and Tenure. The Governing Board shall select and appoint a Chief Executive Officer who shall be its direct executive representative in the management of the affairs and activities of the Authority. The Chief Executive Officer shall serve at the pleasure of the Governing Board, subject to the provisions of any contract of employment between the Authority and the Chief Executive Officer. The Governing Board shall at least annually evaluate the performance of the Chief Executive Officer.

Section 8.2 Duties.

8.2.1 The Chief Executive Officer shall have the necessary authority and responsibility to conduct the Authority's activities, subject to the oversight and authority of the Governing Board and the Chairperson. The Chief Executive Officer shall be responsible to carry out the formal and informal policies, procedures and practices of the Authority.

8.2.2 The Chief Executive Officer shall act as the duly authorized representative of the Authority in all matters in which the Authority has not formally designated some other person to act.

8.2.3 The Chief Executive Officer shall designate a Chief Financial Officer and a Chief Medical Officer of the Authority both of whom shall be employees of the Authority. The Chief Executive Officer may also appoint and engage individuals to fill such other executive, administrative and management positions for the Authority as the Governing Board shall authorize by resolution. All personnel shall serve at the pleasure of the Chief Executive Officer, subject to any contract of employment between the Authority and any such employee and the personnel policies adopted by the Governing Board.

ARTICLE IX
CONFLICT OF INTEREST POLICY

Section 9.1 Adoption. The Governing Board shall by resolution adopt and from time to time may amend a Conflict of Interest Code for the Authority as required by applicable law.

Section 9.2 Board Member Statements. Each Board Member shall file statements disclosing reportable investments, business positions, interests in real property and income in accordance with the Political Reform Act of 1974 (Government Code 81000 *et seq.*) and the regulations of the Fair Political Practices Authority.

Section 9.3 Prohibition On Board Members With Financial Interest. Except as may be permitted by Section 9.4, a Board Member shall not make, participate in making, or in any way attempt to influence a Governing Board decision in which the Board Member knows, or has reason to know, that he or she has a financial interest as defined by California law or as set forth in the Authority's Conflict of Interest Code.

Section 9.4 Conflict of Interest Exemption. In accordance with Welfare & Institutions Code § 14087,38(h), a Board Member shall not be deemed to be interested in a contract entered into by the Authority within the meaning of Government Code 1090, *et. seq.* if all of the following apply:

(a) The Board of Supervisors appointed the Board Member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.

(b) The contract authorizes the Board Member or the organization the Board Member represents to provide services to beneficiaries under the Authority's programs.

(c) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Board Member was appointed to represent.

(d) The Board Member does not influence or attempt to influence the Governing Board or another Board Member to enter into the contract in which the Board Member is interested.

(e) The Board Member discloses the interest to the Governing Board and abstains from voting on the contract.

(f) The Governing Board notes the Board Member's disclosures and abstention in its official records and authorizes the contract in good faith by a vote of the Governing Board sufficient for the purpose without counting the vote of the interested Board Member.

ARTICLE X
PROCEDURES, PRACTICES AND POLICIES RELATING TO IMPLEMENTATION OF THE TWO-PLAN MODEL

Section 10.1 Compliance With Two-Plan Model. The Authority shall, in connection with the conduct of its business and the discharge of its responsibilities, comply fully with the concepts and philosophy of the Medi-Cal Two-Plan Model for Managed Care ("Two-Plan Model"), as issued by the State Department of Health Care Services ("DHCS"). In conducting its business and discharging its responsibilities, the Authority shall meet the particulars set forth in this Article X.

Section 10.2 Contract Negotiation and Renegotiation. The Authority shall, in negotiating and renegotiating contracts, give preference to providers (sometimes referred to herein as "preferred providers"): (1) based on (a) the number of Section 10.2.1 categories a provider is within, and (b) the number of and extent to which the factors set forth in each Section 10.2.1 category apply to the provider; (2) in the manner prescribed in Section 10.2.2; and (3) in accordance with the standards set forth in Section 10.3.

10.2.1 The following are the preference categories that shall be applicable for the Authority in negotiating and renegotiating contracts:

(a) Disproportionate Share Hospitals. The Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program. For purposes of the Section 10.2.1(a), "regularly and repeatedly" means that, at any particular time, the hospital has been recognized as a disproportionate share hospital under the Medi-Cal program for no less than three (3) of the most recent four (4) years. Among hospitals that have regular and repeatedly qualified for disproportionate share status, the Authority shall giver greater preference to those hospitals that historically have had the highest

levels of disproportionality, as measured on both a relative and absolute basis, over the most recent four (4) years.

(b) Safety Net Providers. The Authority shall give preference to FQHCs and any other providers that DHCS has defined as safety net providers in the general policies relating to the Two-Plan Model.

(c) Traditional Medi-Cal Providers. The Authority may give preference to community-based clinics and private providers with a history of serving a substantial proportion of Medi-Cal patients.

(d) Medically Indigent, Uninsured, and Underinsured Care Providers. The Authority shall give substantial preference to providers that have regularly and repeatedly provided the highest levels of ratios of care to the medically indigent, uninsured, and underinsured.

10.2.2 The following prescribes the manner in which the Authority shall give preference to providers in negotiating and renegotiating contracts:

(a) Generally. Preference shall be given in a fashion to preserve the health care safety net in the County, including public health services, as envisioned by the Two-Plan Model and in accordance with the standards set forth in Section 10.3.

(b) Disproportionate Share Hospitals. The Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program in a fashion to ensure that these hospitals have sufficient Medi-Cal patient participation so that: (1) all available federal funding is retained for the geographic area of the county; and (2) among these hospitals, the hospitals that historically have had the highest levels of disproportionality receive federal funding commensurate with their higher levels of disproportionality. The most recent four (4) years shall be the "historical" period for purposes of this provision.

(c) All Preferred Providers. Subject to provider capacity and patients' medical interests, the Authority may take one or more of the following measures, as necessary or appropriate to meet the requirements of the Section 10.2.2: (1) assign patients to preferred providers, especially to those providers entitled to substantial preference under Section 10.2.1(a) and 10.2.1(d); (2) give preferential pricing terms to preferred providers; (3) give rights of first refusal on negotiating and renegotiating contracts to preferred providers; and (4) furnish preferred providers with such special or additional administrative or clinical support services as may be necessary or appropriate to assist such providers in transitioning to a managed care environment.

(d) Impact of Preferences. As among preferred providers, it is expected that higher levels of funding may be given by the Authority to those entitled to substantial preference, as compared to other preferred providers. The Authority shall fulfill its obligations under this Section 10.2 notwithstanding any detriment or adverse impact to non-preferred providers that

may be caused by the fulfillment of such obligations, and notwithstanding that certain special or additional administrative clinical support services may be unavailable to non-preferred providers.

Section 10.3 Establishment and Maintenance of Provider Network. The Authority shall meet the standards set forth in this Section 10.3 in establishing and maintaining the provider network and in implementing the preferences described in Section 10.2.

10.3.1 The Authority shall foster and maintain the clinical relationships between Medi-Cal, medically indigent, uninsured, and underinsured patients and their health care providers.

10.3.2 The Authority shall, in establishing and maintaining the provider network, recognize and accommodate the cultural and linguistic diversity of Medi-Cal, medically indigent,uninsured, and underinsured patients.

10.3.3 The Authority shall, in establishing and maintaining the provider network, recognize, accommodate and support those special programs and activities of providers that have been regularly and repeatedly successful in addressing the medical and social needs of Medi-Cal, medically indigent, uninsured, and underinsured patients.

ARTICLE XI
MISCELLANEOUS, PROCEDURES, PRACTICES AND POLICIES, INSURANCE, BONDS

Section 11.1 Purchasing, Hiring, Personnel, Etc. The Governing Board shall by resolution adopt and, from time to time may amend policies necessary and appropriate for the proper conduct of the Authority's activities and affairs and in the furtherance of the Authority's authorized purposes. Copies of all such policies shall be maintained with the minutes of proceedings of the Governing Board.

Section 11.2 Enforcement. Subject to the ultimate authority of the Governing Board, the Chief Executive Officer shall be responsible to implement all procedures, practices and policies adopted by the Governing Board.

Section 11.3 Insurance. The Chief Executive Officer shall procure, at the Governing Board's direction, such liability, property, casualty, workers' compensation, and such other insurance (including, without limitation, directors' and officers' liability, professional liability, and health plan re-insurance) in such amounts and with such carriers as the Governing Board shall from time to time determine is prudent in the conduct of its activities; provided, the Governing Board may in its discretion provide self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

Section 11.4 Bonds. The Authority shall require all of the Board Members, as well as the Authority's officers, employees and agents, to be covered by fidelity bonds to the extent required by law, and otherwise to the extent the Governing Board determines prudent in the conduct of its activities. The cost of such bonds shall be paid for by the Authority.

Section 11.5 Defense and Indemnification. So long as such individual was acting within the scope of his or her employment or official capacity, the Authority shall defend and hold harmless its current and former members, officers, employees, and other agents to the full extent set forth by the California Tort Claims Act (Gov. Code 810 *et seq.*) and Section 14087.38(j).

Section 11.6 Immunities. The Authority, all Board Members, and all officers, employees, and agents of the Authority shall, to the full extent set forth by law, be protected by the Immunities applicable to public entities and individuals as provided by the California Tort Claims Act (Gov. Code 810 *et seq.* and Section 14087.38(j)).

Section 11.7 Reports to County Board of Supervisors. The Governing Board shall prepare and deliver to the County Board of Supervisors an annual written report describing the activities of the Authority during the preceding year, and outlining, in general terms, the anticipated nature of the Authority's activities for the forthcoming year.

ARTICLE XII
AMENDMENT OF BYLAWS

The Bylaws may be amended or repealed. Proposed changes to amend or repeal the Bylaws may be forwarded in writing by any Governing Board member to the Chairperson of the Bylaws Committee. The Bylaws Committee by a majority vote must approve proposed changes in advance of submitting proposed Bylaws changes to the governing Board. If approved by the Bylaws committees, the proposed Bylaws changes shall be placed on the agenda and provided to the Governing Board members at least 3 (three) days prior to the Board meeting at which the proposed Bylaw changes shall be considered. The Governing board shall adopt the proposed changes by the voting approval of at least a majority of members of the Governing Board. The Bylaws Committee shall also nominate Officers of the Authority to the Governing Board for consideration.

Attachments—

Executive/Finance Committee Charter
Compliance Committee Charter
Quality Improvement Committee Charter
Consumer Advisory Committee Charter
Provider Advisory Council Committee Charter

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

That I am the duly elected and acting Secretary of the Santa Clara County Health Authority, a local public agency; and

The foregoing Bylaws, comprising 22 pages, including this page, constitute the Bylaws of the Authority, as duly adopted by the Authority at a regular meeting, duly called and held on January 18, 1996, at San Jose, California, and subsequently amended on January 20, 2000, May 23, 2002, January 23, 2003, November 18, 2004,September 22, 2005, April 21, 2011, May 15, 2014, and _____, 2017.

_____

Elizabeth G. Pianca
Secretary of the Authority

Santa Clara
Family Health Plan

Santa Clara County Health Authority

Consumer Advisory Committee Charter

Purpose

The Consumer Advisory Committee (CAC) shall assist Santa Clara Family Health Plan (SCFHP) in establishing and maintaining culturally and linguistically appropriate linkages to the community. The CAC shall serve as one of the essential methodologies for the health plan to gather cultural and linquistic information from stakeholders and the community. The CAC shall assist in promoting SCFHP's mission through education, advocacy, collaboration and feedback.

Members

The CAC membership and representation shall be reflective of the Medi-Cal population in Santa Clara County. It may include consumers, community advocates, and traditional and safety-net providers. SCFHP shall make a good faith effort to include representatives from hard-to-reach populations, e.g., members with physical disabilities, seniors and persons with chronic conditions (such as asthma, diabetes, congestive heart failure). SCFHP shall modify the CAC membership as the beneficiary population changes. The CAC shall have a sufficient number of members to provide community involvement and an appropriate representation of interests of enrolled plan members. The SCFHP Chief Executive Officer (CEO) shall determine the number and composition of the Committee. CAC members shall serve two-year terms which may be renewed at the discretion of the CEO. The CAC shall have a chairperson who is a member of the Governing Board and who is appointed by the Governing Board.

Meetings

The CAC shall generally meet quarterly but not less than two times per year. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Committee members shall attend each meeting in person. The Director of Marketing, Communications and Outreach is responsible for notifying members of dates and times of meetings, and for preparing a record of the Committee's meetings. Committee recommendations and reports shall be regularly and timely reported to the Governing Board.

The Committee may invite other individuals to attend meetings in order to provide pertinent information relating to an agenda item.

Meetings of the CAC shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 *et seq.*)

Responsibilities

CAC members shall provide input and feedback to SCFHP staff and Governing Board to improve services and to support SCFHP in achieving its mission. In order to fulfill the responsibilities of the Committee, CAC members shall become informed and remain current on the mission, services, policies and programs of SCFHP. SCFHP shall regularly update CAC members on key changes to SCFHP operations or mission.

Areas for input and feedback from the Committee include but are not limited to:

- Culturally appropriate service or program design
- Priorities for health education and outreach programs
- Educational and operational issues affecting groups who speak a language other than English
- Member satisfaction survey results
- Findings of health education and cultural and linguistic group needs assessments
- Plan marketing and outreach materials and campaigns
- Communication of needs for provider network development and assessment
- Community resources and information important to SCFHP members

Santa Clara
Family Health Plan

Santa Clara County Health Authority

EXECUTIVE/FINANCE COMMITTEE CHARTER

Purpose

The Executive/Finance Committee shall have and may exercise the authority delegated to it by the Governing Board for any and all matters except amendments to the Bylaws, filling vacancies on the Governing Board, or establishing compensation of Governing Board members. The members of the Executive/Finance Committee shall also serve as the Audit Committee of the Governing Board, and shall ensure performance of all requisite functions of that Committee. Any Governing Board member elected to the Executive/Finance Committee may require that a decision of the Committee be referred to a regular or special meeting of the Board for final resolution. The Committee shall provide minutes of its actions to the Board for review, and all actions of the Committee shall be reported at the next regularly scheduled Board meeting.

In the event of a financial, operational, legal, personnel, or public relations emergency, which the Chief Executive Officer or the Executive/Finance Committee reasonably determines requires handling before the next scheduled meeting of the Governing Board or before a special meeting of the Board can be called, the Executive/Finance Committee shall have all of the powers and authority of the Governing Board to act in the intervals between meetings of the Board.

Members

Pursuant to the Bylaws, the Governing Board shall appoint a five (5) member Executive/Finance Committee from among the Governing Board members of the Authority. At least one of the members of the Committee shall have financial expertise. One Alternate may be appointed by the Governing Board. The Alternate shall be entitled to vote as an Executive/Finance Committee member when a Committee member is absent from the Executive/Finance Committee meeting.

The Committee shall consist of a Chair, appointed by the Governing Board, plus four (4) other Board members. The Alternate shall be a Board member.

The Chief Executive Officer and Chief Financial Officer of the Health Authority shall serve as ex officio members of the Executive/Finance Committee, without vote.

Meetings

Regular meetings of the Executive/Finance Committee shall be scheduled in those months the Board is not scheduled to convene a regular meeting. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chair, the Chief Executive Officer, or a majority of the members of the Committee.

Committee members may attend each meeting in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the voting members of the Committee shall constitute a quorum for the transaction of business.

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

Meetings of the Committee shall be open and public, except such meetings or portions thereof that may be held in closed session to the extent permitted by applicable law including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*) and Section 14087.38.

Minutes of all meetings of the Committee shall be recorded.

Responsibilities

The following functions shall be the common recurring activities of the Executive/Finance Committee. These functions should serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

Executive Responsibilities

- Serve in an advisory capacity for management on emerging issues, problems, and initiatives.
- Exercise decision-making authority between Governing Board meetings as needed, with actions to be ratified by the full Board at its next meeting.
- Oversee organizational dashboard metrics.
- Review potential provider and vendor agreements that fall outside the parameters of contracting policy.

Financial Responsibilities

- Review and approve finance, accounting, and investment policies.
- Ratify investment activity on an annual basis.
- Review the proposed annual operating budget and variations from the budget.
- Review and accept monthly financial statements.

- Oversee the financial strength of capitated and delegated entities.

Audit Responsibilities

- Oversee selection, appointment, and compensation of the audit firm for the external audit.
- Meet with the external auditors annually, or more often as needed, and review the results of the audit.
- Review with management the results of any regulatory financial audits.
- Oversee related party agreements.

Santa Clara
Family Health Plan

Santa Clara County Health Authority

QUALITY IMPROVEMENT COMMITTEE CHARTER

Purpose

The Quality Improvement Committee (QIC) shall oversee Santa Clara Family Health Plan's Quality Improvement Program, which is an organization-wide commitment to utilize 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 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.

Members

Pursuant to the Bylaws, the Governing Board shall establish a QIC to provide expertise to the Health Plan relative to their professional experience. The QIC shall have a sufficient number of members to provide the necessary expertise and to work effectively as a group. The QIC shall include contracted providers from a range of specialties as well as other representatives from the community, including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All QIC members, including the Chairperson, shall be appointed by the Health Plan's Chief Executive Officer (CEO). All QIC members, including the Chairperson, can serve up to three two-year terms. Additional terms may be appointed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

QIC members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the Committee.

Meetings

Regular meetings of the QIC shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chairperson, the CEO, or a majority of the members of the Committee.

Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.

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

Meetings of the QIC shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 et seq.)

The Director of Quality Improvement is responsible for notifying members of the dates and times of meetings and preparing a record of the Committee's meetings.

Responsibilities

The goals and objectives below shall serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The QIC also oversees the Utilization Management Committee, Credentialing and Peer Review Committee, and Pharmacy and Therapeutics Committee. The Committee is responsible for the review and approval of health services, credentialing, pharmacy, and quality policies. The QIC shall also carry out any other responsibilities delegated to it by the Board from time to time.

Quality improvement Program goals and objectives are to monitor, evaluate and improve:

- 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 plan population
- The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risks, and disease profiles for both acute and chronic illnesses, and preventive care
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population

- The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Compliance with regulatory agencies and accreditation standards
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Design, measure, assess, and improve the quality of the organization's governance, management, and support processes
- Monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
- Provide oversight of quality monitors from the contracted facilities to continuous assess that the care and service provided satisfactorily meet quality goals

Santa Clara
Family Health Plan

Santa Clara County Health Authority

Compliance Committee Charter

Purpose

The primary purpose of the Compliance Committee (Committee) is to assist the Santa Clara Family Health Plan (SCFHP) Governing Board in its oversight of the implementation and effectiveness of SCFHP's Compliance Program. The Committee is accountable to provide support and guidance necessary to the Compliance Officer in overseeing the outcomes and performance of activities initiated under the Compliance Program to ensure compliance with state and federal regulators. The Committee shall provide minutes of its actions to the Board for review, and all actions of the Committee shall be reported at the next regularly scheduled Board meeting.

Members

The Compliance Committee shall be comprised of the Executive Team including the Compliance Officer and a Governing Board member, as appointed by the full Board, who is free from any relationship that in the opinion of the Board would interfere with the exercise of his or her independent judgment as a member of the Committee.

Meetings

Regular meetings of the Compliance Committee shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate.

Committee members may attend each meeting in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the members of the Committee shall constitute a quorum for the transaction of business.

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

Meetings of the Committee shall be open and public, except such meetings or portions thereof that may be held in closed session to the extent permitted by applicable law including, but not limited to, the Ralph M. Brown Act (Gov. Code § 54950 et seq.) and Section 14087.28.

Minutes of all meetings of the Committee shall be recorded.

Responsibilities

The following functions shall be the common recurring activities of the Compliance Committee. These functions should serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

- Review and approve the following documents, including but not limited to:
    - Compliance Program
    - Compliance risk assessment;
    - Compliance monitoring and auditing work plan
- Oversee the development, implementation, annual review, and approval of appropriate Standards of Conduct, business ethics, and compliance program policies and procedures.
- Oversee the development and implementation of operational policies to ensure satisfactory relationships with SCFHP's principal regulatory authorities.
- Oversee employee training on the Standards of Conduct, business ethics, SCFHP's Compliance Program and compliance policies, and training on the detection, correction and prevention of fraud, waste, and abuse (FWA) in government programs.
- Ensure that the full Governing Board meets all compliance and FWA training requirements annually.
- Oversee SCFHP's annual Conflict of Interest reporting process.
- Reviewing effectiveness of the system of internal controls, such as dashboards, designed to reveal compliance issues and compliance with key regulatory requirements.
- Ensure that SCFHP maintains clear channels of communication, through which employees and FDRs may seek advice on application of the Plan's Compliance Program.
- Ensure that SCFHP maintains a hotline through which employees, FDRs and members may report potential compliance violations confidentially or anonymously (if desired) without fear of retaliation.
- Oversee and receive periodic reports regarding investigations of compliance violations and potential FWA reported to the SCFHP Compliance Officer.
- Ensure that appropriate internal and external monitoring and auditing (e.g., including first, tier, downstream and related entities (FDRs)) are conducted to verify adherence to SCFHP's Compliance Program guidelines and procedures.

- Monitor audits/examinations/corrective action plans conducted and issued by governmental or other regulatory agencies.
- The Compliance Committee will monitor the overall effectiveness of the Compliance Program. Some indicators of an effective compliance program are:
    - Use of monitoring to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, warning letters, CMS sanctions, training completion/pass rates, etc.;
    - Implementation of new or updated Medicare requirements (e.g., tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation;
    - Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, beneficiaries through customer service calls, or the Complaint Tracking Module (CTM), Parts A, B and D issues, etc.;
    - Timely response to reported noncompliance and potential FWA, and effective resolution (i.e., non-recurring issues);
    - Consistent, timely and appropriate disciplinary action; and
    - Detection of noncompliance and FWA issues through monitoring and auditing.

Santa Clara
Family Health Plan

Santa Clara County Health Authority

Provider Advisory Council Charter

Purpose

Pursuant to the Bylaws, the Governing Board shall establish a Provider Advisory Council whose members can provide expertise to the Santa Clara Family Health Plan (SCFHP) relative to their respective specialties. The Provider Advisory Council shall act as an advisory committee to assist SCFHP in creating and maintaining a system of care in accordance with the six C's of care -- Community, Collaboration, Coordination, Communication, Caring, and Compassion.

The Council's mission is to discuss regional or national issues regarding the relationships and interactions between provider, their patients and SCFHP. These issues include improving health care and clinical quality, improving communications, relations, and cooperation between providers and SCFHP, and clinical or regulatory matters that affect interactions between providers and SCFHP.

Members

The Provider Advisory Council shall have a sufficient number of members to provide necessary expertise and work effectively as a group. The Provider Advisory Council shall include contracted providers from a range of specialties as well as other representatives from the community including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All Provider Advisory Council (PAC) members, including the Chairperson, shall be appointed by the SCFHP's Chief Executive Officer.

All PAC members, including the Chair, serve two-year terms which may be renewed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

Provider Advisory Council members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the Committee.

Meetings

Regular meetings of the Provider Advisory Council shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chair, the Chief Executive Officer, or a majority of the members of the Committee.

Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.

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

Meetings of the Provider Advisory Council shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 et seq.)

The Director of Provider Network Management is responsible for notifying members of the dates and times of meetings and preparing a record of the Council's meetings.

Responsibilities

The following responsibilities shall serve as a guide, with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

- Address clinical and administrative topics that affect interactions between physicians/providers and SCFHP.
- Discuss regional, state, and national issues related to enhancing patient care.
- Provide input on health care services of SCFHP.
- Provide input on the coordination of services between networks of SCFHP.
- Improve communications, relations, and cooperation between physicians/providers and SCFHP.
- Provide expertise to SCFHP relative to a Committee member's area of practice.

Santa Clara
Family Health Plan

Santa Clara County Health Authority

Consumer Advisory Committee Charter

Purpose

The Consumer Advisory Committee (CAC) shall assist Santa Clara Family Health Plan (SCFHP) in establishing and maintaining culturally and linguistically appropriate linkages to the community. The CAC shall serve as one of the essential methodologies for the health plan to gather cultural and linquistic information from stakeholders and the community. The CAC shall assist in promoting SCFHP's mission through education, advocacy, collaboration and feedback.

Members

The CAC membership and representation shall be reflective of the Medi-Cal population in Santa Clara County. It may include consumers, community advocates, and traditional and safety-net providers. SCFHP shall make a good faith effort to include representatives from hard-to-reach populations, e.g., members with physical disabilities, seniors and persons with chronic conditions (such as asthma, diabetes, congestive heart failure). SCFHP shall modify the CAC membership as the beneficiary population changes. The CAC shall have a sufficient number of members to provide community involvement and an appropriate representation of interests of enrolled plan members. The SCFHP Chief Executive Officer (CEO) shall determine the number and composition of the Committee. CAC members shall serve two-year terms which may be renewed at the discretion of the CEO. The CAC shall have a chairperson who is a member of the Governing Board and who is appointed by the Governing Board.

Meetings

The CAC shall generally meet quarterly but not less than two times per year. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Committee members shall attend each meeting in person. The Director of Marketing, Communications and Outreach is responsible for notifying members of dates and times of meetings, and for preparing a record of the Committee's meetings. Committee recommendations and reports shall be regularly and timely reported to the Governing Board.

The Committee may invite other individuals to attend meetings in order to provide pertinent information relating to an agenda item.

Meetings of the CAC shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 *et seq.*)

Responsibilities

CAC members shall provide input and feedback to SCFHP staff and Governing Board to improve services and to support SCFHP in achieving its mission. In order to fulfill the responsibilities of the Committee, CAC members shall become informed and remain current on the mission, services, policies and programs of SCFHP. SCFHP shall regularly update CAC members on key changes to SCFHP operations or mission.

Areas for input and feedback from the Committee include but are not limited to:

- Culturally appropriate service or program design
- Priorities for health education and outreach programs
- Educational and operational issues affecting groups who speak a language other than English
- Member satisfaction survey results
- Findings of health education and cultural and linguistic group needs assessments
- Plan marketing and outreach materials and campaigns
- Communication of needs for provider network development and assessment
- Community resources and information important to SCFHP members

OFFICE OF THE COUNTY COUNSEL
COUNTY OF SANTA CLARA

County Government Center
70 West Hedding Street
East Wing, 9th Floor
San Jose, California 95110-1770

(408) 299-5900
(408) 292-7240 (FAX)

James R. Williams
COUNTY COUNSEL

Greta S. Hansen
CHIEF ASSISTANT COUNTY COUNSEL

Winifred Botha
Danny Y. Chou
Robert M. Coelho
Steve Mitra
ASSISTANT COUNTY COUNSEL

June 15, 2017

Chairperson Robert Brownstein
Santa Clara County Health Authority Governing Board
Santa Clara Family Health Plan
210 E. Hacienda Avenue
Campbell, CA 95008-6617

Re: Notice of Resignation

Dear Chairperson Brownstein:

In accordance with Section 3.3 of the Bylaws of the Santa Clara County Health Authority, please accept this letter as my resignation as Secretary of the Governing Board for the Health Authority. Thank you.

Very truly yours,

JAMES R. WILLIAMS
County Counsel

Elizabeth G. Pianca
Lead Deputy County Counsel

Copy: Christine Tomcala, Chief Executive Officer
James R. Williams, County Counsel

20th Anniversary Celebration Update

SCFHP received a commendation from the Santa Clara County Board of Supervisors on June 5, recognizing SCFHP's 20 years of dedication and commitment to ensuring residents have accessible, quality health care.

Santa Clara
Family Health Plan

Community Benefit - Partnership with Veggielution

- Create outdoor classroom space
  - To host educational and community outreach programs benefitting SCFHP members and the community
  - Includes shade structure, circular benches, outdoor chalkboard, and shed for supplies
- Ribbon cutting event
  - Moving from August 17 to the Fall to accommodate construction permitting process
  - Save the Date will be sent when the date is confirmed

Robert's Rules For Dummies®

Cheat Sheet

Deciding Which Motion to Use

When you're in the thick of debate on a main motion in your meeting, you'll be glad to have this chart handy. It's designed to help you choose the right motion for the right reason. Flip to Part II in the book, which explains each motion listed here. (The subsidiary and privileged motions are listed in descending order of precedence; that is, motions lower on the list can't be made if anything higher is pending.)

			Can Interrupt	Requires Second	Debatable	Amendable	Vote Required	Can Reconsider
SECONDARY MOTIONS	PRIVILEGED	Fix the Time to Which to Adjourn		S		A	M	R
		Adjourn		S			M	
		Recess		S		A	M	
		Raise a Question of Privilege	I				Chair decides	
		Call for Orders of the Day	I				Chair decides	
	SUBSIDIARY	Lay on the Table		S			M	Negative Only*
		Previous Question		S			2/3	R*
		Limit or Extend Limits of Debate		S		A	2/3	R*
		Postpone Definitely		S	D	A	M	R*
		Commit (or Refer)		S	D	A	M	R*
		Amend		S	D*	A*	M	R
		Postpone Indefinitely		S	D		M	Affirmative Only
Main Motion				S	D	A	M	R

* See text for exceptions

M = Majority vote

Copyright © 2005 Wiley Publishing, Inc.
All rights reserved. Item 7574-0.
For more information about Wiley Publishing, call 1-800-762-2974.

Wiley, the Wiley Publishing logo, For Dummies, the Dummies Man logo, the For Dummies Bestselling Book Series logo and all related trade dress are trademarks or registered trademarks of John Wiley & Sons, Inc. and/or its affiliates. All other trademarks are property of their respective owners.

Robert's Rules For Dummies®

Cheat Sheet

Making and Handling Motions

When that light bulb goes off in your head and you have a great idea, you make a motion to get your idea discussed and a decision made. Here are the eight steps required from start to finish to make a motion and get the group to decide whether they agree. Each step is a required part of the process. I cover this process in detail in Chapter 6.

Step	What to say
1. The member rises and addresses the chair.	"Madam Chairman. . . ."
2. The chair recognizes the member.	"The chair recognizes Ms. Gliggenschlapp."
3. The member makes a motion.	"I move to purchase a copy of *Robert's Rules For Dummies* for our president."
4. Another member seconds the motion.	"Second."
5. The chair states the motion.	"It is moved and seconded to purchase a copy of *Robert's Rules For Dummies* for your president. Are you ready for the question?"
6. The members debate the motion.	"The chair recognizes Ms. Gliggenschlapp to speak to her motion. . . ."
7. The chair puts the question and the members vote.	"All those in favor of adopting the motion to buy a copy of *Robert's Rules For Dummies* for your president will say 'aye,' [pause] those opposed will say 'no'."
8. The chair announces the result of the vote.	"The ayes have it and the motion carries, and a copy of *Robert's Rules For Dummies* will be purchased for your president."

Standard Order of Business

An easy way to remember Robert's Rules' *standard order of business* is with the mnemonic 3R-SUN — you can see it clearly in the list below. This list is a quick reference to make it easy for you to set up a basic agenda for your meeting quickly and without much fuss. For the full treatment on order of business and agendas, turn to Chapter 5.

1. **R**eading and Approval of the Minutes
2. **R**eports of Officers, Boards, and Standing Committees
3. **R**eports of Special (Select or Ad Hoc) Committees
4. **S**pecial Orders
5. **U**nfinished Business and General Orders
6. **N**ew Business

ROBERTS RULES CHEAT SHEET

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Adjourn	"I move that we adjourn"	No	Yes	No	No	Majority
Recess	"I move that we recess until…"	No	Yes	No	Yes	Majority
Complain about noise, room temp., etc.	"Point of privilege"	Yes	No	No	No	Chair Decides
Suspend further consideration of something	"I move that we table it"	No	Yes	No	No	Majority
End debate	"I move the previous question"	No	Yes	No	No	2/3
Postpone consideration of something	"I move we postpone this matter until…"	No	Yes	Yes	Yes	Majority
Amend a motion	"I move that this motion be amended by…"	No	Yes	Yes	Yes	Majority
Introduce business (a primary motion)	"I move that…"	No	Yes	Yes	Yes	Majority

The above listed motions and points are listed in established order of precedence. When any one of them is pending, you may not introduce another that is listed below, but you may introduce another that is listed above it.

To:	You say:	Interrupt Speaker	Second Needed	Debatable	Amendable	Vote Needed
Object to procedure or personal affront	"Point of order"	Yes	No	No	No	Chair decides
Request information	"Point of information"	Yes	No	No	No	None
Ask for vote by actual count to verify voice vote	"I call for a division of the house"	Must be done before new motion	No	No	No	None unless someone objects
Object to considering some undiplomatic or improper matter	"I object to consideration of this question"	Yes	No	No	No	2/3
Take up matter previously tabled	"I move we take from the table…"	Yes	Yes	No	No	Majority
Reconsider something already disposed of	"I move we now (or later) reconsider our action relative to…"	Yes	Yes	Only if original motion was debatable	No	Majority
Consider something out of its scheduled order	"I move we suspend the rules and consider…"	No	Yes	No	No	2/3
Vote on a ruling by the Chair	"I appeal the Chair's decision"	Yes	Yes	Yes	No	Majority

The motions, points and proposals listed above have no established order of preference; any of them may be introduced at any time except when meeting is considering one of the top three matters listed from the first chart (Motion to Adjourn, Recess or Point of Privilege).

PROCEDURE FOR HANDLING A MAIN MOTION

NOTE: Nothing goes to discussion without a motion being on the floor.

Obtaining and assigning the floor

A member raises hand when no one else has the floor

- The chair recognizes the member by name

How the Motion is Brought Before the Assembly

- The member makes the motion: *I move that (or "to")* ... and resumes his seat.
- Another member seconds the motion: *I second the motion* or *I second it* or *second*.
- The chair states the motion: *It is moved and seconded that ... Are you ready for the question?*

Consideration of the Motion

1. Members can debate the motion.
2. Before speaking in debate, members obtain the floor.
3. The maker of the motion has first right to the floor if he claims it properly
4. Debate must be confined to the merits of the motion.
5. Debate can be closed only by order of the assembly (2/3 vote) or by the chair if no one seeks the floor for further debate.

The chair puts the motion to a vote

1. The chair asks: *Are you ready for the question?* If no one rises to claim the floor, the chair proceeds to take the vote.
2. The chair says: *The question is on the adoption of the motion that ... As many as are in favor, say 'Aye'.* (Pause for response.) *Those opposed, say 'Nay'*. (Pause for response.) *Those abstained please say 'Aye'.*

The chair announces the result of the vote.

1. *The ayes have it, the motion carries, and* ... (indicating the effect of the vote) or
2. *The nays have it and the motion fails*

WHEN DEBATING YOUR MOTIONS

1. Listen to the other side
2. Focus on issues, not personalities
3. Avoid questioning motives
4. Be polite

HOW TO ACCOMPLISH WHAT YOU WANT TO DO IN MEETINGS

MAIN MOTION

You want to propose a new idea or action for the group.

- After recognition, make a main motion.
- Member: "Madame Chairman, I move that _____."

AMENDING A MOTION

You want to change some of the wording that is being discussed.

- After recognition, "Madame Chairman, I move that the motion be amended by adding the following words _____."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words _____."
- After recognition, "Madame Chairman, I move that the motion be amended by striking out the following words, _____, and adding in their place the following words _____."

REFER TO A COMMITTEE

You feel that an idea or proposal being discussed needs more study and investigation.

- After recognition, "Madame Chairman, I move that the question be referred to a committee made up of members Smith, Jones and Brown."

POSTPONE DEFINITELY

You want the membership to have more time to consider the question under discussion and you want to postpone it to a definite time or day, and have it come up for further consideration.

- After recognition, "Madame Chairman, I move to postpone the question until _____."

PREVIOUS QUESTION

You think discussion has gone on for too long and you want to stop discussion and vote.

- After recognition, "Madam President, I move the previous question."

LIMIT DEBATE

You think discussion is getting long, but you want to give a reasonable length of time for consideration of the question.

- After recognition, "Madam President, I move to limit discussion to two minutes per speaker."

POSTPONE INDEFINITELY

You want to kill a motion that is being discussed.

- After recognition, "Madam Moderator, I move to postpone the question indefinitely."

POSTPONE INDEFINITELY

You are against a motion just proposed and want to learn who is for and who is against the motion.

- After recognition, "Madame President, I move to postpone the motion indefinitely."

RECESS

You want to take a break for a while.

- After recognition, "Madame Moderator, I move to recess for ten minutes."

ADJOURNMENT

You want the meeting to end.

- After recognition, "Madame Chairman, I move to adjourn."

PERMISSION TO WITHDRAW A MOTION

You have made a motion and after discussion, are sorry you made it.

- After recognition, "Madam President, I ask permission to withdraw my motion."

CALL FOR ORDERS OF THE DAY

At the beginning of the meeting, the agenda was adopted. The chairman is not following the order of the approved agenda.

- Without recognition, "Call for orders of the day."

SUSPENDING THE RULES

The agenda has been approved and as the meeting progressed, it became obvious that an item you are interested in will not come up before adjournment.

- After recognition, "Madam Chairman, I move to suspend the rules and move item 5 to position 2."

POINT OF PERSONAL PRIVILEGE

The noise outside the meeting has become so great that you are having trouble hearing.

- Without recognition, "Point of personal privilege."
- Chairman: "State your point."
- Member: "There is too much noise, I can't hear."

COMMITTEE OF THE WHOLE

You are going to propose a question that is likely to be controversial and you feel that some of the members will try to kill it by various maneuvers. Also you want to keep out visitors and the press.

- After recognition, "Madame Chairman, I move that we go into a committee of the whole."

POINT OF ORDER

It is obvious that the meeting is not following proper rules.

- Without recognition, "I rise to a point of order," or "Point of order."

POINT OF INFORMATION

You are wondering about some of the facts under discussion, such as the balance in the treasury when expenditures are being discussed.

- Without recognition, "Point of information."

POINT OF PARLIAMENTARY INQUIRY

You are confused about some of the parliamentary rules.

- Without recognition, "Point of parliamentary inquiry."

APPEAL FROM THE DECISION OF THE CHAIR

Without recognition, "I appeal from the decision of the chair."

Rule Classification and Requirements

Class of Rule	Requirements to Adopt	Requirements to Suspend
Charter	Adopted by majority vote or as proved by law or governing authority	Cannot be suspended
Bylaws	Adopted by membership	Cannot be suspended
Special Rules of Order	Previous notice & 2/3 vote, or a majority of entire membership	2/3 Vote
Standing Rules	Majority vote	Can be suspended for session by majority vote during a meeting
Modified Roberts Rules of Order	Adopted in bylaws	2/3 vote

Robert's Rules of Order Cheat Sheet

HOW TO INTRODUCE NEW BUSINESS – The Main Motion Process

1
- Member makes a **clearly worded motion to take action or a position.**
- "I move..."
- Motions recorded in minutes

2
- **Motion must be seconded.**
- "Second!"
- A second allows discussion to occur; it does not signify approval.
- A motion without a second does not move forward.

3
- **Chairman restates the motion**.
- "It is moved and seconded that..."
- Provides clarity

4
- **Discussion/debate occurs**.
- Maker of motion starts discussion.
- Ammendments may be offered - return to step 1 to ammend motion: "I move to amend the motion by..."

5
- Chair closes discussion and **states the question/asks for a vote**.
- "The question is on the adoption of the motion that…"
- Motion repeated word-for-word

6
- Chairman provides **voting directions**:
  - "Those in favor of the motion, say aye";
  - "Those opposed, say no"

7
- Chairman announces the **result of the vote**:
  - "The ayes have it, and the motion is adopted" or
  - "The noes have it, the motion is lost."
  - Recorded in minutes

Robert's Rules of Order Cheat Sheet

WHAT DO I SAY?

To Do This	Motion	You Say This	Debate Allowed?	Vote Required
Introduce Business	Main	"I move that…"	Yes	Majority
Second a Motion	Second	"Second!"	No	No
Change the Wording or add Clarity of a Motion	Amend	"I move to amend the motion by…" (adding words; striking out words; substitute words)	Yes	Majority
Send to Committee	Commit/ Refer	"I move the motion be referred to …"	Yes	Majority
Postpone Action until a Specific Time	Postpone	"I move the motion be postponed until…" (provide a specific time on the agenda or next meeting date)	Yes	Majority
Postpone Action until an Unspecified Time (a motion will be required to discuss in the future)	Lay on the Table	"I move to lay the motion on the table."	No	Majority
Limit Debate	Limit Debate	"I move that the debate on this motion be limited to (one) speech of (two) minutes for each member."	No	Two-thirds
End Debate or Request a Vote	Previous Question	"I move the previous question."	No	Two-thirds
Take Intermission	Recess	"I move to recess for (time)."	No	Majority
Close Meeting	Adjourn	"I move to adjourn."	No	Majority

Robert's Rules of Order Additional Information

Why follow Robert's Rules of Order?

- Allows for democratic speech and action
- Preservers order
- Rights of the organization supersede the rights of individuals
- Facilitates group decisions

Meeting Agendas

1. Approval of Minutes
2. Reports (from officers, committees, task forces)
3. Unfinished Business (replaces term "old business")
4. New Business – items brought forward by motion procedure

Meeting Minutes

- Minutes are a legal record of meetings and the organization.
- Minutes are a record of what is done at a meeting, not what is said.

Minutes should include:

1. Name, date and location of meeting
2. List of attendees (note presence of a quorum)
3. Time meeting was called to order
4. Conflict of Interest & Antitrust Avoidance Affirmation
5. Approval of previous meeting minutes
6. Motion text and name of maker
7. Status/results of motions
8. Time meeting was adjourned

Minutes do not include:

- Discussion
- Personal opinion
- Name of seconder of a motion is not necessary
- Motions withdrawn
- Entire reports (rather attach to minutes)

Motion

- A motion is a formal proposal by a member that the group take a certain action or position.
- A main motion is required to begin the decision making process.
- A motion occurs prior to discussion

Ground Rules for Debating

- Remarks must be germane (relevant and appropriate to the discussion); stay on subject.
- Debate issues, not personalities

Robert's Rules of Order Additional Information

Subsidiary Motions
Assist in treating or disposing of a main motion

- **Postpone Indefinitely** = a way to dispose of an embarrassing motion before it can be brought to vote
- **Amend** = a way to clarify or modify wording
    - Amendments should say exactly where in the main motion the change is to be made, and precisely what words to use.
    - Amendments must be germane
    - Follow the motion process for an amendment, then follow procedure to vote on the newly revised main motion.
    - Rather than amend an amendment; ask group to strike down the pending amendment vote then offer a different version.
- **Commit/Refer** = when additional time or information is needed, the item may be sent to a committee or task force (either an existing or newly created)
    - Before voting on a main motion, you may feel the main motion may require additional study and/or redrafting.
    - Motion to commit or refer should specifically state the committee and deadline
    - A special committee may be formed through the motion to commit (motion should include committee make-up and deadline)
    - Motion is debatable, but only about the matters of the referral and not on the main motion
- **Postpone to a Certain Time** = to move to a later time on the agenda or to the next meeting
    - A time is specified when motion will be addressed
    - Preferred over laying on the table
- **Limit or Extend Debate** = when circumstances call for shorter or longer speech
- **Previous Question** = to close debate and bring to an immediate vote
- **Lay on the Table** = lay motion aside temporarily without setting a time for its consideration
    - Taken up again, via motion process, when the majority decides
    - Often misused term for postpone to a certain time

Motions that Bring a Question Before the Assembly Again

1. **Take from the Table** = resume consideration of a main motion
2. **Rescind, Repeal or Annul** = cancel something that has been previously adopted
3. **Amend Something Previous Adopted** = proposal to modify wording or text previously adopted
4. **Discharge a Committee** = if a question has been referred or a task assigned to a committee that has not made a final report the committee may be discharged to allow the Board to take action or to drop the motion
5. **Reconsider** = within the same meeting a motion has been voted on the question may come before the assembly again as if it had not been voted on

Robert's Rules of Order Information for Chairs

Effective Presiding

1. Start On Time
2. Stick to the Agenda
3. Memorize Frequently Used Procedures
4. Make Sure All Know What is Being Debated and Voted On
    a. See that motions are worded clearly
    b. Repeat wording of motions frequently
    c. Make the effects of amendments clear
5. Learn How to Conduct Voting

Voting

Types of Votes

1. **Majority*** = More than half of the votes cast by persons entitled to vote, excluding blanks or abstentions. Whenever a majority vote of the Board of Directors is taken, it shall mean of the quorum present.
2. **Two-Thirds** = two-thirds of the votes cast by persons entitled to vote, excluding abstentions. Whenever a two-thirds vote of the Board is required, it shall mean of the entire Board whether voting or not.
3. **Majority of Entire Membership** = a majority of the total number of those who are members of the voting body at the time of the vote

*Note: A majority vote is different than a plurality vote, which is the largest number of votes (which may be less than a majority) when there are three or more alternatives. Under Robert's Rules of Order, a plurality vote is not sufficient. Re-vote to achieve a majority.

Voting Methods

1. Voice Vote
2. Standing Vote
3. Show of Hands Vote
4. Counted Vote
5. Ballot Vote

Putting the Motion to a Vote

When no one seeks the floor to debate, the chairman asks, "Is there any further debate?"

Voice Vote

The question is on the adoption of the motion that … (repeat the motion)
Those in favor of the motion, say aye
[pause]
Those opposed, say no
[pause]

The ayes have it and the motion is adopted
- or -
The noes have it and the motion is lost

Robert's Rules of Order Information for Chairs

Show of Hands Vote
The question is on the adoption of the motion that … (repeat the motion)
Those in favor of the motion will raise the right hand
[Pause]
Thos opposed with raise the right hand
[Pause]

Majority vote:
The affirmative has it and the motion is adopted
- or -
The negative has it and the motion is lost

Two-thirds vote:
There are two-thirds in the affirmative and the motion is adopted.
- or -
The are less than two-thirds in the affirmative and the motion is lost

Counted Show of Hands Vote
The question is on the adoption of the motion that … (repeat the motion)
Those in favor of the motion will raise the right hand and keep it raised until counted
[Pause]
Thos opposed with raise the right hand and keep it raised until counted
[Pause]
There are __ in the affirmative and ___ in the negative

Majority vote:
The affirmative has it and the motion is adopted
- or -
The negative has it and the motion is lost

Two-thirds vote:
There are two-thirds in the affirmative and the motion is adopted.
- or -
The are less than two-thirds in the affirmative and the motion is lost

Compliance Department Activity
May - June 2017

Reporting

- Regulatory Filings/Reports/Other: All Filed Timely
  - Routine DMHC Plan Filings: 7
  - Routine DHCS Reports: 12
  - Routine CMC Report: 8
  - Ad Hoc Reports/Requests: 7

Regulatory Communications

- DMHC
  - Timely Access
    - SCFHP completed its annual DMHC Timely Access submission. This included validation of the data by an outside validation vendor.

- DHCS
  - The Final Medicaid Managed Care Regulation (e.g. Medicaid Managed Care Final Rule):
    - The DHCS contract amendment is under review by CMS. It inserts Final Rule requirements into the Plan's contract.
    - DHCS has issued a number of All Plan Letters requiring plan operational changes:
      - Monthly Certification that all documents and data submitted by the Plan are accurate and complete
      - Changes in G&A process and notices
      - Updated reporting requirements related to Provider Preventable Conditions
      - Non-Emergency Medical and Non-Medical Transportation

- Member Complaints via Regulator
  - DMHC
    - Total of 5 Member complaints (all concerned coverage determinations).
    - 4 cases resolved (2 upheld, 2 overturned), 1 pending
- Medicare
  - Contract Management Team (CMT) Calls
    - The May focus discussion was on Care Coordination and vaccinations. The June focus discussion was on Hospice claims.
  - Medicare Data Validation (MDV) Audit
    - The annual Medicare data validation audit will be completed by the end of June 2017.
  - Application for 2018 MAPD-DSNP
    - SCFHP withdrew its 2018 MAPD-DSNP application as the governor has included funding for Cal MediConnect in the 2017-2018 State budget.
  - MMP Denial Letter Monitoring
    - SCFHP completed submission of its documentation for the MMP Denial letter monitoring. The Plan is awaiting its final results from CMS' review.

Monitoring/Auditing

- 2017 DHCS Audit
  A report has not been received for the DHCS 2017 annual medical audit that was conducted in April 2017.

- 2016 Joint DHCS/DMHC Audit
  DMHC responded to SCFHP's corrective actions submitted to address 18 identified deficiencies. 3 CAPS were accepted, 4 CAPS will be validated when DMHC returns in 14-16 months, and DMHC requested additional information for 11 CAPS.

- Misdirected Claims Process
  The Misdirected Claims workgroup continues to meet weekly. The Compliance rate for forwarding misdirected claims to the appropriate payer within 10 days of SCFHP's receipt of the claim is 98% for May and 99% for June.

- Provider Dispute Resolution (PDR) Process
  The PDR backlog is completed and closed. Current PDRs are compliant with turn-around times. The beneficiary impact report showed only one member had paid out of pocket and was subsequently reimbursed by the provider.

- HIPAA
  2 privacy incidents were reported to DHCS.

- Fraud, Waste, Abuse
  There have been no credible cases of fraud reported to DHCS or CMS (MEDIC).

Oversight

- Delegation Oversight

  There are currently 5 active CAPS open.

POLICY

Santa Clara
Family Health Plan

Policy Title:	Employee Recognition Gift Cards	**Policy No.:**	FA.13
Replaces Policy Title	N/A	**Replaces Policy No.**	N/A
Issuing Department:	Finance	**Policy Review Frequency:**	Annual
Lines of Business	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose:

The purpose of this policy is to describe the Chief Executive Officer's authority to issue gift card awards to employees in recognition of extraordinary effort and/or contributions to the Plan.

II. Policy:

It is the policy of Santa Clara Family Health Plan (SCFHP) that the Chief Executive Officer (CEO) may award gift cards to employees in recognition of extraordinary efforts, commitment to a key project or initiative, or other extraordinary contributions to Plan objectives.

An employee may be awarded one gift card per recognition event, in an amount not to exceed $100. The aggregate value of all gift card awards issued by the CEO within a single fiscal year may not exceed $10,000.

The CEO shall provide periodic reports to the Governing Board on the issuance of gift cards.

III. Responsibilities:

- The Finance Department is responsible for ensuring IRS laws are followed with respect to the issuance of gift cards and for maintaining custody and control of the gift cards prior to issuance.
- The Human Resource Department is responsible for coordinating the delivery of an employee award according to the terms of this policy.

IV. References:

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Dave Cameron	Signature Christine M. Tomcala
Name Chief Financial Officer	Name Chief Executive Officer
Title	Title
Date	Date

Policy Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
FA.13	Original	N/A	N/A	

Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Ten Months Ended April 2017
(Unaudited)

Table of Contents

Fiscal Year 2016-17 Year-To-Date Highlights

- **Net Surplus –** April $3.1 million surplus and YTD $21.0 million surplus ($10.8 million favorable to budget)
- **Enrollment –** April 2017 membership: 277,665 (0.1% favorable to budget) and April YTD: 2,793,381 member months (1.6% favorable to budget and 5.5% higher than April YTD last year)
  - Medi-Cal membership dropped slightly continuing the downward trend that started in November 2016. CMC membership reversed its recent slight increase trend. HK membership transition to Medi-Cal is slower than planned.
- **Revenue –** Favorable YTD budget by $56.1 million (+5.9%)
  - Increase was largely due to higher than budgeted member months YTD, which was partially offset by unfavorable variance in Medi-Cal Expansion, Hep C, and Medi-Cal CMC revenue. Medicare revenue was favorable due to higher risk scores of the plan members. Part D Medicare revenue was unfavorable to budget.
- **Medical Expenses –** Unfavorable YTD budget by $45.5 million (-5.0%)
  - Unfavorable variance was due to higher member months resulting in higher capitation costs as well as higher inpatient, LTC, and provider risk sharing/CCI and CMC recast reserve expenses. Prior year medical expense estimate reduction offset some of this unfavorable variance.
- **Administrative Expenses –** Unfavorable YTD budget by $4,466 (0.0%)
  - Lower payroll costs are offset by unfavorable consulting/temporary expense; rent is favorable due to deferred expansion plans; advertising and postage expenses are favorable due to timing, and contract services are favorable due to a non-recurring pharmacy administration expense goodwill credit.
- **Other Income/Expenses –** Net expense favorable to budget by $0.2 million due to favorable to budget interest earnings
- **Balance Sheet**
  - Cash position has increased significantly due to a reduction in prior period receivables as well as DHCS paying monthly capitation prospectively. Most receivables now relate to only IHSS and MCO. As a result, SCFHP will meet its MCO payment obligation and also plans to add excess funds to its county investment pool. DHCS expects to begin collection of MCE overpayments in July 2017.
  - TNE of $121.3 million or 332% of most recent Required TNE of $36.5 million per DMHC ($6.4 million below the SCFHP low-end Equity Target and $84.8 million above the low-end Liquidity Target).
  - YTD Capital Expenses increased by $6.4 million largely due to capitalization of Trizetto/QNXT claims system expenses versus annual capital budget of $10.9 million.

Consolidated Performance
April 2017 and Year to Date

	Month	YTD
Revenue	$102 million	$1008 million
Medical Costs	$96 million	$951 million
Medical Loss Ratio	93.6%	94.3%
Administrative Costs	$3.4 million (3.3%)	$35.4 million (3.5%)
Other Income/ Expense	($40,705)	($619,276)
Net Surplus (Loss)	$3,115,465	$21,040,700

Cash on Hand	$448 million
Net Cash Available to SCFHP	$207 million
Receivables	$0 million
Current Liabilities	$771 million
Tangible Net Equity	$121 million
Percent Of DMHC Requirement	**332%**

Santa Clara Family Health Plan
CFO Finance Report
For the Month and Year to Date Ended April 30, 2017

Summary of Financial Results

For the month of April 2017, SCFHP recorded a net surplus of $3.1 million compared to a budgeted net surplus of $1.0 million resulting in a favorable variance from budget of $2.1 million. For year to date April 2017, SCFHP recorded a net surplus of $21.0 million compared to a budgeted net surplus of $10.2 million resulting in a favorable variance from budget of $10.8 million. The table below summarizes the components of the overall variance from budget.

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

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$102,064,624	$ 96,026,345	$ 6,038,278	6.3%	Revenue	$ 1,008,019,755	$ 951,926,846	$ 56,092,909	5.9%
95,550,286	91,307,010	(4,243,275)	-4.6%	Medical Expense	950,932,201	905,426,423	(45,505,778)	-5.0%
6,514,338	4,719,335	1,795,003	38.0%	Gross Margin	57,087,554	46,500,424	10,587,131	22.8%
3,358,169	3,637,198	279,030	7.7%	Administrative Expense	35,427,578	35,432,045	4,466	0.0%
3,156,170	1,082,137	2,074,033	191.7%	Net Operating Income	21,659,976	11,068,379	10,591,597	95.7%
(40,705)	(85,842)	45,138	52.6%	Non-Operating Income/Exp	(619,276)	(858,424)	239,148	27.9%
$ 3,115,465	$ 996,294	$ 2,119,171	212.7%	Net Surplus/ (Loss)	$ 21,040,700	$ 10,209,955	$ 10,830,745	106.1%

Member Months

For the month of April 2017, overall member months were higher than budget by 182 (+0.1%). For year to date April 2017, overall member months were higher than budget by 43,069 (+1.6%).

In the ten months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 2.8%, membership in Healthy Kids program decreased by 37.0%, and membership in CMC program decreased by 7.8%.

Member months, and changes from prior year, are summarized on Page 10.

Revenue

The Plan recorded net revenue of $102.1 million for the month of April 2017, compared to budgeted revenue of $96.0 million, resulting in a favorable variance from budget of $6.0 million, or 6.3%. For year to date April 2017, the Plan recorded net revenue of $1.0 billion, compared to budgeted revenue of $951.9 million, resulting in a favorable variance from budget of $56.1 million, or 5.9%. The favorable variance was largely due to higher than budgeted members year to date. The Plan also received prior year revenue and higher than budgeted supplemental revenues (Behavioral Health, Maternity, and Abortion). This positive variance was partially offset by unfavorable variances in Medi-Cal Expansion, Hep C, and Medi-Cal CMC revenue. Medi-Cal Expansion revenue is unfavorable due to both lower than budgeted member months and PMPM. Hep C revenue is unfavorable due to lower than budgeted actual rate and Medi-Cal CMC revenue is lower due to lower than budgeted member months. Medicare revenue was favorable due to higher PMPM reflecting the higher risk scores of the plan members.

A statistical and financial summary for all lines of business is included on page 15 of this report.

Medical Expenses

For the month of April 2017, medical expense was $95.6 million compared to budget of $91.3 million, resulting in an unfavorable budget variance of $4.2 million, or -4.6%. For year to date April 2017, medical expense was $950.9 million compared to budget of $905.4 million, resulting in an unfavorable budget variance of $45.5 million, or -5.0%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs of $10.6 million. Increased inpatient and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by a lowering of the prior year medical cost reserves, lower than budgeted Pharmacy expenses including a cost saving share credit, and a net reinsurance recovery over premiums paid. Additionally, the Plan has set aside $21.5 million for IHSS/recast reserves and provider risk sharing.

Administrative Expenses

Overall administrative costs were favorable to budget by $0.3 million (7.7%) for the month of April 2017 and favorable to budget by $4K (0.0%) for year to date April 2017. A significant reason for April's favorability was due to receipt of a non-recurring pharmacy administration expense goodwill credit. Occupancy cost was favorable due to deferred expansion plans and advertising/postage expenses were favorable due to timing. Lower personnel costs due to open positions were offset by higher consulting/temporary expenses.

Overall administrative expenses were 3.5% of revenue for year to date April 2017.

Balance Sheet

Current assets totaled $889.3 million compared to current liabilities of $771.0 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0 as of April 30, 2017. Working capital increased by $11.2 million for the ten months year to date ended April 30, 2017.

Cash as of April 30, 2017, increased by $301.8 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by $15.0 million during the same ten month period ended April 30, 2017. The cash position increased largely due to the receipt of prior period receivables, capitation revenue paid at the prospective rates, and an overall increase in the payables. SCFHP intends to invest a significant amount of the excess cash over short term liquidity needs in its county investment pool to increase its interest income.

Liabilities increased by a net amount of $303.0 million during the ten months ended April 2017. Liabilities increased primarily due to the overpayment of Medi-Cal expansion premium revenues by the State to $180.8 million and an increase in IHSS/MCO payables year to date.

Capital Expenses increased by $6.4 million for the ten months ended April 30, 2017. The capital expenses include:

Expense	YTD Actual	Annual Budget
Trizetto	5,302,340	6,800,000
Computers	914,454	3,134,500
Leasehold Improvement & Furniture	192,316	992,700
TOTAL	**6,409,110**	**10,927,200**

Reserves Analysis

Tangible Net Equity (TNE) was $121.3 million at April 30, 2017 or 332% of the most recent quarterly Department of Managed Health Care (DMHC) minimum requirement of $36.5 million. A chart showing TNE trends is shown on page 16 of this report.

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 April 30, 2017, the Plan's TNE was $6.4 million below the low-end Equity Target and $84.8 million above the low-end Liquidity Target and the Plan's TNE was $61.2 million below the high-end Equity Target and $44.1 million above the high-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	$121,334,156
Current Required TNE	$36,507,000
Excess TNE	$84,827,156
Required TNE Percentage	332%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	$127,774,500
500% of Required TNE (high end)	$182,535,000
TNE Above/(Below) SCFHP Low End Target	**($6,440,344)**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	$447,853,943
Less Net Receivable/(Payable):	
State of CA*	(225,239,027)
Others	($15,736,592)
Total Net Receivable/(Payable)	(240,975,620)
Net Cash Available to SCFHP	$206,878,324
SCFHP Target Liquidity:	
45 days of Total Operating Expenses	($122,070,436)
60 days of Total Operating Expenses	($162,760,582)
Liquidity Above/(Below) SCFHP Low End Target	**$84,807,887**

*Pass-Throughs from State of CA (excludes IHSS)	
Receivables Due to SCFHP	36,114,438
Payables Due from SCFHP	(261,353,465)
Net Receivable/(Payable)	($225,239,027)

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Apr 2017			Ten Months Ending Apr 2017				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**FY17 vs. FY16**
Medi-Cal	267,304	268,379	(0.4%)	2,685,917	2,649,625	1.4%	2,520,043	6.6%
Healthy Kids	2,794	1,426	96.0%	30,178	23,856	26.5%	43,215	(30.2%)
Medicare	7,567	7,678	(1.4%)	77,286	76,830	0.6%	85,373	(9.5%)
Total	277,665	277,483	0.1%	2,793,381	2,750,312	1.6%	2,648,631	5.5%

Santa Clara Health Authority
Apr 2017

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**	**Enrollment**	**% of Total**
Direct Contact Physicians	27,559	10%	361	13%	7,567	100%	35,487	13%
SCVVHS, Safety Net Clinics, FQHC Clinics	140,000	52%	1,462	52%	-	0%	141,462	51%
Palo Alto Medical Foundation	7,564	3%	81	3%	-	0%	7,645	3%
Physicians Medical Group	48,328	18%	727	26%	-	0%	49,055	18%
Premier Care	16,573	6%	163	6%	-	0%	16,736	6%
Kaiser	27,280	10%	-	0%	-	0%	27,280	10%
Total	**267,304**	**100%**	**2,794**	**100%**	**7,567**	**100%**	**277,665**	**100%**
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	2.8%		-37.0%		-7.8%		1.8%	

Santa Clara Family Health Plan
Enrollment by Aid-Category

		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,197	31,372	31,863	31,603	31,396	31,072	30,836	30,479	30,204
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006	108,627	108,876	107,489	106,719	106,926	106,305	106,181
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,078	10,138	10,199	10,216	10,206	10,371	10,400	10,400	10,520
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,262	11,125	11,108	11,037	10,962	10,922	10,865	10,815	10,783	11,017	11,000	11,049	11,028	11,013	11,016	11,052	11,073	11,097
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350	1,297	1,150	1,078	973	921	879	845
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,513	83,721	84,679	84,327	84,551	83,031	82,715	82,618	82,751
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38	37	35	35	34	38	38	39
	Long Term Care	194	194	205	212	229	247	246	288	294	289	294	294	299	304	303	310	321	327	327	315	312	301
	Total Non-Duals	221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928	248,061	247,556	246,095	243,543	243,203	242,104	241,938
DUAL	Aged	10,003	10,678	11,583	12,426	13,380	14,034	14,071	14,197	14,273	14,246	14,365	14,451	14,469	14,524	14,655	14,723	14,800	14,935	15,338	15,950	16,131	16,281
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,023	6,027	6,024	6,034	6,033	6,353	6,478	6,506	6,507
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,832	1,856	1,896	1,879	1,891	1,727	1,686	1,621	1,427
	Long Term Care	644	722	814	904	983	1,065	1,061	1,087	1,074	1,061	1,053	1,043	1,047	1,048	1,043	1,030	1,024	1,046	1,153	1,148	1,178	1,151
	Total Duals	16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427	23,581	23,673	23,737	23,905	24,571	25,262	25,436	25,366
	Total Medi-Cal	238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509	271,734	271,293	270,000	268,114	268,465	267,540	267,304
	Healthy Kids	4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962	2,662	2,458	2,581	2,585	2,780	2,752	2,794
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,526	9,304	8,783	8,526	8,373	8,147	8,033	7,872	7,779	7,696	7,591	7,491	7,275	7,241	7,227	7,311	7,342	7,293
	CMC - Long Term Care	294	312	325	352	380	395	376	360	355	341	334	331	329	329	318	310	308	305	300	287	280	274
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909	7,801	7,583	7,546	7,527	7,598	7,622	7,567
	Total Enrollment	**250,307**	**254,629**	**258,516**	**262,767**	**267,842**	**272,675**	**269,304**	**269,290**	**272,918**	**270,396**	**271,930**	**272,669**	**276,311**	**280,384**	**280,380**	**282,197**	**281,334**	**280,127**	**278,226**	**278,843**	**277,914**	**277,665**

Santa Clara County Health Authority
Balance Sheet

	APR 17	MAR 17	FEB 17	JUN 16
Assets				
Current Assets				
Cash and Marketable Securities	$ 447,853,943	$ 289,101,317	$ 303,617,915	$ 146,082,070
Premiums Receivable				
In Home Support Services (IHSS)	395,416,617	378,868,888	361,125,308	235,710,453
All Other	36,748,083	203,921,463	197,371,703	181,456,519
Prepaid Expenses and Other Current Assets	9,279,170	10,125,364	7,764,853	6,766,163
Total Current Assets	889,297,814	882,017,032	869,879,780	570,015,205
Long Term Assets				
Equipment	20,126,909	19,196,267	19,124,839	13,717,799
Less: Accumulated Depreciation	(10,395,375)	(10,218,119)	(10,040,964)	(8,775,886)
Total Long Term Assets	9,731,533	8,978,148	9,083,875	4,941,913
Total Assets	$ 899,029,347	$ 890,995,181	$ 878,963,655	$ 574,957,118
Deferred Outflow of Resources	$ 1,570,339	$ 1,570,339	1,570,339	1,570,339
Total Deferred Outflows and Assets	900,599,686	892,565,520	880,533,994	576,527,457
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 4,906,546	$ 5,073,718	$ 5,351,195	$ 4,824,017
Deferred Rent	100,899	105,050	109,201	142,408
Employee Benefits	1,273,680	1,198,230	1,150,530	1,013,759
Retirement Obligation per GASB 45	597,797	538,017	478,237	
Advance Premium - Healthy Kids	52,515	47,050	40,104	65,758
Deferred Revenue - Medicare		8,436,842		
Liability for ACA 1202	2,065,180	2,065,180	2,065,180	5,503,985
Payable to Hospitals (SB90)	12,328,486			55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,378,461	1,382,777	1,381,822	1,717,483
Due to Santa Clara County Valley Health Plan and Kaiser	5,347,329	8,642,584	20,901,222	6,604,472
MCO Tax Payable - State Board of Equalization	34,529,672	53,486,885	46,338,820	10,779,014
Due to DHCS	226,823,793	220,020,766	225,345,089	107,213,315
Liability for In Home Support Services (IHSS)	397,894,217	383,545,576	363,801,996	238,387,141
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	81,378,845	79,216,042	81,933,950	84,321,012
Total Current Liabilities	771,016,409	766,097,708	751,236,336	462,966,494
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	0	0	5,618,386	5,018,386
Total Liabilities	776,935,909	772,017,208	762,774,222	473,904,380
Deferred Inflow of Resources	2,329,621	2,329,621	2,329,621	2,329,621
Net Position / Reserves				
Invested in Capital Assets	9,731,533	8,978,148	9,083,875	4,941,913
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	90,256,573	91,009,958	90,904,231	67,383,691
Current YTD Income (Loss)	21,040,700	17,925,235	15,136,696	27,662,502
Net Position / Reserves	121,334,156	118,218,691	115,430,152	100,293,456
Total Liabilities, Deferred Inflows, and Net Assets	$ 900,599,686	$ 892,565,520	$ 880,533,994	$ 576,527,457

Santa Clara County Health Authority
Income Statement for Ten Months Ending Apr 30, 2017

	For the Month of Apr 2017					For Ten Months Ending Apr 30, 2017				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 93,338,957	91.5%	$ 87,675,353	91.3%	$ 5,663,604	$ 918,758,099	91.1%	$ 867,519,004	91.1%	$ 51,239,094
HEALTHY KIDS	$ 288,825	0.3%	$ 126,122	0.1%	$ 162,703	$ 2,963,875	0.3%	$ 2,105,570	0.2%	$ 858,305
MEDICARE	$ 8,436,842	8.3%	$ 8,224,871	8.6%	$ 211,971	$ 86,297,781	8.6%	$ 82,302,272	8.6%	$ 3,995,509
TOTAL REVENUE	$ 102,064,624	100.0%	$ 96,026,345	100.0%	$ 6,038,278	$ 1,008,019,755	100.0%	$ 951,926,846	100.0%	$ 56,092,909
MEDICAL EXPENSES										
MEDI-CAL	$ 83,428,112	81.7%	$ 83,544,730	87.0%	$ 116,617	$ 861,539,430	85.5%	$ 826,937,692	86.9%	$ (34,601,737)
HEALTHY KIDS	$ 236,276	0.2%	$ 121,206	0.1%	$ (115,070)	$ 2,416,694	0.2%	$ 2,028,237	0.2%	$ (388,456)
MEDICARE	$ 11,885,898	11.6%	$ 7,641,075	8.0%	$ (4,244,823)	$ 86,976,077	8.6%	$ 76,460,493	8.0%	$ (10,515,584)
TOTAL MEDICAL EXPENSES	$ 95,550,286	93.6%	$ 91,307,010	95.1%	$ (4,243,275)	$ 950,932,201	94.3%	$ 905,426,423	95.1%	$ (45,505,778)
MEDICAL OPERATING MARGIN	$ 6,514,338	6.4%	$ 4,719,335	4.9%	$ 1,795,003	$ 57,087,554	5.7%	$ 46,500,424	4.9%	$ 10,587,131
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 2,338,474	2.3%	$ 2,079,839	2.2%	$ (258,635)	$ 18,562,566	1.8%	$ 19,291,481	2.0%	$ 728,914
RENTS AND UTILITIES	$ 114,349	0.1%	$ 136,480	0.1%	$ 22,132	$ 1,068,345	0.1%	$ 1,215,534	0.1%	$ 147,189
PRINTING AND ADVERTISING	$ 11,075	0.0%	$ 54,108	0.1%	$ 43,033	$ 522,718	0.1%	$ 710,833	0.1%	$ 188,115
INFORMATION SYSTEMS	$ 167,447	0.2%	$ 202,184	0.2%	$ 34,737	$ 1,806,159	0.2%	$ 1,899,376	0.2%	$ 93,217
PROF FEES / CONSULTING / TEMP STAFFING	$ 359,296	0.4%	$ 743,780	0.8%	$ 384,484	$ 9,491,518	0.9%	$ 7,902,309	0.8%	$ (1,589,209)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 239,947	0.2%	$ 239,478	0.2%	$ (470)	$ 2,011,052	0.2%	$ 2,000,662	0.2%	$ (10,390)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 30,416	0.0%	$ 89,180	0.1%	$ 58,764	$ 1,116,418	0.1%	$ 1,474,797	0.2%	$ 358,379
MEETINGS / TRAVEL / DUES	$ 85,606	0.1%	$ 79,369	0.1%	$ (6,237)	$ 757,274	0.1%	$ 849,706	0.1%	$ 92,433
OTHER	$ 11,559	0.0%	$ 12,780	0.0%	$ 1,221	$ 91,527	0.0%	$ 87,347	0.0%	$ (4,181)
TOTAL ADMINISTRATIVE EXPENSES	$ 3,358,169	3.3%	$ 3,637,198	3.8%	$ 279,030	$ 35,427,578	3.5%	$ 35,432,045	3.7%	$ 4,466
OPERATING SURPLUS (LOSS)	$ 3,156,170	3.1%	$ 1,082,137	1.1%	$ 2,074,033	$ 21,659,976	2.1%	$ 11,068,379	1.2%	$ 10,591,597
ALLOWANCE FOR UNCOLLECTED PREMIUMS	$ (11,278)	0.0%		0.0%	$ (11,278)	$ (91,539)	0.0%		0.0%	$ (91,539)
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	$ (59,780)	-0.1%	$ (50,592)	-0.1%	$ (9,187)	$ (597,797)	-0.1%	$ (505,923)	-0.1%	$ (91,874)
GASB 68 - UNFUNDED PENSION LIABILITY	$ (75,000)	-0.1%	$ (75,000)	-0.1%	$ -	$ (750,000)	-0.1%	$ (750,000)	-0.1%	$ -
INTEREST & OTHER INCOME	$ 105,353	0.1%	$ 39,750	0.0%	$ 65,603	$ 820,060	0.1%	$ 397,498	0.0%	$ 422,561
NET SURPLUS (LOSS) FINAL	$ 3,115,465	3.1%	$ 996,294	1.0%	$ 2,119,171	$ 21,040,700	2.1%	$ 10,209,955	1.1%	$ 10,830,745

Santa Clara Family Health Plan
Statement of Cash Flows
For Ten Months Ended Apr 30, 2017

Cash flows from operating activities		
Premiums received	$	1,136,383,163
Medical expenses paid	$	(795,624,435)
Administrative expenses paid	$	(33,306,266)
Net cash from operating activities	$	307,452,463
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(6,409,110)
Cash flows from investing activities		
Interest income and other income, net	$	728,521
Net (Decrease) increase in cash and cash equivalents	$	301,771,874
Cash and cash equivalents, beginning of year	$	146,082,070
Cash and cash equivalents at Apr 30, 2017	$	447,853,943
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	20,312,179
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	1,619,490
Changes in operating assets and liabilities		
Premiums receivable	$	(14,997,727)
Due from Santa Clara Family Health Foundation	$	-
Prepaids and other assets	$	(2,513,008)
Deferred outflow of resources	$	-
Accounts payable and accrued liabilities	$	9,381,013
State payable	$	143,361,136
Santa Clara Valley Health Plan and Kaiser payable	$	(1,257,143)
Net Pension Liability	$	(5,018,386)
Medical cost reserves and PDR	$	(2,942,167)
Deferred inflow of resources	$	-
Total adjustments	$	287,140,283
Net cash from operating activities	$	307,452,463

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

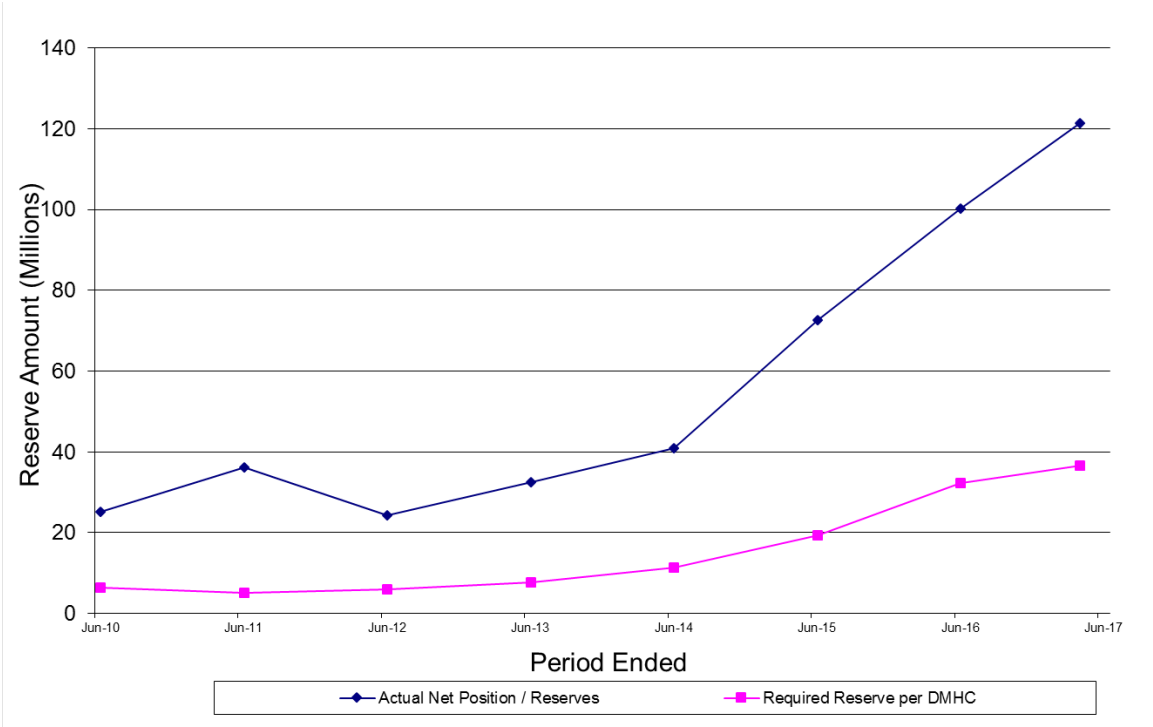
Ten Months Ended Apr 30, 2017

	Medi-Cal	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	$896,612,425	$108,443,455	$2,963,875	**$1,008,019,755**
MEDICAL EXPENSES	834,971,540	113,543,967	2,416,694	**950,932,201**
(MLR)	93.1%	104.7%	81.5%	**94.3%**
GROSS MARGIN	61,640,886	(5,100,513)	547,181	**57,087,554**
ADMINISTRATIVE EXPENSES	31,512,088	3,811,323	104,168	**35,427,578**
(% MM allocation except CMC)				
OPERATING INCOME/(LOSS)	30,128,798	(8,911,836)	443,014	**21,659,976**
OTHER INCOME/(EXPENSE)	(550,833)	(66,622)	(1,821)	**(619,276)**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$29,577,965	($8,978,458)	$441,193	**$21,040,700**
PMPM (ALLOCATED BASIS)				
REVENUE	$333.82	$1,403.14	$98.21	**$360.86**
MEDICAL EXPENSES	310.87	1,469.14	80.08	**340.42**
GROSS MARGIN	22.95	(66.00)	18.13	**20.44**
ADMINISTRATIVE EXPENSES	11.73	49.31	3.45	**12.68**
OPERATING INCOME/(LOSS)	11.22	(115.31)	14.68	**7.75**
OTHER INCOME / (EXPENSE)	(0.21)	(0.86)	(0.06)	**(0.22)**
NET INCOME / (LOSS)	$11.01	($116.17)	$14.62	**$7.53**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*2,685,917*	*77,286*	*30,178*	***2,793,381***
Member MONTHS by LOB	*96.2%*	*2.8%*	*1.1%*	***100%***
Revenue by LOB	*88.9%*	*10.8%*	*0.3%*	***100%***

Note: CMC includes Medi-Cal portion of the CCI data

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

	6/30/2010	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	4/30/2017
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	121,334,156
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	36,507,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	73,014,000
Actual as % Required	393%	722%	410%	419%	357%	377%	310%	332%



Date: June 22 2017

To: Governing Board, Santa Clara County Health Authority

From: Christine Tomcala, CEO & Dave Cameron, CFO

Re: **Fiscal Year 2017-18 Operating Forecast and Capital Budget**

The enclosed package contains a draft of the Fiscal Year 2017-18 Operating and Capital Budget for your review and consideration. The proposed Fiscal Year 2017-18 Operating Budget anticipates revenues of $1.1 billion, representing a 9.9% decrease over fiscal year 2016-17 forecasted revenue of $1.2 billion. The proposed budget surplus of $13.4 million, or 1.2% of revenue, represents a decrease of $9.6 million from the fiscal year 2016-17 forecast.

Santa Clara Family Health Plan experienced a modest 4.8% growth in average monthly membership in FY 2016-17 after growing 84.3% over the three previous years. This was driven by the Affordable Care Act (ACA), Medi–Cal expansion, and the launch of new products and benefits including the Coordinated Care Initiative (CCI) pilot, which includes Cal MediConnect (CMC) and MLTSS. The expanded Medi-Cal benefits in the CCI pilot are for long-term care, behavioral health services, Multi Services Senior Program, In-Home Supportive Services, and Medicare.

In the upcoming fiscal year, SCFHP is projecting a slight decline in overall membership of 2.2% with the fiscal year 2017-18 budget reflecting 270,159 members at June 2018 versus 276,107 members at June 2017 per the 2016-17 forecast.

Key Fiscal Year 2017-18 budget assumptions include:

Membership

- Overall, the projected membership decrease between fiscal year 2016-17 forecast and the fiscal Year 2017-18 budget is expected to be 5,948 members or 2.2%, with member months decreasing by 72,363 or 2.2 %.
- Medi-Cal membership is projected to decrease 2.2% reflecting a 2.7% decrease in Medi-Cal Classic enrollment (primarily in the MCE, Child & Adult categories of aid) partially offset by a 2.2% increase in Duals enrollment. Both reflect recent enrollment trends.
- CMC membership declined in this past year but has been stable in recent months and is projected to remain flat for FY 2017-18.
- Healthy Kids enrollment is expected to remain flat, with most members now in the C-CHIP program.

Revenue

- Revenue is expected to decrease from $1.2 billion per the fiscal year 2016-2017 forecast to $1.1 billion per the fiscal year 2017-2018 budget.
    - Much of the decrease reflects the mid-year cessation of IHSS benefits from the CCI Pilot program effective December 31.
- Revenue reflects draft rates received from DHCS in April 2017 with estimates added for Countywide averaging and risk-sharing.

- Medi-Cal Classic reflects an overall increase of 3.8% (primarily in the SPD category of aid)
- Medi-Cal MCE reflects a decrease of 3.2%
- Overall, Medi-Cal reflects an overall increase of 0.4%

< CMC revenue is based on 2017 rates from CMS, with the Medi-Cal component based on CY 2015 rates, further adjusted for actual enrollment in the specified population cohorts. The budget also includes the Year 3 CMS savings target of 5% and quality withhold of 3%.

< Healthy Kids revenue is expected to remain flat.

Health Care Expense

< Health care expense are expected to decrease from $1.1 billion per the fiscal year 2016-17 forecast to $1.0 billion per the fiscal year 2017-2018 budget.
  - Much of the decrease reflects the mid-year cessation of IHSS benefits from the CCI Pilot program effective December 31.
  - Lower projected membership also contributes to the decrease in overall health care expense.

< Health care cost projections are based on several methods, predominantly current trends calculated from historical experience. In addition, adjustments were made to account for known changes to program structure, expected provider increases, and/or actuarial estimates for Medi-Cal Classic, Medi-Cal Expansion, CMC, and CCI.

Administrative Expense

< Administrative expense includes higher expenses for (1) additional staffing and (2) significant depreciation for recent and anticipated capital acquisitions.

< Administrative expenses, still low by industry standards, are budgeted for fiscal year 2017-18 at $50.1 million or 4.6% of revenue.

Operating Surplus

The fiscal year 2017-2018 budget yields a projected annual surplus of $13.4 million or 1.2% of revenue.

Capital Expenditures

The fiscal year 2017-18 budget includes a capital expenditures of $17.2 million of which $14.2 million pertains to the acquisition and renovation of the 50 Great Oaks Boulevard, San Jose property. In addition, I.T. systems, hardware, and software purchases of $2.8 million are included. Smaller amounts are included for (1) facilities enhancements at 210 East Hacienda (to accommodate additional staff) and (2) a new delivery van.

Respectfully submitted,

Christine Tomcala, CEO
Dave Cameron, CFO

Santa Clara
Family Health Plan
The Spirit of Care

Fiscal Year 2017-2018

Proposed Operating and Capital Budgets

Governing Board Meeting

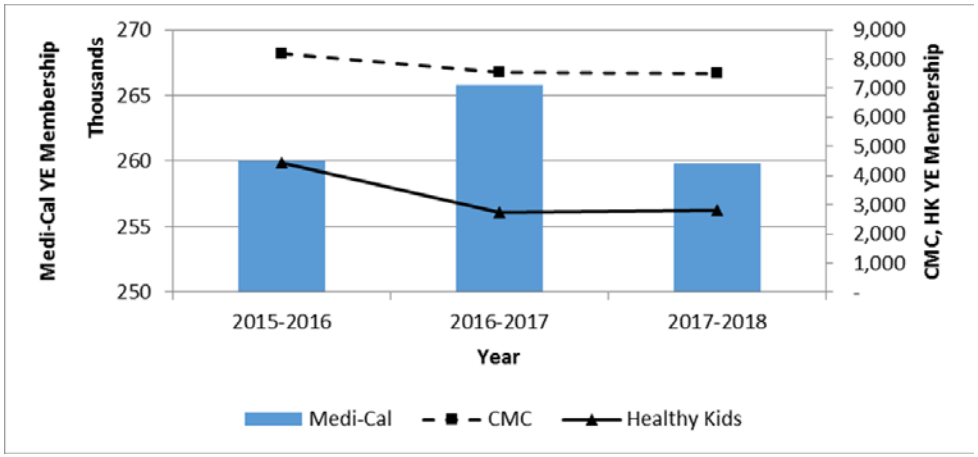
June 22, 2017

Overview

- Budget Assumptions
- Enrollment, Revenue, and Expense Details
- Summary by Line of Business
- General and Administrative Expenses
- Fund Balance and TNE
- Capital Budget

Budget Assumptions (Enrollment)

- **Medi-Cal**
  - Enrollment projections are based on actual data through June 2017 and trended through June 2018. Based on these trends the budget assumes decreases in most non-dual aid categories and growth in most dual aid categories. Overall membership declines to 259,859 by June 30, 2018 from 265,805 at the close of the FY 2017 (annual decline of 2.2%)
- **Cal MediConnect**
  - After a steady decline for most of FY16/17 the Cal MediConnect membership has begun to stabilize in recent months. We are projecting flat growth in the budget. Overall membership is projected to remain at 7,500.
- **Healthy Kids**
  - Enrollment is expected to remain at current level (~2,800) with the majority now enrolled through the C-CHIP program as their income level exceeds the Medi-Cal eligibility limit.



Medi-Cal Enrollment

NON DUALS	Jun 17 Projected	Jun 18 Budget	Variance Increase/ (Decrease)	Variance %
Adult Expansion	82,418	79,533	(2,885)	-3.5%
Adult/Family (under 19)	106,137	103,377	(2,760)	-2.6%
Adult/Family (over 19)	30,028	28,376	(1,652)	-5.5%
Aged	10,538	11,507	969	9.2%
Disabled	11,117	10,939	(178)	-1.6%
BCCTP	16	16	0	0.0%
Long Term Care	273	285	12	4.5%
Sub-Total Non Duals	*240,527*	*234,035*	*(6,492)*	*-2.7%*
DUALS				
Adult Expansion	921	221	(700)	-76.0%
Adult/Family (21 over)	467	541	74	15.9%
Aged	16,308	17,123	815	5.0%
Disabled	6,458	6,781	323	5.0%
BCCTP	1	1	0	0.0%
Long Term Care	1,123	1,157	34	3.0%
Sub-Total Duals	*25,278*	*25,824*	546	2.2%
Grand Total	265,805	259,859	(5,946)	-2.2%

Enrollment

	Actual Member Months										Budget
	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18
Medi-Cal	926,571	1,020,926	1,127,964	1,228,903	1,348,643	1,553,229	1,928,866	2,586,104	3,039,275	3,217,527	3,149,632
Annual Growth	*7.4%*	*10.2%*	*10.5%*	*8.9%*	*9.7%*	*15.2%*	*24.2%*	*34.1%*	*17.5%*	*5.9%*	*-2.1%*
Cal MediConnect								39,516	101,943	92,376	90,000
Annual Growth									*158.0%*	*-9.4%*	*-11.7%*
Healthy Kids	136,240	114,387	104,141	87,437	77,970	69,109	63,893	57,356	52,025	35,692	33,600
Healthy Families	177,695	192,882	194,456	205,944	205,439	103,451	212	-	-	-	-
Healthy Workers	-	-	77	1,616	4,754	6,730	3,395	-	-	-	-
Healthy Generations	18,234	40,350	24,679	-	-	-	-	-	-	-	-
Total	1,258,740	1,368,545	1,451,317	1,523,900	1,636,806	1,732,519	1,996,366	2,682,976	3,193,243	3,345,595	3,273,232
Annual Growth	*6.9%*	*8.7%*	*6.0%*	*5.0%*	*7.4%*	*5.8%*	*15.2%*	*34.4%*	*19.0%*	*4.8%*	*-2.2%*
Average Covered Lives	104,895	114,045	120,943	126,992	136,401	144,377	166,364	223,581	266,104	278,800	272,769

Overall, SCFHP's covered lives are projected to average 272,769 resulting in 3,273,232 member months for 2017-18.

Budget Assumptions (Revenue)

- **Revenue decreases from $1.2 billion in FY 2017 to $1.1 billion in FY 2018 (annual decline of 9.9%). The decrease is largely attributed to: (1) mid-year phase out of the IHSS program, and (2) a decrease in Medi-Cal membership.**
  - Medi-Cal Classic reflects a 3.8% rate increase; Medi-Cal Expansion reflects a 3.2% rate decrease; Overall Medi-Cal budget reflects 0.4% rate increase.
  - CMC revenue is based on FY 2017 actual rates from CMS, with the Medi-Cal component based on rates released for CY 2015, which were further adjusted for actual enrollment in the specified population cohorts.
    - Does not include projections for sweep risk adjustment. Assumes Year 3 CMS savings target 5% and quality withholds of 3%.
  - Healthy Kids revenue is projected to be flat at FY 2017 PMPM rates.

Budget Assumptions (Expense)

- **Health care costs decrease from $1.1 billion in FY 2017 to $1.0 billion in FY 2018 (annual decline of 10.2%).**
  - FY 2018 Health care costs are projected to be 94.1% of revenue.
  - IHSS will be phased out of the CCI program mid-year.
  - Several methods were utilized in the development of medical expense forecasts; primarily, projections were based on trends calculated from historical experience.
  - Adjustments were applied to account for expected changes to operations, program structure, benefits, and regulatory policies.
- **Administrative costs increase from $43.7 million in FY 2017 to $50.1 million in FY 2018 (annual increase of 14.8%). The increase is largely attributed to: (1) additional staffing needed to fill significant gaps in various departments and (2) depreciation of significant new capital assets added in FY 2017 and FY 2018.**
  - Administrative expenses for FY 2018 are projected to be 4.6% of revenue.

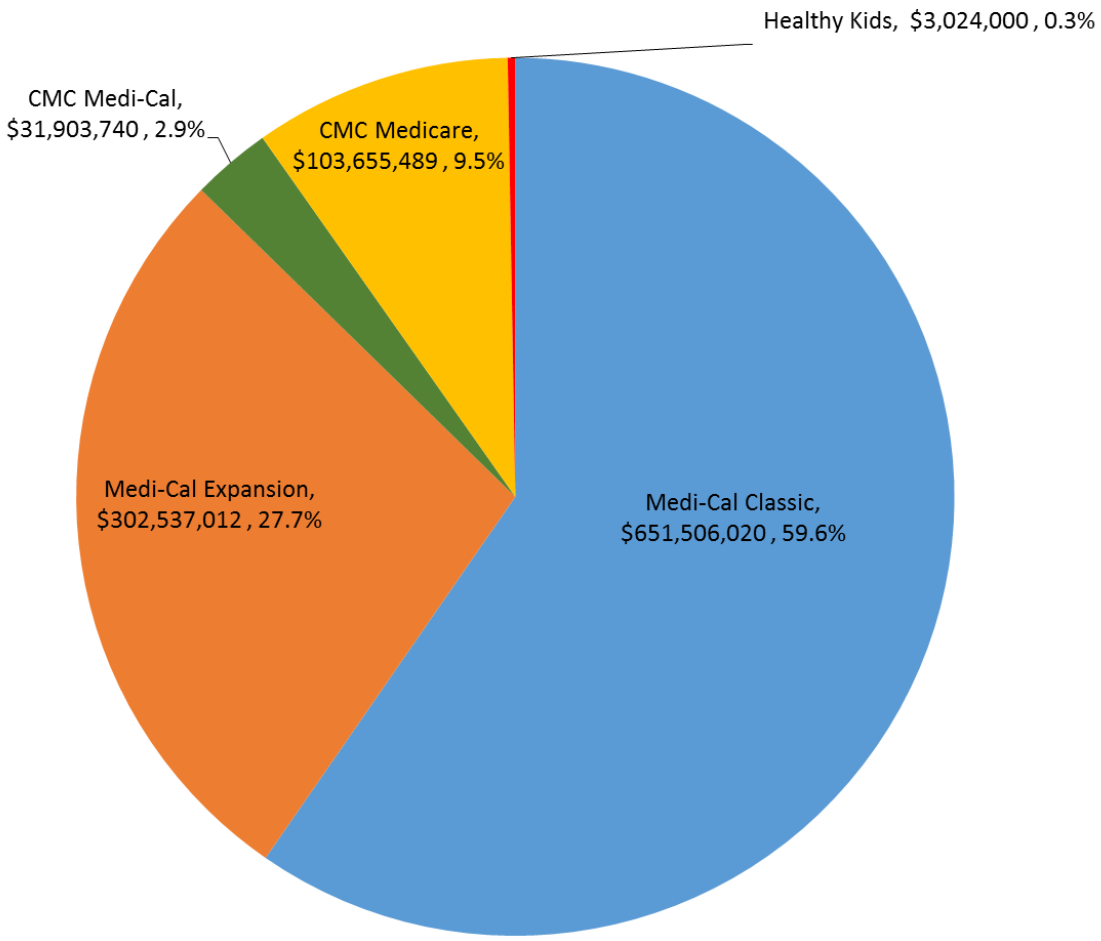
Consolidated Budget

	FY 2016-17 Forecast	FY 2017-18 Budget
Average Monthly Enrollment	278,800	272,769
Revenues	$1,212,149,002	$1,092,626,261
Health Care Costs	1,144,713,949	1,028,213,514
Gross Margin	67,435,053	64,412,747
Administrative Expenses	43,675,080	50,145,642
Other Expense	700,685	835,524
Net Surplus	$23,059,288	$13,431,581
Medical Loss Ratio	94.4%	94.1%
Administrative Ratio	3.6%	4.6%
Net Surplus %	1.9%	1.2%

Consolidated Budget by LOB

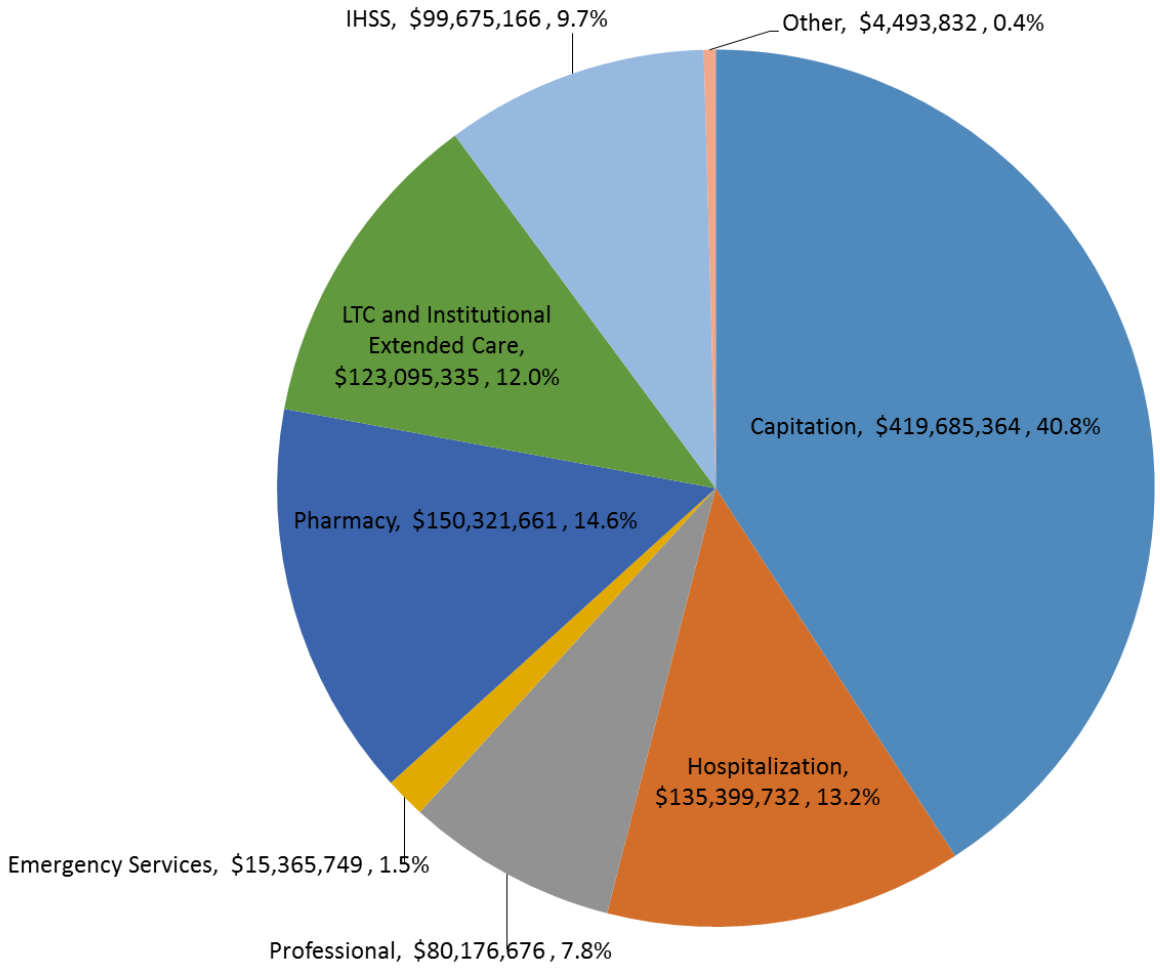
	Consolidated	Medi-Cal		CalMediConect		Healthy Kids	
	Totals	Totals	PMPM	Totals	PMPM	Totals	PMPM
Member Months	**3,273,232**	3,149,632		90,000		33,600	
Revenues:							
Capitation and Premium Revenue	**$ 1,093,084,085**	$ 954,500,856	$ 303.05	$ 135,559,229	$ 1,506.21	$ 3,024,000	$ 90.00
MCO Revenue net of expense	**$ (457,824)**	$ (457,824)	$ (0.15)		$ -	$ -	$ -
Total Revenues	**$ 1,092,626,261**	$ 954,043,032	$ 302.91	$ 135,559,229	$ 1,506.21	$ 3,024,000	$ 90.00
Medical Expenses:							
Capitation	**$ 419,685,364**	$ 418,182,985	$ 132.77	$ -	$ -	$ 1,502,379	$ 44.71
Hospitalization	**$ 135,399,732**	$ 75,375,574	$ 23.93	$ 59,884,425	$ 665.38	$ 139,732	$ 4.16
Professional	**$ 80,176,676**	$ 69,085,909	$ 21.93	$ 10,069,897	$ 111.89	$ 1,020,870	$ 30.38
Emergency Services	**$ 15,365,749**	$ 11,547,275	$ 3.67	$ 3,765,790	$ 41.84	$ 52,684	$ 1.57
Pharmacy	**$ 150,321,661**	$ 121,381,224	$ 38.54	$ 28,777,344	$ 319.75	$ 163,093	$ 4.85
LTC and Institutional Extended Care	**$ 123,095,335**	$ 95,274,284	$ 30.25	$ 27,821,052	$ 309.12	$ -	$ -
IHSS	**$ 99,675,166**	$ 99,675,166	$ 31.65	$ -	$ -	$ -	$ -
Other	**$ 4,493,832**	$ 4,337,714	$ 1.38	$ 151,973	$ 1.69	$ 4,144	$ 0.12
Total Medical Expenses	**$ 1,028,213,514**	$ 894,860,131	$ 284.12	$ 130,470,481	$ 1,449.67	$ 2,882,902	$ 85.80
MLR	**94.1%**	93.8%		96.2%		95.3%	
Gross Margin	**$ 64,412,747**	$ 59,182,901	$ 18.79	$ 5,088,748	$ 56.54	$ 141,098	$ 4.20
Administrative Expenses	**$ 50,145,642**	$ 43,785,420	$ 13.90	$ 6,221,436	$ 69.13	$ 138,785	$ 4.13
ALR	**4.6%**	4.6%		4.6%		4.6%	
Other Expenses/(Income)	**$ 835,524**	$ 729,550	$ 0.23	$ 103,661	$ 1.15	$ 2,312	$ 0.07
Net Surplus (Deficit) $	**$ 13,431,581**	**$ 14,667,931**	**$ 4.66**	**$ (1,236,349)**	**$ (13.74)**	**$ 0.00**	**$ 0.00**
Net Surplus (Deficit) %	1.2%	1.5%		-0.9%		0.0%	

Revenue Composition



Total FY18 Revenue = $1,092,626,261

Health Care Costs Composition



Total FY18 Health Care Costs = $1,028,213,514

Medi-Cal

$954,043,032

Revenue

- Projects modest membership decline of 2.2% overall, with the Dual population growing 2.2% and Non-Dual population declining 2.7%. Expansion membership declines at 3.5% annual rate.
- Revenues based on preliminary FY 2018 rates received from DHCS, which reflect an overall 0.4% increase with significant increases in Adult and SPD rates and a 3.2% decrease in Expansion rate.
- IHSS being phased out of Managed Care effective 1/1/18.

$894,860,131

Health Care Expense

- FFS costs based on historic claims experience adjusted for utilization trends and contracted rates. Upward unit cost trends: 5% for pharmacy and specialists, and 10% for Inpatient and Outpatient services.
- Capitation payments based on expected capitation rates and network distribution as of April 2017.
- LTC expense growth projected to stabilize after a rapid increase in FY 2015 & 2016. Expense trend upward 3% based on state rate increases.
- IHSS expenses higher than revenues based on historic trends. Phased out of Managed Care effective 1/1/18.

$ 43,785,420

Admin Cost

- Based on 2018 admin budget with line of business allocations based on premium revenue.
- Admin cost as a % of revenue = 4.6%.

Projected Surplus of $14,667,931

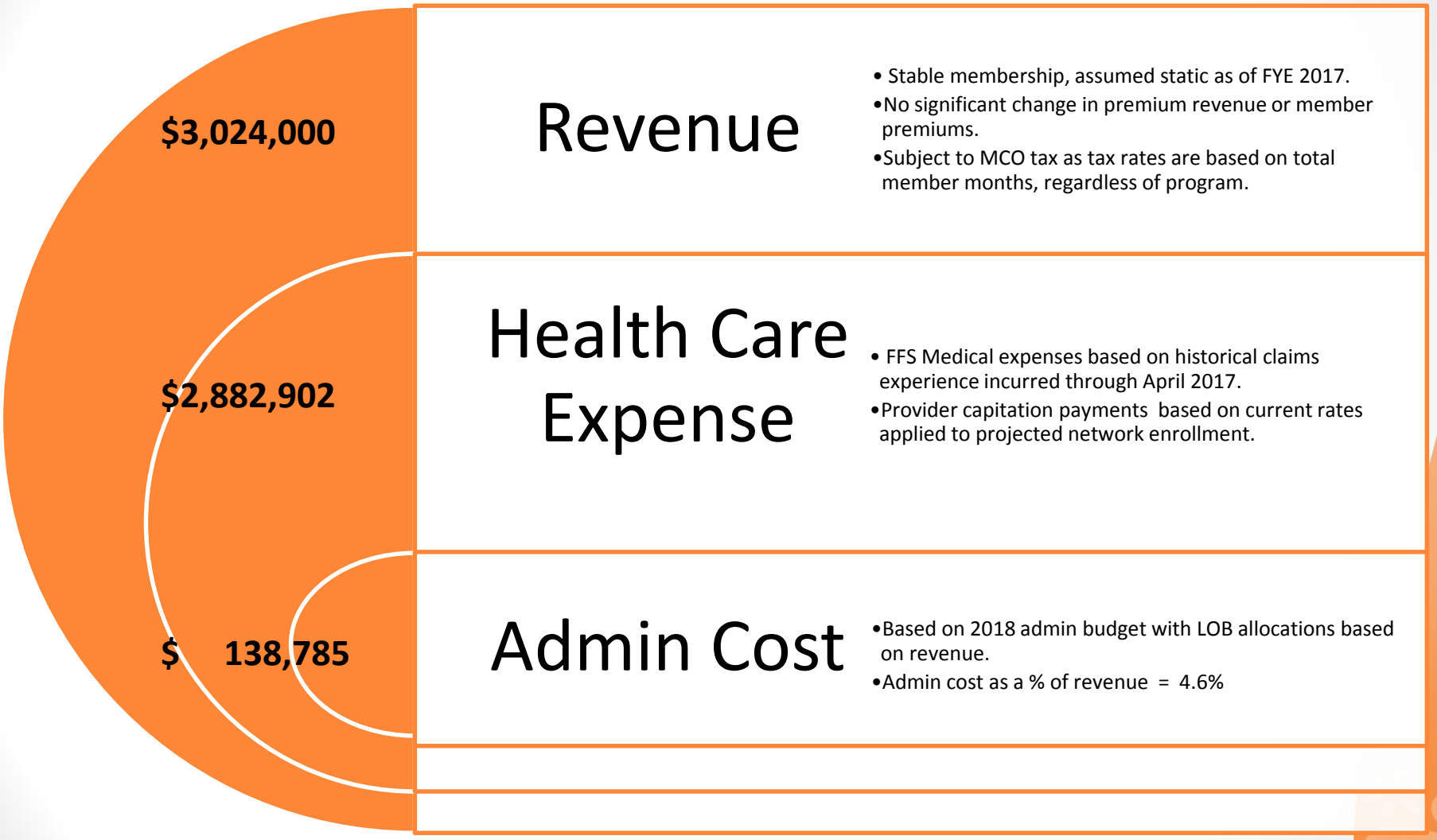
Cal MediConnect

(including Medi-Cal and Medicare)

$135,559,229	Revenue	•Membership reflects a modest decline but stabilizing at ~7,500 level. Plans in place to enhance retention. •Medicare Revenue based on 2017 actual premiums with CMS savings and quality withhold targets included. •Medi-Cal revenue blending based on projected membership mix and recently-reconciled DHCS rates.
$130,470,481	Health Care Expense	•FFS costs based on historical claims experience adjusted for utilization trends and contracted rates. •Long Term Care expenses have been trended with a expected 3% rate increase. • Pharmacy based on current experience plus a 5% trend factor. • IHSS costs are included through December 2017, removed from managed care effective January 1st,2018.
$ 6,221,436	Admin Cost	•Based on 2018 admin budget with LOB allocations based on premium revenue. •Admin cost as a % of revenue = 4.6%.

Projected deficit of $(1,236,349)

Healthy Kids



Projected Break-Even

Administrative Expense

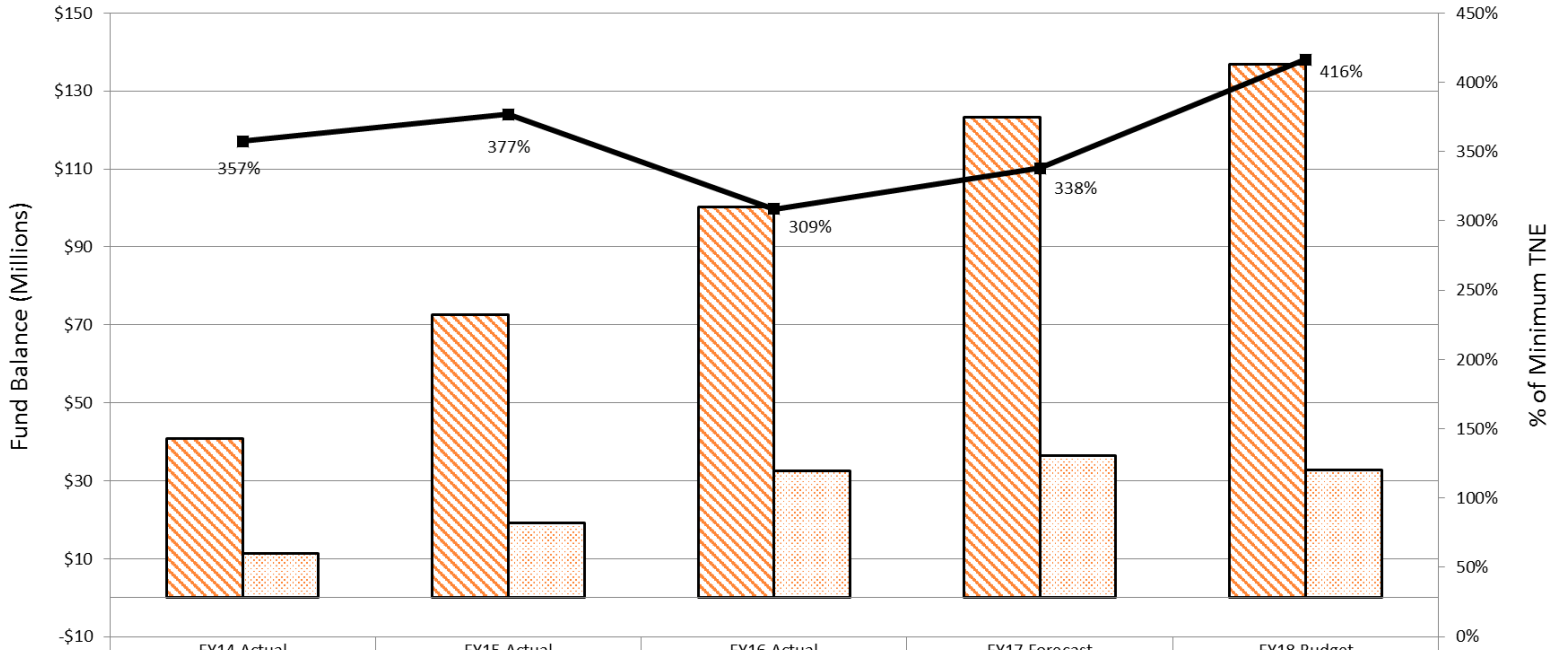
- **Personnel Costs:**
  - Total cost increase over FY17 = 20%
    - Proposed Budget adds 17 new positions. The hiring for these positions is contingent upon meeting pre-determined efficiency and/or compliance metrics.
    - Total current staff: 208 FTEs, 42 open positions, 29 temporary staff, and 10 consultants. Several of these temporary staff are expected to fill the vacant/new positions.
    - Temporary labor costs are expected to decrease as hiring ramps up.
- **Non-Personnel Costs:**
  - Total cost increase over FY17 = 9%
  - Largest increase is due to added depreciation resulting from capitalization of FY 2017 and FY 2018 assets and the purchase of a new building.
  - Purchased Services costs are higher due to:
    - IT initiatives to address membership growth, personnel growth, and need to upgrade systems.
    - Higher postage and printing costs due to increased mailing needs to meet compliance requirements as well as to prepare for a change in address due to relocation to the new building.
    - Higher Advertising and Promotion costs as the Plan targets membership retention and growth.
    - General increase in business fees, phone costs, supplies, etc. as the headcount grows.
  - Professional Services costs are lower due to:
    - Lower Consulting costs as key hires come on board and special projects are completed.
    - Lower Legal costs due to increased in-house legal review with the hiring of the Chief Compliance Officer as well as decreased needs for SEIU and other matters.

Administrative Expense

Comparative Analysis

	FY 2016-17 Forecast		FY 2017-18 Budget	
Revenue	$ 1,212,149,002		$ 1,092,626,261	
Member Months	3,345,595		3,273,232	
FTEs (at fiscal year end)	208		267	
	EXPENSE	PMPM	EXPENSE	PMPM
Salaries & Benefits	$ 22,223,514	$ 6.64	$ 28,056,520	$ 8.57
Temporary Labor	$ 1,467,959	$ 0.44	$ 269,575	$ 0.08
Sub-total Personnel Costs	*$ 23,691,474*	*$ 7.08*	*$ 28,326,095*	*$ 8.65*
Professional Fees	$ 4,495,128	$ 1.34	$ 2,917,226	$ 0.89
Purchased Services	$ 10,222,325	$ 3.06	$ 11,153,304	$ 3.41
Advertising and Promotion	$ 53,627	$ 0.02	$ 246,200	$ 0.08
Business Fees & Insurance	$ 1,390,607	$ 0.42	$ 1,552,909	$ 0.47
Occupancy costs	$ 1,323,679	$ 0.40	$ 1,391,212	$ 0.43
Supplies & Other	$ 524,541	$ 0.16	$ 737,069	$ 0.23
Depreciation	$ 1,973,699	$ 0.59	$ 3,821,627	$ 1.17
Sub-total Non-Personnel Costs	*$ 19,983,606*	*$ 5.97*	*$ 21,819,546*	*$ 6.67*
Total Administrative Expenses	$ 43,675,080	$ 13.05	$ 50,145,642	$ 15.32
Administrative Ratio	3.6%		4.6%	

Fund Balance and TNE



	FY14 Actual	FY15 Actual	FY16 Actual	FY17 Forecast	FY18 Budget
Fund Balance	40,872,580	72,630,954	100,293,456	123,352,744	136,784,326
Minimum TNE	11,434,000	19,269,000	32,503,000	36,507,000	32,856,300
% of Minimum TNE	357%	377%	309%	338%	416%

Capital Budget Summary

Description	Estimated Cost
New Building	
Acquisition Costs	$ 9,700,000
Building Improvements	$ 4,600,000
Sub-total Building and Improvements	*$ 14,300,000*
Systems	
Data Warehouse	$ 920,000
Grievance & Appeals system (Essette)	$ 360,000
SCFHP website	$ 200,000
IVR Upgrade (Inbound and Outbound)	$ 75,000
New Budgeting System	$ 35,000
Ticket Request and PM Web System (WorxHub)	$ 5,000
Sub-total Systems	*$ 1,595,000*
Hardware	
PureStorage / Nimble Expansion - additional capacity	$ 300,000
VM Ware Upgrade UCS Hardware	$ 150,000
Server, Desktops, Other Computer Equipment	$ 116,500
Disaster Recovery Equipment	$ 45,000
Sub-total Hardware	*$ 611,500*
Software	
MS Windows and VM Ware Licenses	$ 455,000
Network Security, Firewall, Virus Protection etc.	$ 103,000
Citrix Upgrade and Desktop Cloning Software	$ 16,000
Training Portals	$ 13,000
Sub-total Software	*$ 587,000*
Furniture and Fixtures	
Office Furniture	$ 40,000
Automobile	
New Van	$ 33,000
Leasehold Improvements	
Office Space reconfiguration	$ 10,000
Total Capital Request	**$ 17,176,500**

Capital Budget Detail

- **Building & Improvements:**
  - **Acquisition Cost:** purchase price of the new building at 50 Great Oaks, San Jose
  - **Building Improvements:** *Estimated* refurbishing costs of the new building

- **Systems:**
  - **Data Warehouse** – A central repository of data that enables efficient reporting for internal and external customers
  - **Grievance & Appeals System** - Essette is a specialized system to document grievance and appeals that meets the compliance requirements
  - **SCFHP Website** – An updated website that refreshes the Plan's brand, improves provider and member access, and to reflect SCFHP's new physical location
  - **IVR Upgrade** – An upgrade to the customer service telephone system that improves efficiency by guiding callers to self-service menus
  - **Budgeting System** – A customized budget development and tracking system to replace a manual Excel based system
  - **Ticket Request & PM Web System** - WorxHub is a facilities work request tracking system to improve efficiency and track expenses

Capital Budget Detail (continued)

- **Hardware:**
  - **Pure Storage** – A system that phases out the older storage to current flash storage. The new system will also be a faster, scalable, and eliminate the need for more rack space for at least 5 years
  - **VM Ware** – Virtual servers to replace aging network equipment
  - **Server, Desktop & Other Computer Equipment** – a variety of projects to enhance SCFHP's usage of technology including:
    - **New Phone Network** – Patching panels and routing for the new building required to manage a single story building, which requires equipment stationed at appropriate intervals to manage the data needs
    - **Training Room** – Video conference camera for the training room to enable face to face meetings without traveling.
    - **Server** – A dedicated server for the Finance Team to improve the data retrieval time that enables faster and better analytics to analyze financial performance.
    - **Evault** – Additional storage space to archive the data for efficiency and compliance needs.
    - **Phone System** – A phone system to manage the disaster recovery plans for the Denver site.
    - **Agility Recovery** – A dedicated disaster recovery site in case of emergencies.
    - **Workstations** – Replacement computer equipment for new employees and applications as well as to manage the hardware refresh cycle for obsolescent equipment/technology.
  - **Disaster Recovery Equipment** – additional equipment to ensure real-time network failover to secure Denver location.

Capital Budget Detail (continued)

- **Software:**
  - Licensing:
    - **MS Licensing** – To address the new business model in use by Microsoft. Includes incidental licensing for server, email, and SQL, and VDI machines. Also needed for move to Office 365 to achieve significant savings via improved administration and security.
    - **VM Ware Licensing** -- Required licenses to allow virtual desktop administration and controls. Will replace individual PC administration for 80% of users.
  - **Network Protection –** Variety of IT software tools to ensure SCHP's network is protected from threats, including:
    - **Network Security** – Various security upgrades to prevent phishing and hacking attempts.
    - **ASA Firewall** –Standardize firewall.
    - **Solarwinds** – Network monitoring.
    - **Malwarebytes** – Manages malware threats.
    - **Pluralsight** – Training for programming, scripting and networking.
    - **Cloning –** Enables cloning of desktop and laptops for remote access.
    - **Iron Point** –Enhanced email protection.
  - **Citrix Upgrade and Desktop Cloning** - Upgrade remote management software to the new version.
  - **Training Portals –** Software to assist with searching company internal resources to respond to customer service inquiries that improves accuracy and consistency of responses. Improves the customer service training methodology and makes it more efficient.

Capital Budget Detail (continued)

- **Furniture and Fixtures:**
  - Office Furniture – To manage forecasted FTE growth. Usable in new location.

- **Automobile:**
  - New Van – The van will be used more during the relocation to the new building. There is a need to replace the aging and unreliable van that requires significant annual maintenance.

- **Leasehold improvements:**
  - 210 East Hacienda - Office space reconfiguration for the remainder of the occupancy period to manage forecasted FTE growth.

Santa Clara Family Health Plan

FY 2016-17 FOCUS
Improve Infrastructure & Achieve Operational Excellence

	Plan Objectives	Success Measures	Preliminary Year-End Status
1	**Enhance compliance program for audit readiness**	• **≥ 95% of metrics on Compliance Dashboard in compliance** • **Continue strengthening Fraud Waste & Abuse Program through June 2017** • **Develop Annual Compliance/FWA Risk Assessment in 1Q'17** • **Update Business Continuity Plan in 1Q'17**	o Compliance Dashboard in production o Completed CAPs for Misdirected Claims & PDRs o Chief Compliance & Regulatory Affairs Officer hired in April o Decision to outsource FWA; vendor engaged in May o Draft Risk Assessment developed in 1Q'17; Finance risk assessment conducted by Moss Adams in April o Business Continuity Plan update completed in 2Q'17
2	**Upgrade systems to meet operational needs of the plan**	• **De-host by 3Q'16** • **Implement QNXT for Medi-Cal & Healthy Kids by July 1, 2017** • **Select and implement CMC web portals by 1Q'17** • **Select and initiate implementation of CMC CM system by 2Q'17**	o Completed de-hosting in 4Q'16 o On target for QNXT go-live July 1, 2017 o Member portal loaded in May awaiting launch; provider portal launch planned for July upon QNXT implementation o CMC Care Management system successfully implemented in June
3	**Pursue benchmark quality performance**	• **Achieve provisional NCQA accreditation for CMC by June 2017** • **Five Medi-Cal HEDIS measures increase to next percentile tier, including two achieving 90th percentile benchmark** • **No Medi-Cal HEDIS measures below 10th percentile**	o Interim accreditation application under review; anticipate approval based on internal scoring o Eight HEDIS measures moved up a tier; none achieved 90th percentile o No HEDIS measures below 25th percentile o Implemented updated Medi-Cal Provider Incentive Program methodology with quarterly report cards
4	**Develop reporting and analytics structure**	• **Routinely generate essential dashboards/key monitoring metrics** • **Implement risk adjustment initiatives by 4Q'16** • **Develop quality withhold initiatives**	o Effort to establish culture, capability, & consistency of routine metric reporting o Medical Economics Workgroup routinely met to review cost & utilization data o Refined metrics for ongoing generation of monthly Operations and Compliance dashboards o Commenced risk adjustment initiatives for data accuracy & timeliness, retrospective chart review, and prospective risk assessments in homes/nursing homes in 4Q'16 o Anticipate return of ≥50% of CMC Quality Withhold in Demonstration Year 2 (up from 25% in DY1)

5	**Foster membership growth and retention**	• **Develop and implement CMC and Medi-Cal retention activities** • **Initiate marketing and outreach program for CMC by January 2017** • **Transition eligible Healthy Kids to Medi-Cal**	o Analyzed disenrollment trends to inform retention initiatives o Participated in 20 events with seniors; implemented streamlined CMC enrollment in November; hired an Outreach Manager and an Agent in 2Q'17 o 3,000+ children transitioned from Healthy Kids to newly available coverage options (Medi-Cal or CCHIP)
6	**Establish complex care delivery expertise**	• **Implement Model of Care for CMC & SPD by January 2017**	o Model of Care fully implemented for CMC in 4Q'16 o Partial MOC implementation for SPDs; plans to utilize new CM system in conjunction with a vendor for HRA completion in 3Q'17
7	**Collaborate with Valley Health Plan and Valley Medical Center**	• **Support Whole Person Care initiative** • **Engage in joint strategic planning with the County**	o Collaborated with SCVHHS on Whole Person Care expansion; application received CMS approval in June o Joint planning underway (extended due to election results)
8	**Convene Compensation Committee with SEIU**	**Re-write all job descriptions and benchmark pay ranges by 4Q'16**	o All union job descriptions drafted; finalizing last few with SEIU o Pay range benchmarks provided by vendor; to be reviewed with SEIU
9	**Achieve budgeted financial performance**	**Achieve FY 2016-17 Net Surplus of $11.7 million**	o Projected to exceed budgeted FY 2016-17 Net Surplus

Critical Priority

Membership Growth:	**June '17 – 276,107 members**	**1.3% increase in members (3,440)**
	June '16 – 272,667 members	**4.8% increase in member months**
Revenue Growth:	**FY 2016-17 – $1,212 million**	**$ 43 million increase in revenue**
	FY 2015-16 – $1,169 million	**3.7% increase in revenue**
Employee Hiring:	**June '17 – 207 staff/25 temps**	**15.6% turnover rate (29 departures)**
	June '16 – 164 staff/25 temps	**69 new hires**

Santa Clara Family Health Plan

FY 2017-18 FOCUS
Improve Infrastructure & Achieve Operational Excellence

	Plan Objectives	Success Measures	Sponsors
1	**Enhance compliance program for audit readiness**	• ≥ 95% of metrics on Compliance Dashboard in compliance • Implement vendor-based Fraud Waste & Abuse and Special Investigations Unit • 90% of routine regulatory reports submitted timely, without rejection • Strengthen staff preparedness for onsite & virtual audit process	**Robin Larmer** – Chief Compliance & Regulatory Affairs Officer
2	**Optimize technology for operational efficiency**	• Achieve a 70% Medi-Cal claims auto-adjudication rate • Redesign phone system by 4Q'17 • Implement Credentialing software by 4Q'17 • Implement Customer Service workflow software by 1Q'18 • Implement Grievance & Appeals system solution by 1Q'18	**Jonathan Tamayo** – CIO
3	**Expand reporting and analytics**	• Streamline availability & reporting of dashboard metrics • Continue risk adjustment initiatives for accurate, complete, & timely risk scores • Develop an enterprise data warehouse by June 2018	**Dave Cameron** – CFO
4	**Relocate office**	• Build out office with employee-friendly design features • Move by June 2018 with minimal business disruption	**Dave Cameron** – CFO
5	**Foster membership growth and retention**	• Implement plan to answer 80% of Customer Service calls in ≤ 30 seconds • Implement CMC and Medi-Cal retention activities • Build marketing and outreach program for CMC by September 2017 • Engage Supplemental Security Income vendor • Develop a robust provider network strategy	**Chris Turner** – COO
6	**Pursue benchmark quality performance**	• Five Medi-Cal HEDIS measures increase a percentile tier; two achieve 90th percentile benchmark; none below the MPL (25th percentile) • Improve HEDIS auto-assignment measures by 2 percentage points/measure • Develop CMC Quality Withhold initiatives by 3Q'17	**Jeff Robertson, MD** – CMO
7	**Collaborate with Valley Health Plan and Valley Medical Center**	• Implement Whole Person Care expansion • Continue joint strategic planning with the County • Transition non-CCHIP Healthy Kids to Valley Kids	**Christine Tomcala** – CEO
8	**Achieve budgeted financial performance**	• Achieve FY 2017-18 Net Surplus of $13.4 million	**Dave Cameron** – CFO

Critical Priority

Santa Clara
Family Health Plan

Fiscal Year 2017-2018 Team Incentive Compensation
June 22, 2017

Performance Level	**Payout** *(% of salary/ wages)*	**Compliance Metrics** *(% of dashboard metrics in compliance)*	**Service Level** *(calls answered in ≤ 30 seconds)*
weighting		*70%*	*30%*
Maximum	5%	97% - 100%	85%-100%
Target	3%	94% - 96.9%	80%-84.9%
Minimum	1%	91% - 93.9%	75%-79.9%

Calculation:

- 0.70 (Compliance Metrics Payout %) + 0.30 (Service Level Payout %) = **Overall Percent Payout**
- All staff are eligible to receive the Overall Percent Payout multiplied by the salary/wages they were paid as a regular employee from July 2017 through June 2018. (Does not include PTO cash out.)

Process:

- Santa Clara Family Health Plan must achieve a **Net Operating Surplus** as a gate to any incentive award consideration.
- Incentive compensation will be determined upon receipt of the audited financial statements for the fiscal 2017-18 performance year.
- **Compliance Metrics** will be calculated as the percent of January – June 2018 compliance dashboard measures that meet or exceed regulatory requirements.
- **Service Level** will be calculated as the percentage of member and provider calls in the Customer Service and Utilization Management call queues answered in ≤ 30 seconds from January – June 2018.
- To be eligible to receive a payout, an employee must be employed by Santa Clara Family Health Plan in a regular position at the time of distribution.

Santa Clara County Health Authority
Updates to Pay Schedule
June 22, 2017

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Accounts Payable and Payroll Specialist	Annually	48,363	60,454	72,545
Analytics Developer	Annually	83,102	108,033	132,964
Manager, Customer Service Operations Manager	Annually	72,112	91,943	111,774
Manager, Customer Service Quality	Annually	62,706	79,951	97,195
Manager, Customer Service Training & Quality	Annually	72,112	91,943	111,774
Compliance Lead	Annually	55,618	69,522	83,427
Manager, Support Services, Eligibility and Enrollment	Annually	83,102	108,033	132,964
Medicare Outreach Agent	Annually	62,706	79,951	97,195
Training and Quality Monitoring Associate	Annually	48,363	60,454	72,545

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
June 22, 2017

Accounts Payable Clerk	Annually	38,993	47,766	57,367
Data Warehouse Architect	Annually	83,102	108,033	132,964
Enrollment and Eligibility Manager	Annually	83,102	108,033	132,964
Member Services Manager	Annually	72,112	91,943	111,774
Process and Quality Improvement Manager	Annually	72,112	91,943	111,774
Support Services Supervisor	Annually	48,363	60,454	72,545
VP of Vendor Relations and Delegation Oversight	Annually	135,082	178,984	222,886
Workforce and Quality Improvement Manager	Annually	62,706	79,951	97,195

2017 Employee Survey
Final Report

Prepared for:

Santa Clara Family Health Plan

April 24, 2017

By:

A Business Research Lab Web Site

http://www.EmployeeSurveys.com

Houston, TX: 713-467-6619
Chester, VT: 802-875-1788

Table of Contents

I. INTRODUCTION

A. PROCEDURES

SCFHP conducted this survey of employees March 20 through April 4, 2017. A total of 204 employees were invited to participate, and 188 returned completed questionnaires, an outstanding response rate of 92%.

B. RELIABILITY

The "unreliability" of a survey refers to those inaccuracies in measurement that are of a chance or random nature. A reliable survey is one in which those inaccuracies are minimal. In principle, this means if the survey were repeated a number of times, it would produce the same results each time. Statistically, reliability is measured by correlating one set of results with another — i.e., "test-retest" reliability.

However, not only is it not feasible to repeat a survey over and over in a short period of time, but even if it were, the findings would not be persuasive, since the people taking the survey could surely remember how they answered previously.

One way to get around this problem is the split sample test, whose rationale is as follows:

- Since it's not feasible to re-survey the same sample, an alternative is to survey two different samples drawn at random from the same population. Since each random sample provides a projectable measure of the population's attitudes, their results should correlate very highly with each other.

  If so, it can be concluded that the survey is reliable.

- The split-sample test is a variant procedure in which the respondents in one sample are divided randomly into two separate samples. In effect, this is the same as having two separate random samples of the population.

This procedure yielded a reliability coefficient of +.97, showing that the survey findings are highly reliable. (A perfect correlation would be +1.00.)

C STATISTICAL SIGNIFICANCE

All survey findings have a margin of error, so the fact that two percentages are numerically different does not necessarily mean that the difference is real. Moreover, the smaller the samples,

the larger the margin of error. Comparison of the difference between two percentages has to take into account their respective margins of error. That is what statistical significance does.

Because of the nature of statistical calculations, differences between very high or very low percentages (i.e., 85 vs. 90%, or 15% vs. 10%) may be statistically significant, although as a practical matter they are inconsequential, and can be ignored.

Differences that achieve the 90% level of confidence are considered statistically significant. That assures that, if we say a difference is significant, the odds are 10-to-1 that it is a real difference, and not just a sampling error.

II. HIGHLIGHTS OF THE FINDINGS

A. OVERVIEW

Based on the survey findings, SCFHP appears to be a much better place to work than it was in 2012, when the prior survey was conducted. Overall engagement and propensity to recommend SCFHP to a friend for employment improved significantly. Overall satisfaction improved directionally. Scores on these overall measures are about at norm levels.

Of the 49 "agree-disagree" items that were asked in both survey periods, SCFHP improved on 45 and improved significantly on 31 of the items. Of the 43 agree-disagree items for which we have norms, SCFHP exceed the norm on 27. SCFHP is significantly above norm on three items (supervisors treating employees with respect, supervisors giving positive feedback, and communications being frequent enough) and significantly below norm on one item (fairness of the performance appraisal system).

An important focus of this survey is the identification of key strengths and weaknesses. These are summarized on the following tables.

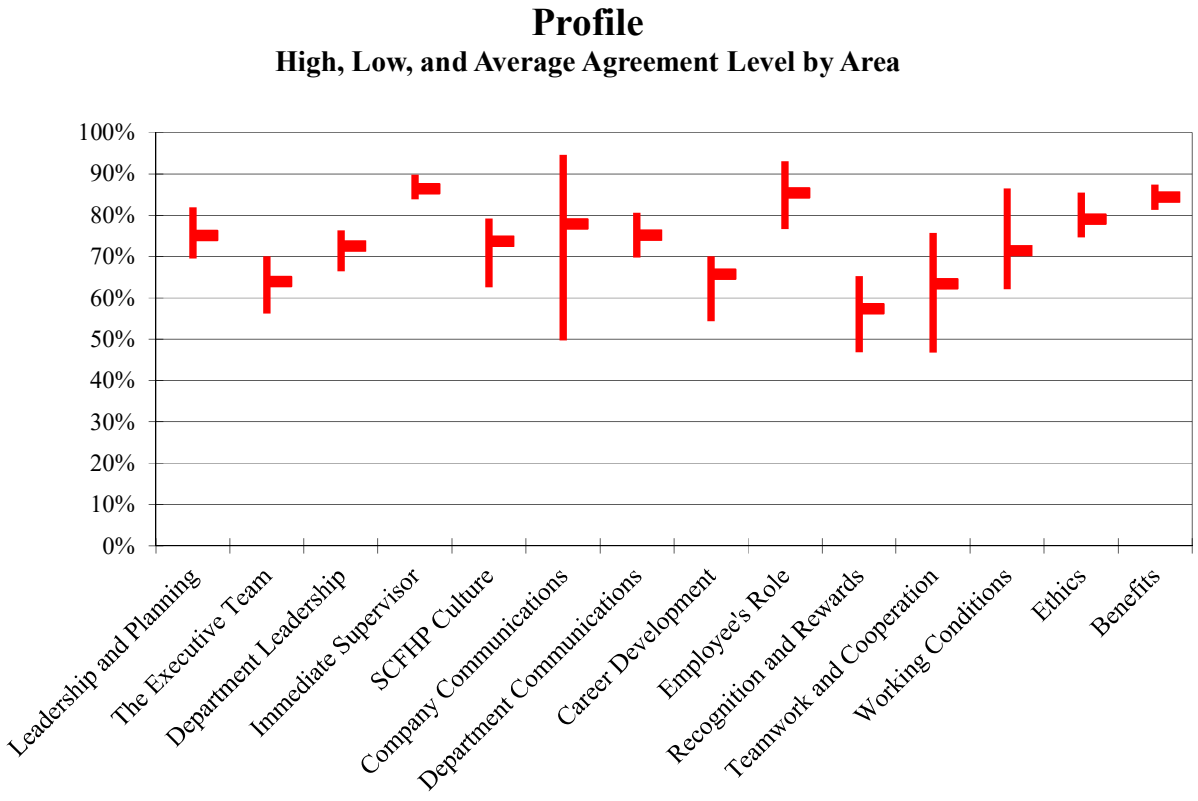
Table 1

Key Strengths
My work gives me a sense of personal accomplishment
I understand how my work supports my department's objectives
I understand how my work supports SCFHP's strategic objectives
My supervisor treats me with respect
I have never felt "pressure" from anyone at SCFHP to violate our ethics or values
My supervisor treats me fairly
I know what is expected of me at work
I understand how my work directly contributes to the overall success of the organization and its mission

Table 2

Key Opportunities for Improvement
"Politics" at this company are kept to a minimum
SCFHP gives enough recognition for work that's well done
My workload is reasonable
Everyone here “pulls their own weight
People at SCFHP are held accountable for their actions
The performance appraisal system is fair
There is adequate communication between departments
My salary is fair for the work that I do

The chart below shows the range of average scores for each section, and the average of those averages.



B. SUMMARY

1. Overall Measures

Engagement

Engagement, as measured by enthusiasm, had a large statistically significant increase since the 2012 measurement. Almost two thirds of employees feel highly enthusiastic about coming to work and doing their best each day. This slightly exceeds the norm.

Satisfaction

The percentage of highly satisfied employees increased five percentage points to 53%, and now is slightly below norm.

Willingness to Recommend

Slightly more than three-fourths of employees say they would be willing to recommend SCFHP to a friend, a significant increase of 13 percentage points. This is slightly higher than norm.

2. Other Ratings

Leadership and Planning

Employees hold SCFHP Leadership and Planning in high regard. Five of the six scores increased significantly. The largest increase was the percentage agreeing that Leadership respects the employees, now 82%, up from 56% in 2012.

Executive Team

All scores on the six Executive Team items previously measured increased, and four of the six increased significantly. Seven of ten employees agreed that the Executive Team listens to employees (a new item this year); that's ten percentage points above norm.

Department Leadership

Agreement with the Department Leadership items ranges from 66% to 76%. Department Leadership scores are higher than Executive Team scores on comparable items.

Immediate Supervisor

All five supervisor items measured in both years increased, and four increased significantly. The largest increase (+21 percentage points) was on agreement that supervisors tell employees when they do their work well. Supervisors treating employees fairly and with respect are key strengths.

SCFHP Culture

We measured four of the Culture items in both years. SCFHP's scores increased significantly on three of the four (enjoyable place to work, individual initiative encouraged, people are held accountable). Agreement with "quality is a top priority" slipped slightly. Despite the improvement in the accountability score, it is a key item in need of improvement.

About three of four employees agree that employees treat each other with respect and that morale is good; new items measured this year.

Company Communications

All communication scores increased, and four of the six increases were significant. The understanding employees have of how their work contributes to SCFHP's success is a key strength; communication between departments is a key item in need of improvement.

Department Communications

The Department Communications section is new this year. Agreement levels range from 70% to 81%.

Career Development

All career development items improved, and four of the six improved significantly. Scores now are about at norm levels, with one exception; the rating of "performance appraisal system fairness," (54% agreement) is significantly below norm and is a key item in need of improvement.

Employee's Role

At least nine of ten employees understand what is expected of them and how their work supports objectives. Eighty-one percent of employees have the materials and equipment they need, a significant improvement from the prior measurement. Authority for decision making and employees' work giving them a sense of personal accomplishment are about at norm levels. Four of the six items in this section are key strengths.

Recognition and Rewards

This is an area where there has been much improvement, yet more progress is needed. There were significant increases in the percentage of employees who feel valued and that SCFHP gives enough recognition for good work. However, both ratings are slightly below norm.

Perceptions of salary fairness are almost unchanged from 2012. The current rating is a statistically significant ten percentage points below norm.

Recognition and salary fairness are key items in need of improvement.

Teamwork and Cooperation

Teamwork and cooperation scores are at about norm levels on the three items for which we have norms. Perceptions that politics are kept to a minimum and everyone "pulls their own weight" improved significantly, but both are key items in need of improvement.

Working Conditions

Perceptions of job security improved significantly and now are at norm levels. Changes in the other items were small. SCFHP is not significantly different from norm on any item, but is several percentage points lower on realistic deadlines and reasonable workload. "Reasonable workload" is a key item in need of improvement.

Ethics

At least 75% of employees agree with each ethics statement. Never feeling pressure to violate ethics or values is a key strength.

Benefits

Overall satisfaction with benefits and understanding of the benefits package is about the same as in 2012; both measures are higher than norm.

3. Diagnostic Measure: Leverage Analysis

Key strengths include employees knowing what is expected of them, feeling their work gives them a sense of accomplishment, understanding of how their work supports department and SCFHP objectives and how it contributes to the success of SCFHP, supervisors treating employees fairly and with respect, and employees not feeling pressure to violate ethics or values.

Key opportunities for improvement include improving accountability and making sure everyone pulls their own weight, performance appraisal system and salary fairness, reducing politics, improving recognition, more-reasonable workloads and improved communication between departments.

4. Employee Comments and Suggestions

The most frequently-requested change to the benefits package was a change to the dental benefits, followed by retirement plan comments and changes to the PTO policy.

When asked what would increase their employee satisfaction, the most common responses were improvements to training, increased compensation, and better communication.

5. Subgroup Differences

Generation

On average, there is hardly any difference in the scores for the three major generations at SCFHP. Those born between 1984 and 2002 have the highest average agreement scores by a slight margin.

Tenure

The longer employees have worked for SCFHP, the less likely they are to give high ratings. This is by no means a normal pattern. Usually, scores begin high, gradually drop, and then improve as tenure increases.

Department

The highest-scoring departments are Executive, Compliance/HR, and Customer Service. The lowest scores are in Behavioral Health/Long Term Support Services and Medical Management.

C. RECOMMENDATIONS

1. **Feedback:** It is important to provide feedback of survey findings to the employees. The feedback does not need to be detailed in every area, but should provide a brief but comprehensive summary of the findings.

   Different organizations choose different methods. Provide the feedback through what works best in your organization. Findings can be presented in emails or intranets or newsletters. Additionally, at a more personal level, senior management can review results with departmental management, who will, in turn, review results with employees.

2. **Act on the Survey Results:** It is important to take actions to address employees' concerns, and to report what actions are being taken (or will be taken) in response to the survey findings. As there is progress on these actions, provide updates to employees.

3. **Improve Accountability:** SCFHP's scores on accountability and people "pulling their own weight" have improved markedly, and the accountability scores are somewhat higher than norm. However, more improvement is needed to improve engagement.

   It is frustrating to hard-working, competent employees to see others being unproductive or producing faulty product and suffering no consequences for it. Allowing unwanted behaviors to continue will result in more unwanted behaviors and a decline in the morale of good workers.

   Proper documentation is important in addressing accountability. Employees should know what you expect of them, and you must measure their performance against those expectations. Make clear the ramifications of not meeting performance objectives, and make certain to reward good performance and punish poor performance as promised.

   Pay special attention to Provider Network Management/Grievance/Appeals, Finance/Facilities/Claims and Medical Management.

4. **Rewarding Performance:** Two items we identified in our quadrant analysis as being in need of improvement are the fairness of the performance appraisal system and salary fairness for the work employees do.

   Opinions of the fairness of the performance appraisal system improved significantly since the 2012 survey. This suggests that SCFHP made improvements to the system. If SCFHP made improvements, we suggest you revisit what was done to make sure the changes made still are being implemented as planned.

   Whether or not the improvement in perceptions of performance appraisal fairness resulted from actions taken by SCFHP, make certain that the appraisal process contains the following components:

   - The system should be objective to the extent possible, with subjectivity minimized. Ideally, different managers would reach the same conclusion about a particular employee's performance if they had access to identical information. Measurable goals

and objectives should be stated in writing, along with an indication of how meeting said goals and objectives will influence a future raise and/or bonus.

- Top-performing employees always should be eligible to receive higher-percentage raises than the average employee. Said another way, there should be no concrete cap on wages that prevents top performers from being financially recognized for their efforts.
- There should be a meaningful difference between the raises received by top performers and average performers, and between average performers and poor performers.

5. **Interdepartmental Communication:** SCFHP has made great strides in communication between departments since the 2012 survey. Even though the current score is somewhat higher than norm, it is an area in need of more improvement.

   As a first step in making further improvements, revisit the plans made after the 2012 survey. This was one of the key items in need of improvement then, and it is conceivable that efforts might need to be revisited, as new employees have been hired in the past five years.

   More generically speaking, communication between departments is a common problem. Ensure that there are not managers who are actively discouraging communication between departments. Make certain that there the incentive system does not discourage communication between departments.

   The frequency, type, content and method of communication necessary will vary by department. This means it is important to solicit input from each department on what interdepartmental communication they would like to see.

   Departments that might need special intention include Enrollment/Support Services/Marketing & Communications and Behavioral Health/Long Term Support Services.

6. **Recognition:** The percentage of employees who agree that SCFHP gives enough recognition for work that is well done increased significantly since the prior survey period, and now is about at norm levels. Further improvement will help to increase employee engagement. Increasing recognition is a relatively low-cost means of improving engagement.

   Recognition can be informal or formal. Both types have a positive influence on employee engagement.

   To boost informal recognition, periodically remind managers of the importance of verbally highlighting positive employee performance.

   Formal recognition programs require a lot of work to make certain that they do not "go stale" or become "gamed" by employees. Still, it can be worthwhile to make the effort to establish a formal program.

7. **Workload:** One way to address heavy workload is to make sure everyone is pulling their own weight, one of the items we have addressed in recommendation number three. If some people are not producing to an acceptable level, others are working harder than they would be otherwise.

Assuming you have addressed accountability, there are other means of improving employee perceptions of workload, beginning with increasing efficiency. Is the proper technology in place? Is the approval process too restrictive? Are some employees being micromanaged?

Lastly, as a business grows, hiring new employees can become inevitable, once everyone is working hard and smart.

8. **Politics:** Minimizing politics is another area where SCFHP has made significant improvements. The 55% who agree with that politics are kept to a minimum slightly exceeds the norm.

   Minimizing politics requires vigilance, because they are so prevalent in the work world. It is worth the effort, however, to keep good workers from being discouraged as they perceive others getting ahead through political expertise rather than their work performance.

   A strong performance appraisal system can help to keep politics at bay. Objectivity and the establishment of measurable goals for promotions (also components of a good performance appraisal system) can help, as can clarity of communication to employees about why specific employees have received promotions.

III. THE FINDINGS IN DETAIL

A. OVERALL SATISFACTION RATINGS

1. Engagement (Enthusiasm)

Engagement, as measured by enthusiasm, had a large statistically significant increase since the 2012 measurement. Almost two thirds of employees feel highly enthusiastic about coming to work and doing their best each day. This slightly exceeds the norm.

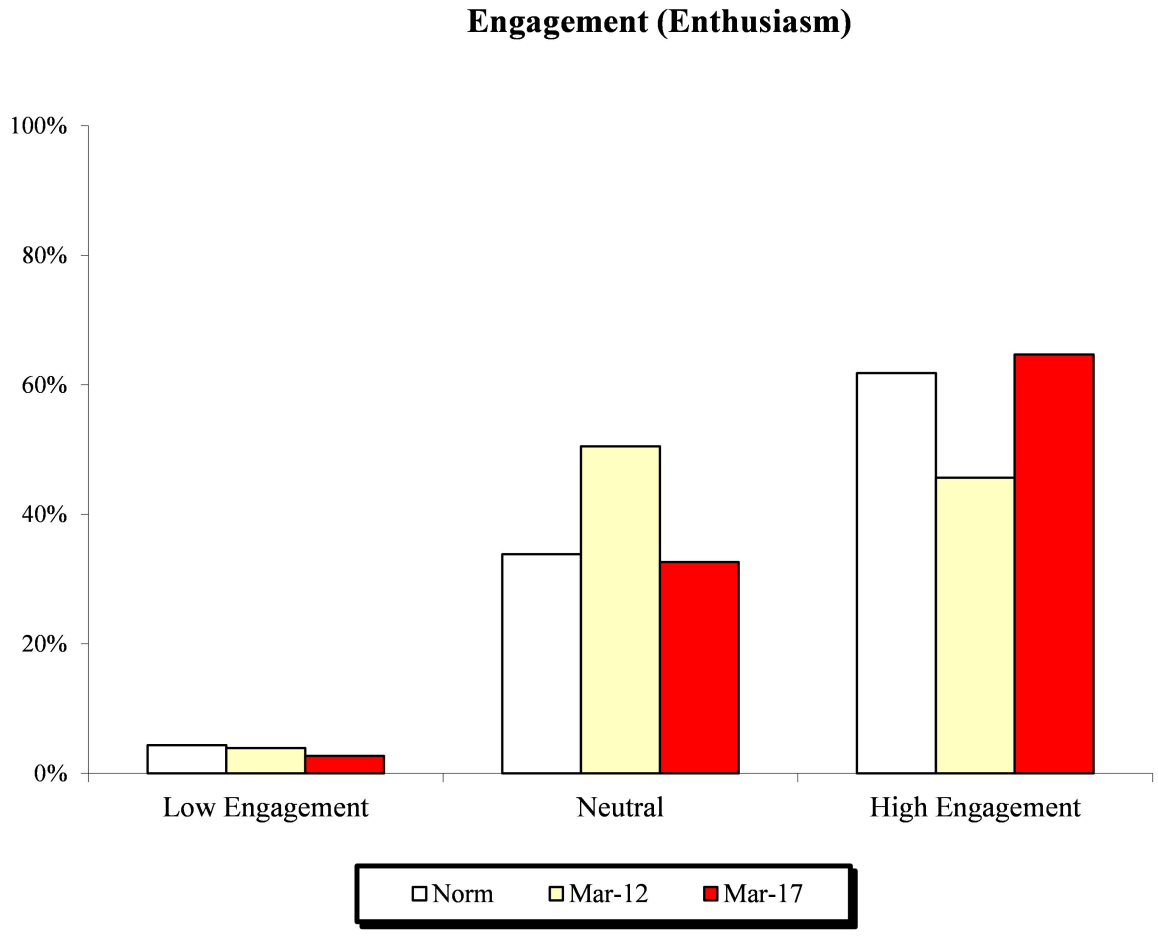


Table 3

Engagement (Enthusiasm)

		SCFHP	
	Norm	Mar-12	Mar-17
High Engagement	**62%**	**46%**	**65%**
7	30%	19%	30%
6	32%	26%	34%
Neutral	**34%**	**50%**	**33%**
5	20%	25%	22%
4	10%	16%	7%
3	4%	10%	3%
Low Engagement	**4%**	**4%**	**3%**
2	3%	3%	2%
1	2%	1%	1%
Base		103	187

[ ] = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

2. Overall Satisfaction

The percentage of highly satisfied employees increased five percentage points to 53%, and now is slightly below norm.

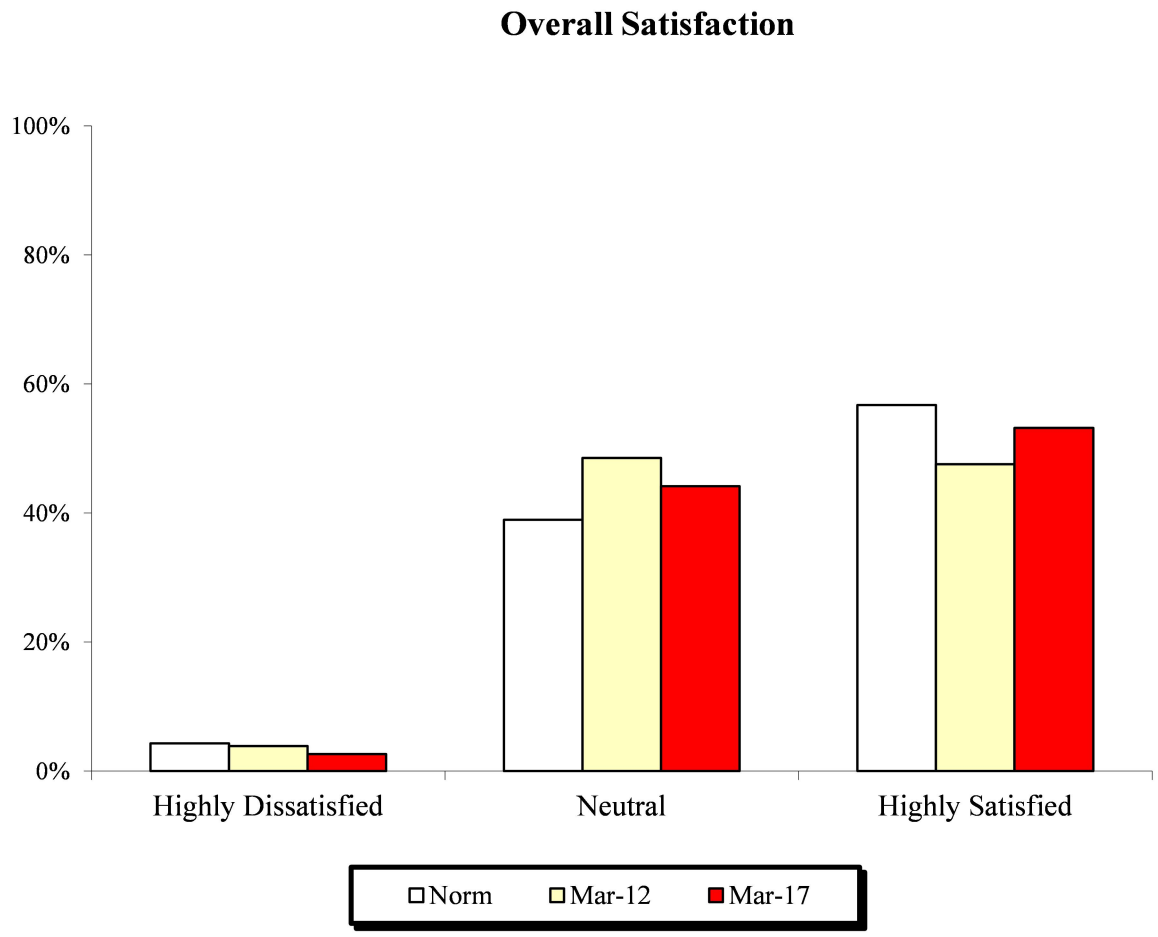


Table 4

Overall Satisfaction

		SCFHP	
	Norm	Mar-12	Mar-17
Highly Satisfied	**57%**	**48%**	**53%**
7	25%	19%	27%
6	32%	28%	26%
Neutral	**39%**	**49%**	**44%**
5	23%	28%	29%
4	11%	13%	12%
3	5%	8%	3%
Highly Dissatisfied	**4%**	**4%**	**3%**
2	3%	2%	2%
1	1%	2%	1%
Base		103	188

= Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

3. Willingness to Recommend SCFHP to a Friend

Slightly more than three-fourths of employees say they would be willing to recommend SCFHP to a friend, a significant increase of 13 percentage points. This is slightly higher than norm.

Willingness to Recommend SCFHP to a Friend Seeking Employment

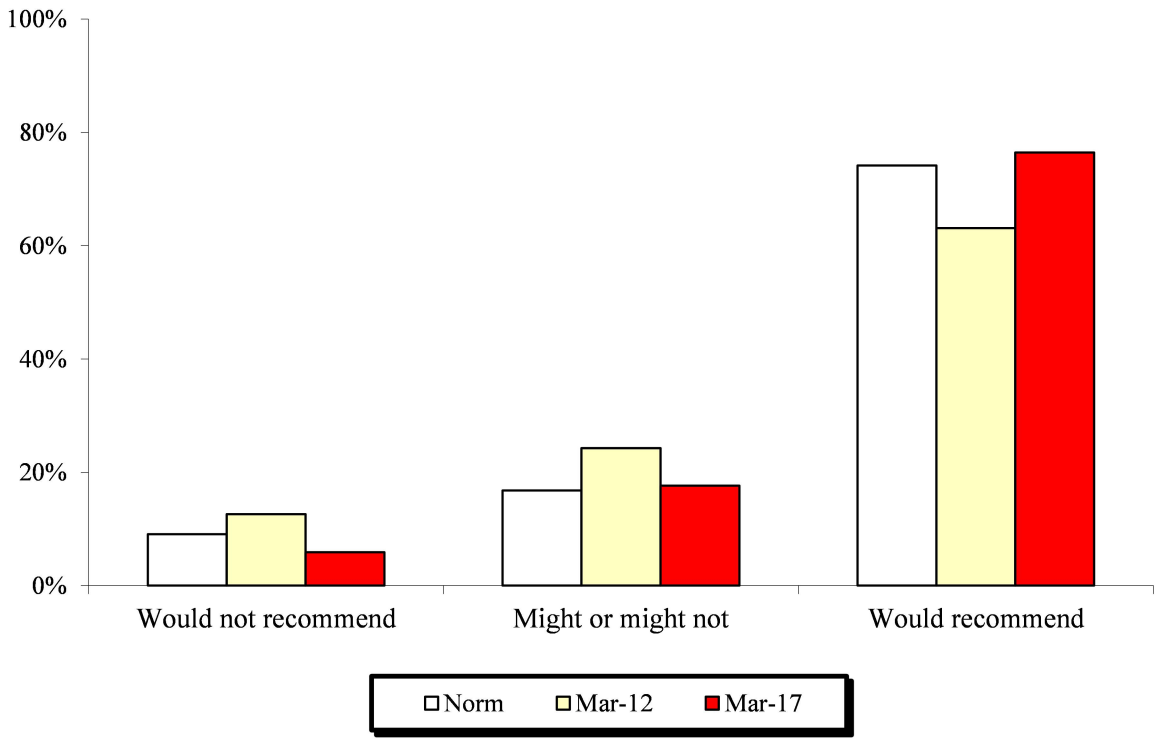


Table 5

Willingness to Recommend SCFHP to a Friend Seeking Employment

	Norm	SCFHP Mar-12	SCFHP Mar-17
Would Recommend SCFHP	**74%**	**63%**	**76%**
Definitely would	47%	37%	44%
Probably would	27%	26%	32%
Might or might not	**17%**	**24%**	**18%**
Would not Recommend SCFHP	**9%**	**13%**	**6%**
Probably not	6%	12%	5%
Definitely not	3%	1%	1%
Base		103	187

[ ] = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

B. OTHER RATINGS

1. Leadership and Planning

Employees hold SCFHP Leadership and Planning in high regard. Five of the six scores increased significantly. The largest increase was the percentage agreeing that Leadership respects the employees, now 82%, up from 56% in 2012.

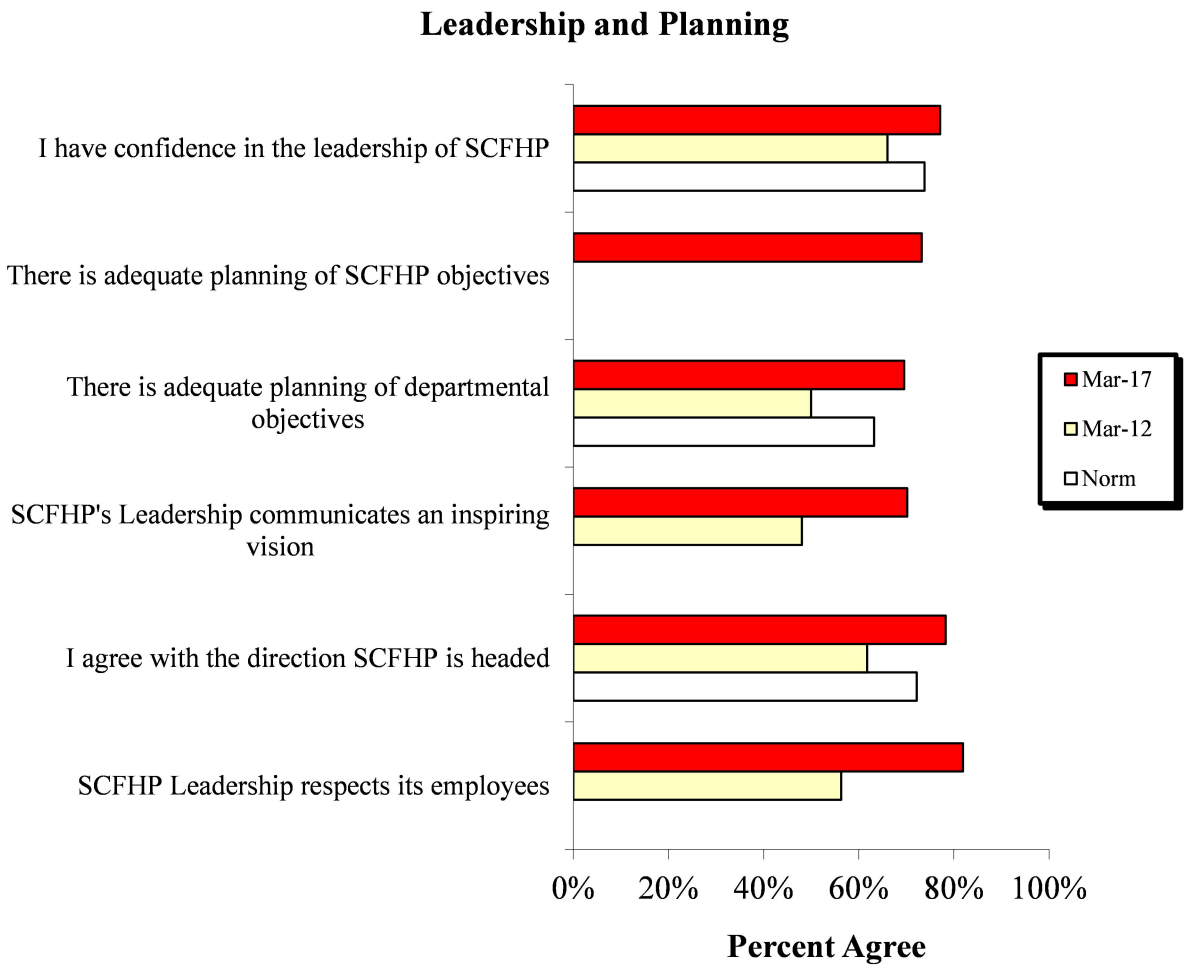


Table 6

Leadership and Planning

	Norm	SCFHP Mar-12	SCFHP Mar-17
I have confidence in the leadership of SCFHP	74%	66%	77%
There is adequate planning of SCFHP objectives	NA	NA	73%
There is adequate planning of departmental objectives	63%	50%	70%
SCFHP's Leadership communicates an inspiring vision	NA	48%	70%
I agree with the direction SCFHP is headed	72%	62%	78%
SCFHP Leadership respects its employees	NA	56%	82%
Base		0 - 103	184 - 188

[ ] = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

2. The Executive Team

All scores on the six Executive Team items previously measured increased, and four of the six increased significantly. Seven of ten employees agreed that the Executive Team listens to employees (a new item this year); that's ten percentage points above norm.

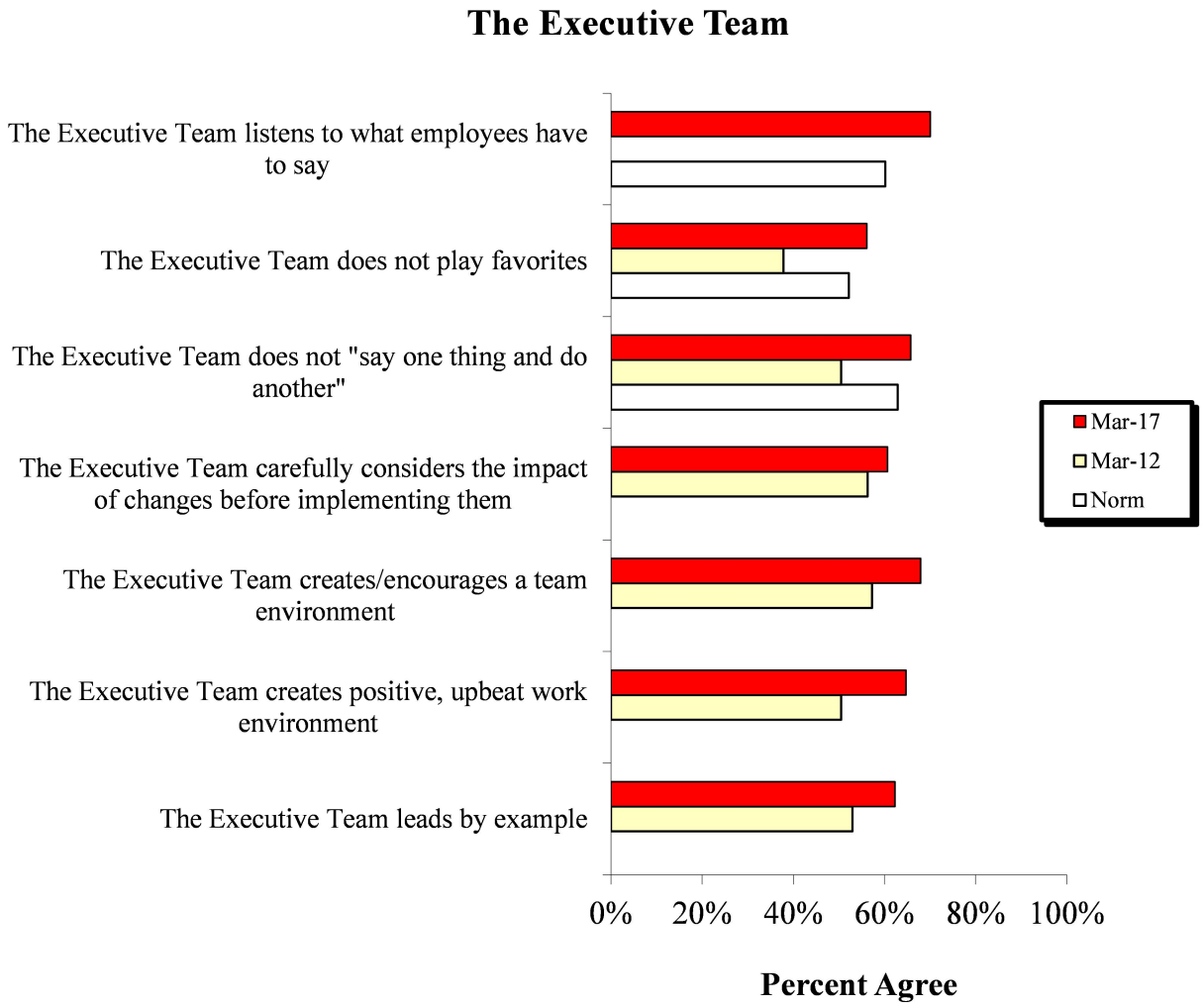


Table 7

The Executive Team

	Norm	SCFHP Mar-12	SCFHP Mar-17
The Executive Team listens to what employees have to say	60%	NA	70%
The Executive Team does not play favorites	52%	38%	56%
The Executive Team does not "say one thing and do another"	63%	50%	66%
The Executive Team carefully considers the impact of changes before implementing them	NA	56%	61%
The Executive Team creates/encourages a team environment	NA	57%	68%
The Executive Team creates positive, upbeat work environment	NA	50%	65%
The Executive Team leads by example	NA	53%	62%
Base		0 - 103	183 - 188

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

3. Department Leadership

This is a new section this year. Agreement with the Department Leadership items ranges from 66% to 76%. Department Leadership scores are higher than Executive Team scores on comparable items.

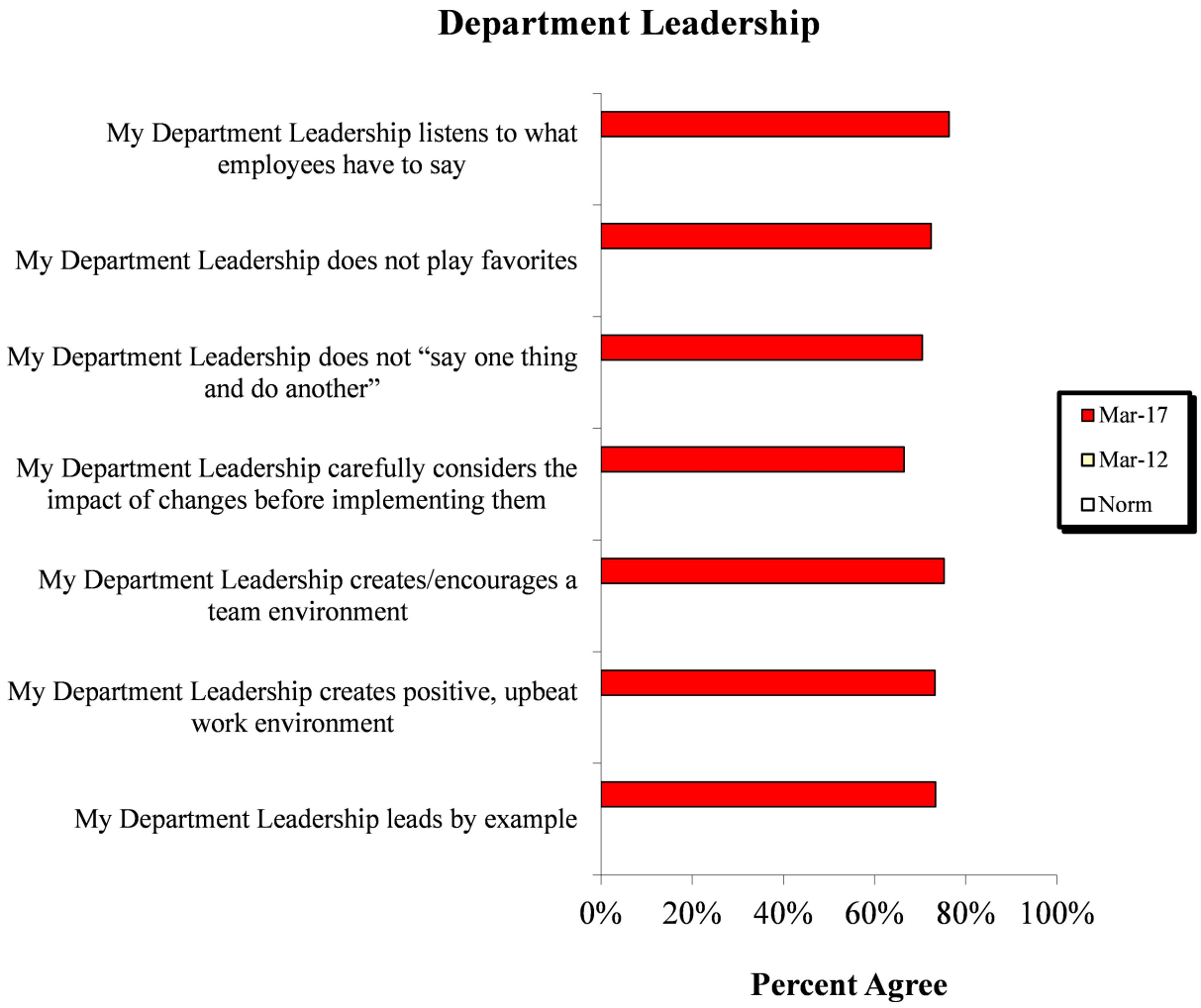


Table 8

Department Leadership

	Norm	SCFHP	
		Mar-12	Mar-17
My Department Leadership listens to what employees have to say	NA	NA	76%
My Department Leadership does not play favorites	NA	NA	72%
My Department Leadership does not "say one thing and do another"	NA	NA	70%
My Department Leadership carefully considers the impact of changes before implementing them	NA	NA	66%
My Department Leadership creates/encourages a team environment	NA	NA	75%
My Department Leadership creates positive, upbeat work environment	NA	NA	73%
My Department Leadership leads by example	NA	NA	73%
Base		0 - 0	183 - 186

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

4. Immediate Supervisor

All five supervisor items measured in both years increased, and four increased significantly. The largest increase (+21 percentage points) was on agreement that supervisors tell employees when they do their work well. Supervisors treating employees fairly and with respect are key strengths.

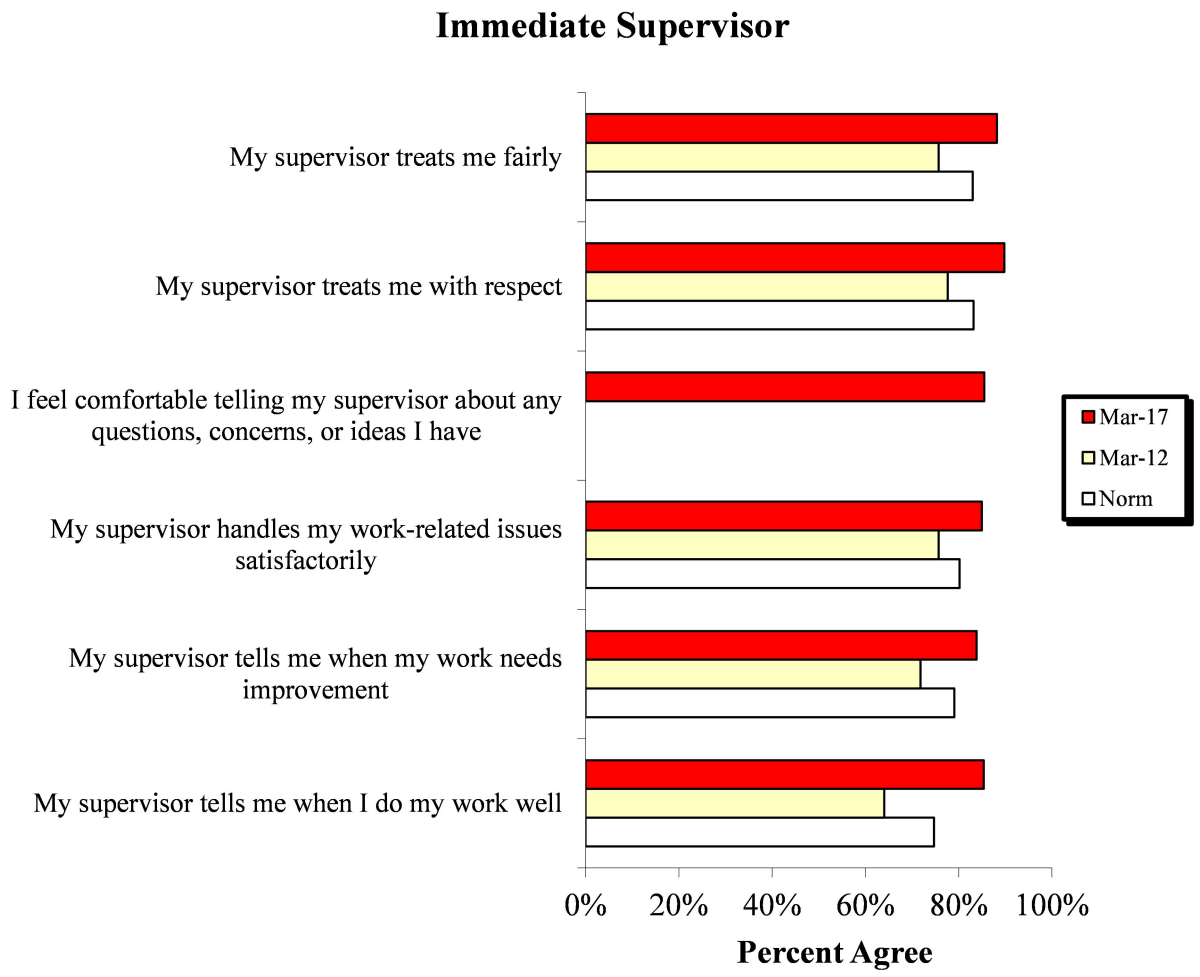


Table 9

Immediate Supervisor

	Norm	SCFHP Mar-12	SCFHP Mar-17	
My supervisor treats me fairly	83%	76%	88%	
My supervisor treats me with respect	83%	78%	90%	*
I feel comfortable telling my supervisor about any questions, concerns, or ideas I have	NA	NA	85%	
My supervisor handles my work-related issues satisfactorily	80%	76%	85%	
My supervisor tells me when my work needs improvement	79%	72%	84%	
My supervisor tells me when I do my work well	75%	64%	85%	*
Base		0 - 103	185 - 187	

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in blue are key strengths.

5. SCFHP Culture

We measured four of the Culture items in both years. SCFHP's scores increased significantly on three of the four (enjoyable place to work, individual initiative encouraged, people are held accountable). Agreement with "quality is a top priority" slipped slightly. Despite the improvement in the accountability score, it is a key item in need of improvement.

About three of four employees agree that employees treat each other with respect and that morale is good; new items measured this year.

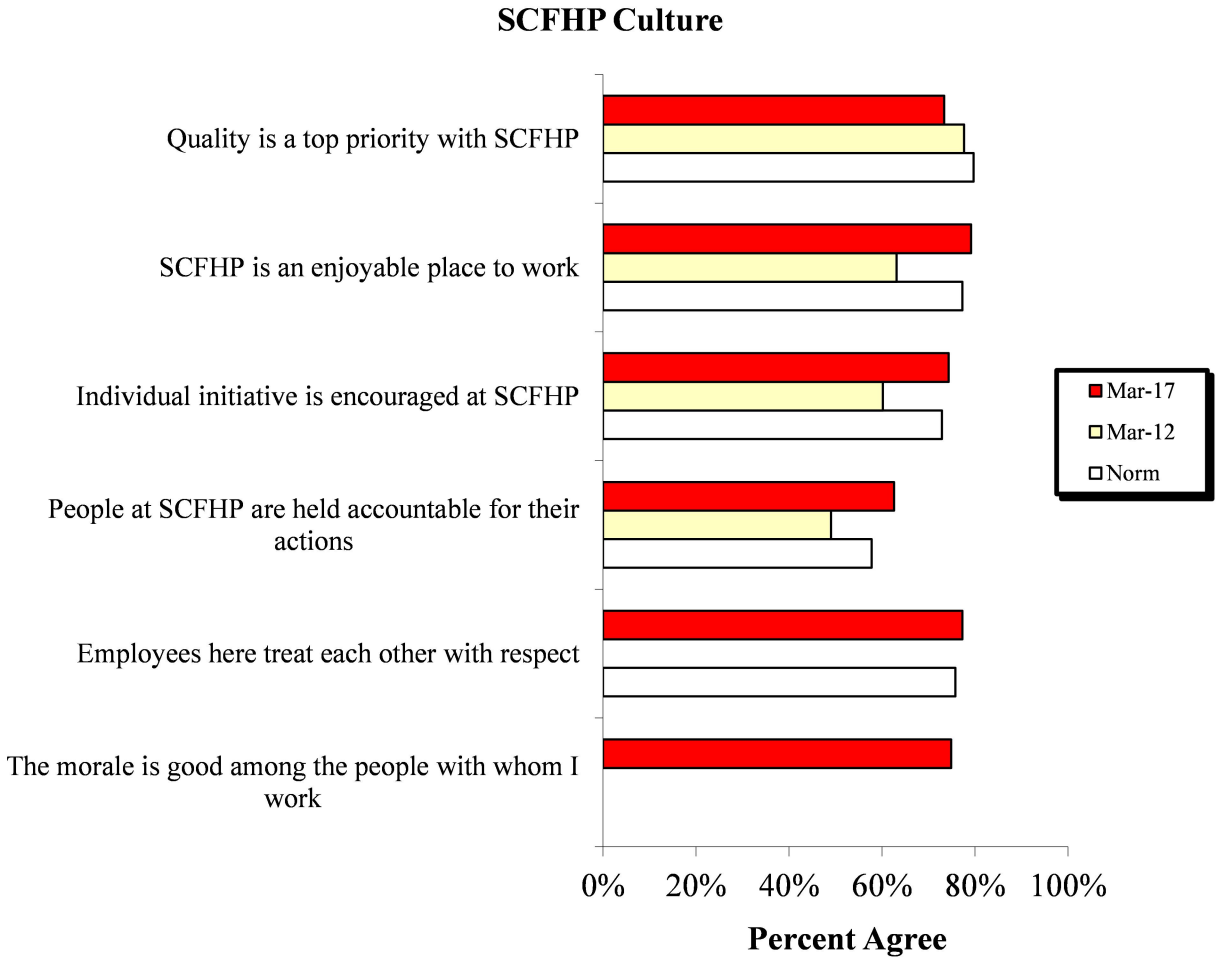


Table 10

SCFHP Culture

	Norm	SCFHP Mar-12	SCFHP Mar-17
Quality is a top priority with SCFHP	80%	78%	73%
SCFHP is an enjoyable place to work	77%	63%	79%
Individual initiative is encouraged at SCFHP	73%	60%	74%
People at SCFHP are held accountable for their actions	58%	49%	63%
Employees here treat each other with respect	76%	NA	77%
The morale is good among the people with whom I work	NA	NA	75%
Base		0 - 103	185 - 188

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in red are key items in need of improvement,

6. Company Communications

All communication scores increased, and four of the six increases were significant. The understanding employees have of how their work contributes to SCFHP's success is a key strength; communication between departments is a key item in need of improvement.

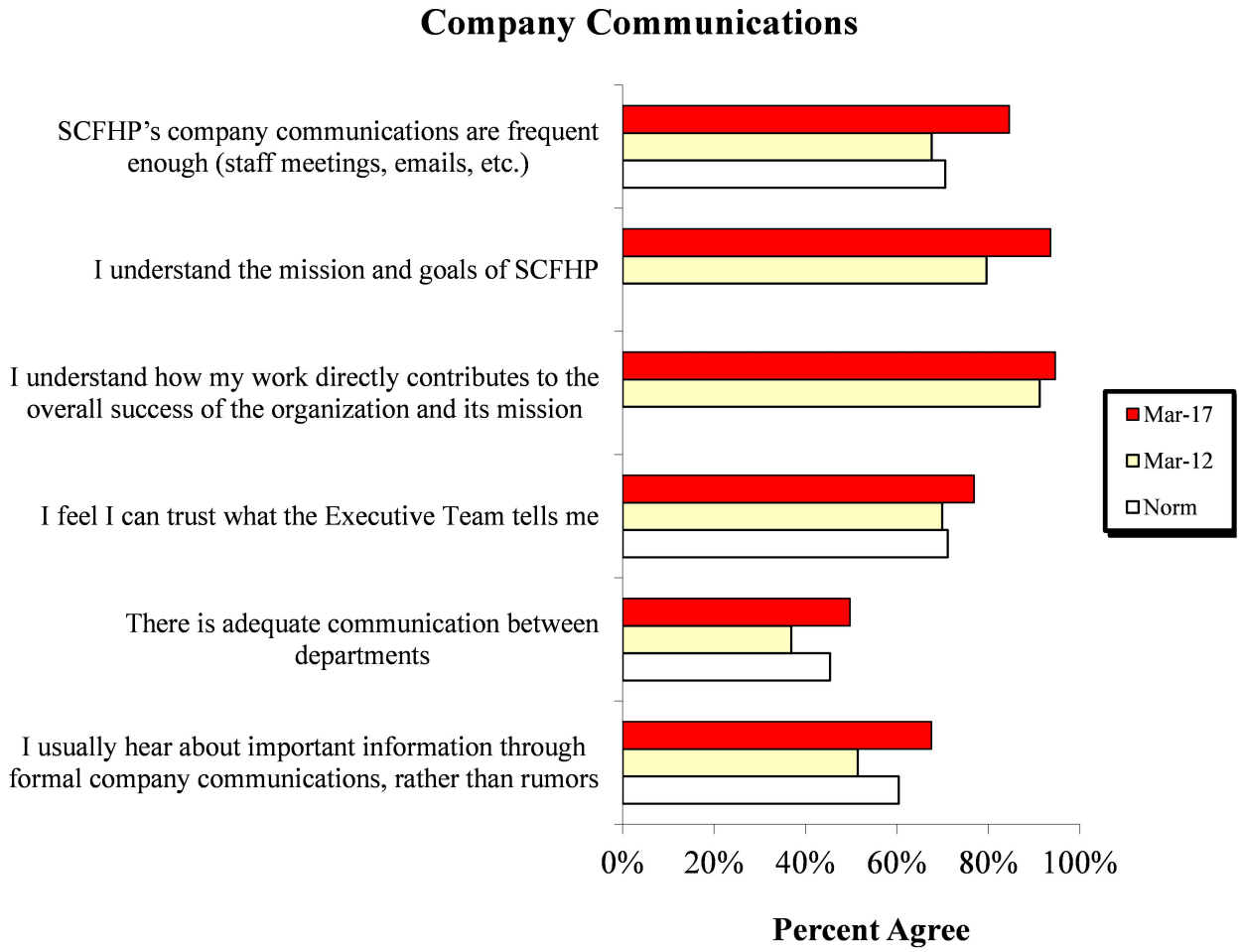


Table 11

Company Communications

	Norm	SCFHP Mar-12	SCFHP Mar-17	
SCFHP's company communications are frequent enough (staff meetings, emails, etc.)	71%	68%	85%	*
I understand the mission and goals of SCFHP	NA	80%	94%	
I understand how my work directly contributes to the overall success of the organization and its mission	NA	91%	95%	
I feel I can trust what the Executive Team tells me	71%	70%	77%	
There is adequate communication between departments	45%	37%	50%	
I usually hear about important information through formal company communications, rather than rumors	60%	51%	68%	
Base		102 - 103	183 - 188	

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in blue are key strengths.

Items in red are key items in need of improvement,

7. Department Communications

The Department Communications section is new this year. Agreement levels range from 70% to 81%.

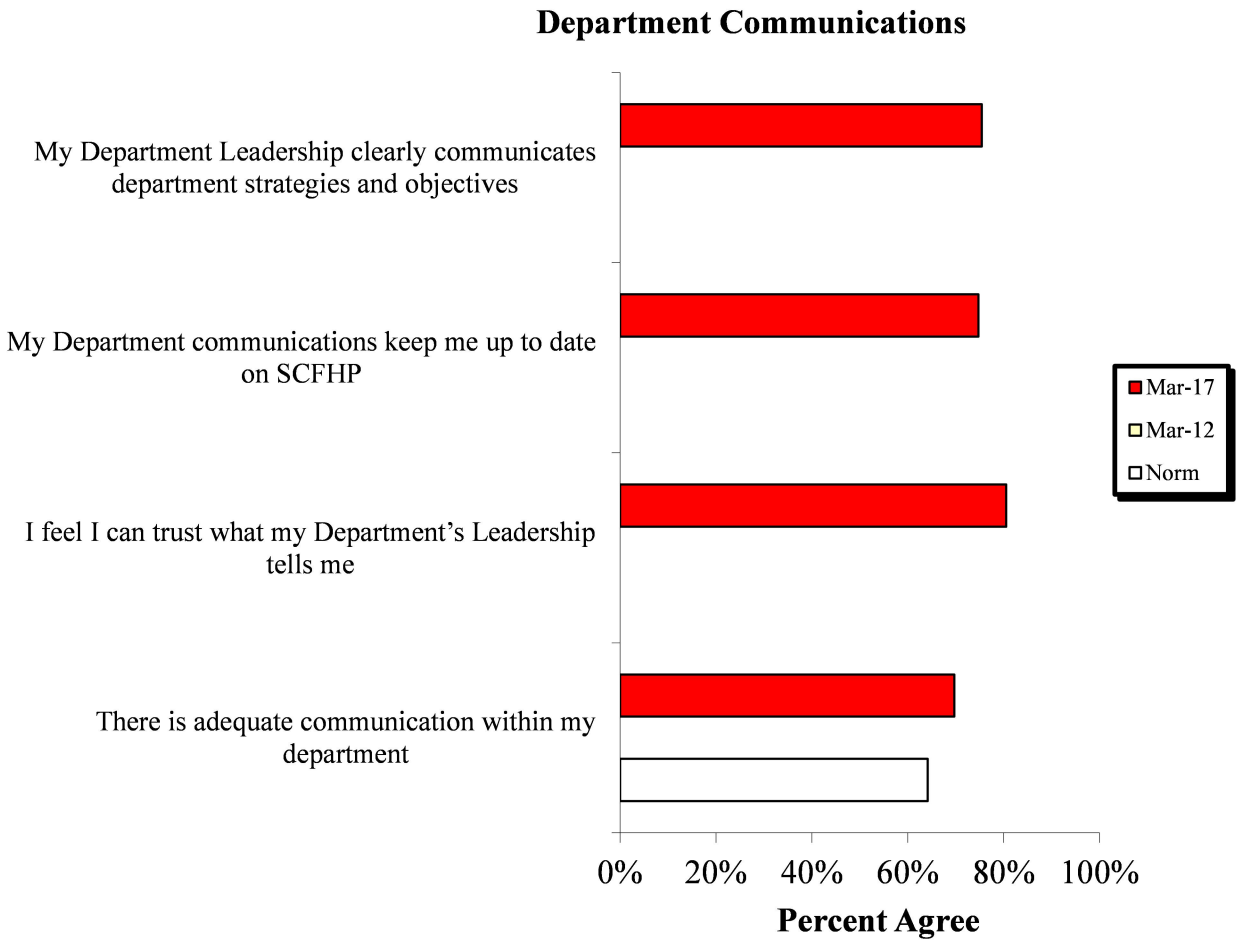


Table 12

Department Communications

	Norm	SCFHP	
		Mar-12	Mar-17
My Department Leadership clearly communicates department strategies and objectives	NA	NA	75%
My Department communications keep me up to date on SCFHP	NA	NA	75%
I feel I can trust what my Department's Leadership tells me	NA	NA	81%
There is adequate communication within my department	64%	NA	70%
Base		0 - 0	185 - 187

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

8. Career Development

All career development items improved, and four of the six improved significantly. Scores now are about at norm levels, with one exception; the rating of "performance appraisal system fairness," (54% agreement) is significantly below norm and is a key item in need of improvement.

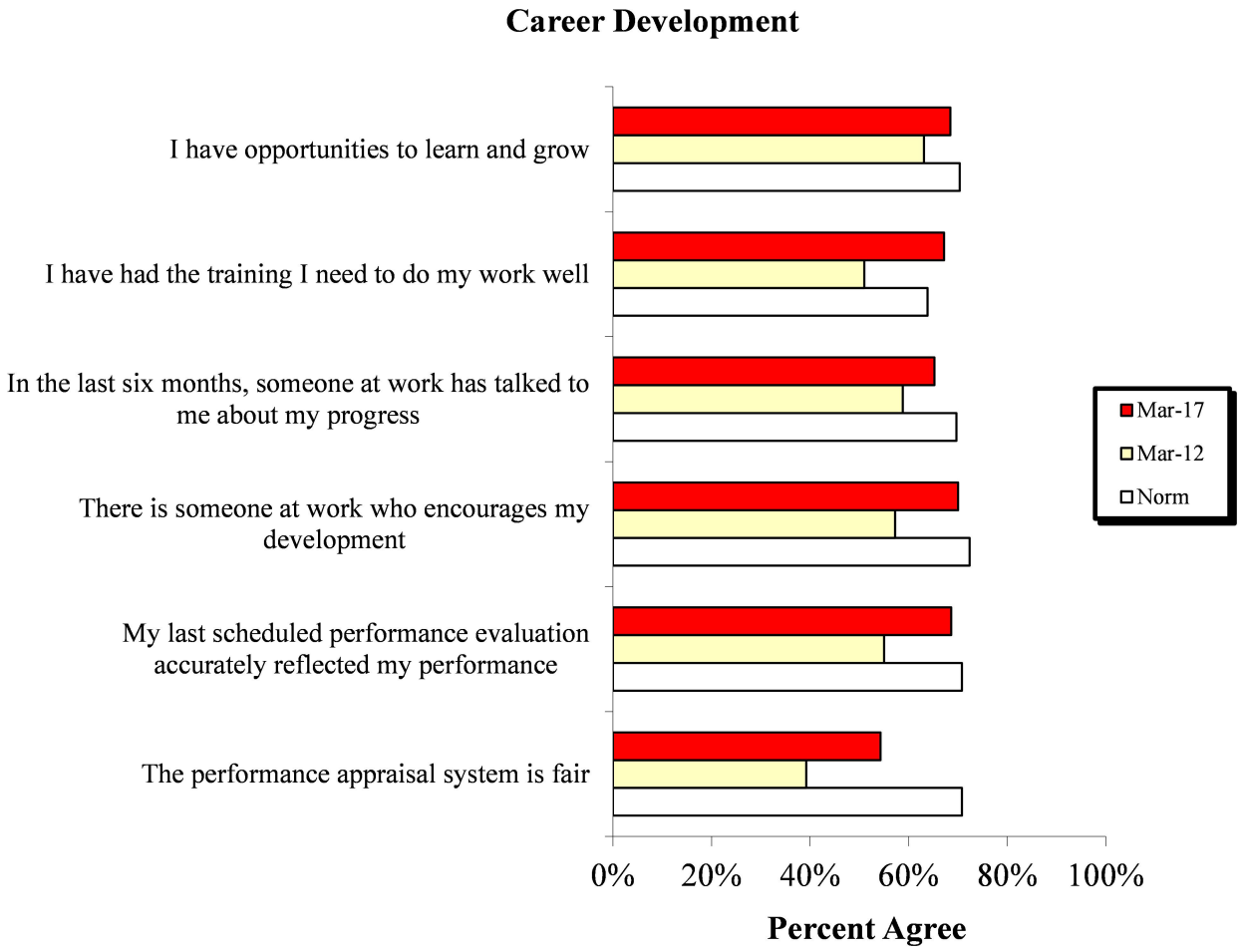


Table 13

Career Development

	Norm	SCFHP Mar-12	SCFHP Mar-17
I have opportunities to learn and grow	70%	63%	68%
I have had the training I need to do my work well	64%	51%	67%
In the last six months, someone at work has talked to me about my progress	70%	59%	65%
There is someone at work who encourages my development	72%	57%	70%
My last scheduled performance evaluation accurately reflected my performance	71%	55%	69%
The performance appraisal system is fair	71%	39%	54% *
Base		100 - 103	185 - 187

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in red are key items in need of improvement,

9. Employee's Role

At least nine of ten employees understand what is expected of them and how their work supports objectives. Eighty-one percent of employees have the materials and equipment they need, a significant improvement from the prior measurement. Authority for decision making and employees' work giving them a sense of personal accomplishment are about at norm levels. Four of the six items in this section are key strengths.

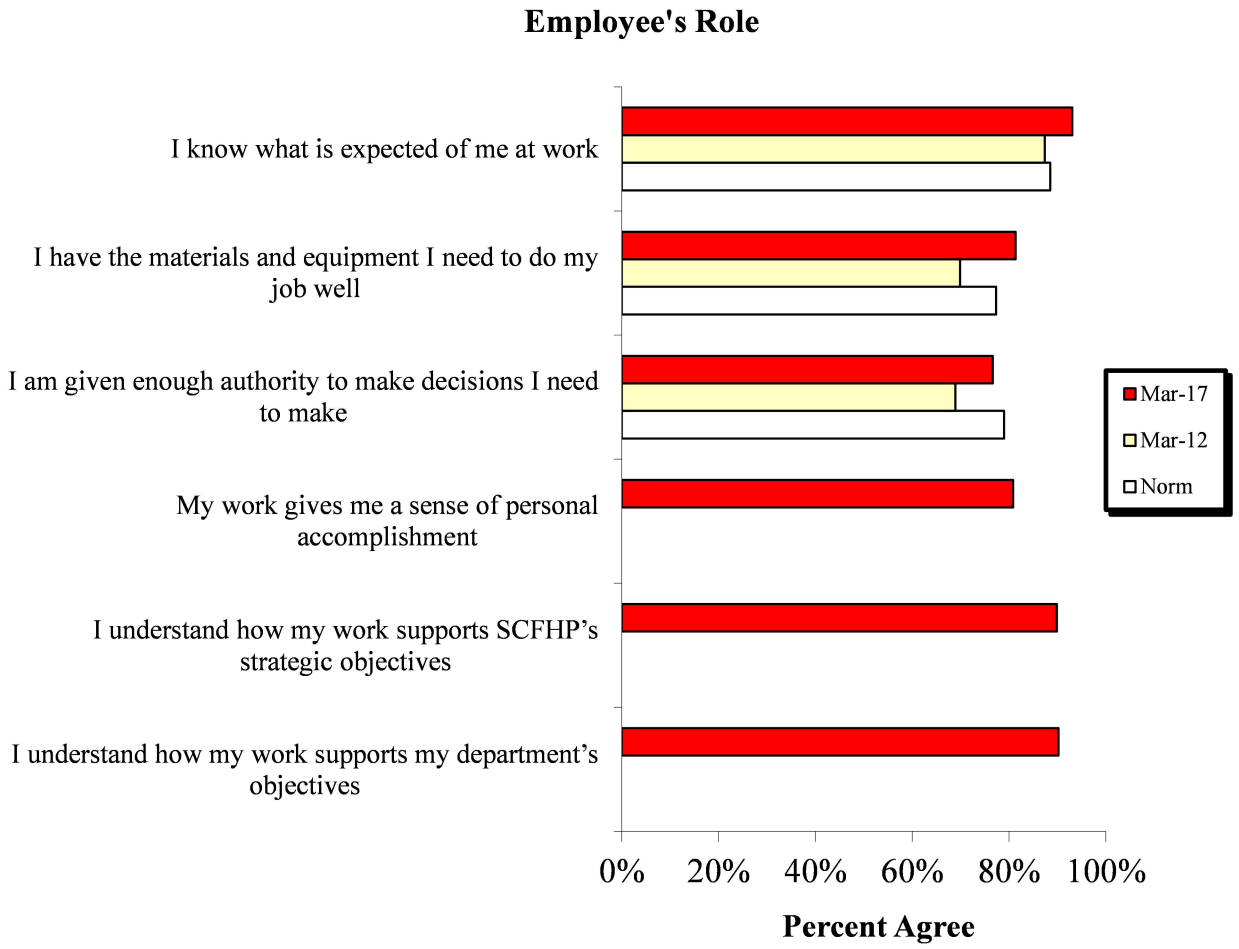


Table 14

Employee's Role

	Norm	SCFHP Mar-12	SCFHP Mar-17
I know what is expected of me at work	89%	87%	93%
I have the materials and equipment I need to do my job well	77%	70%	81%
I am given enough authority to make decisions I need to make	79%	69%	77%
My work gives me a sense of personal accomplishment	85%	NA	81%
I understand how my work supports SCFHP's strategic objectives	NA	NA	90%
I understand how my work supports my department's objectives	NA	NA	90%
Base		0 - 103	184 - 188

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in blue are key strengths.

10. Recognition and Rewards

This is an area where there has been much improvement, yet more progress is needed. There were significant increases in the percentage of employees who feel valued and that SCFHP gives enough recognition for good work. However, both ratings are slightly below norm.

Perceptions of salary fairness are almost unchanged from 2012. The current rating is a statistically significant ten percentage points below norm.

Recognition and salary fairness are key items in need of improvement.

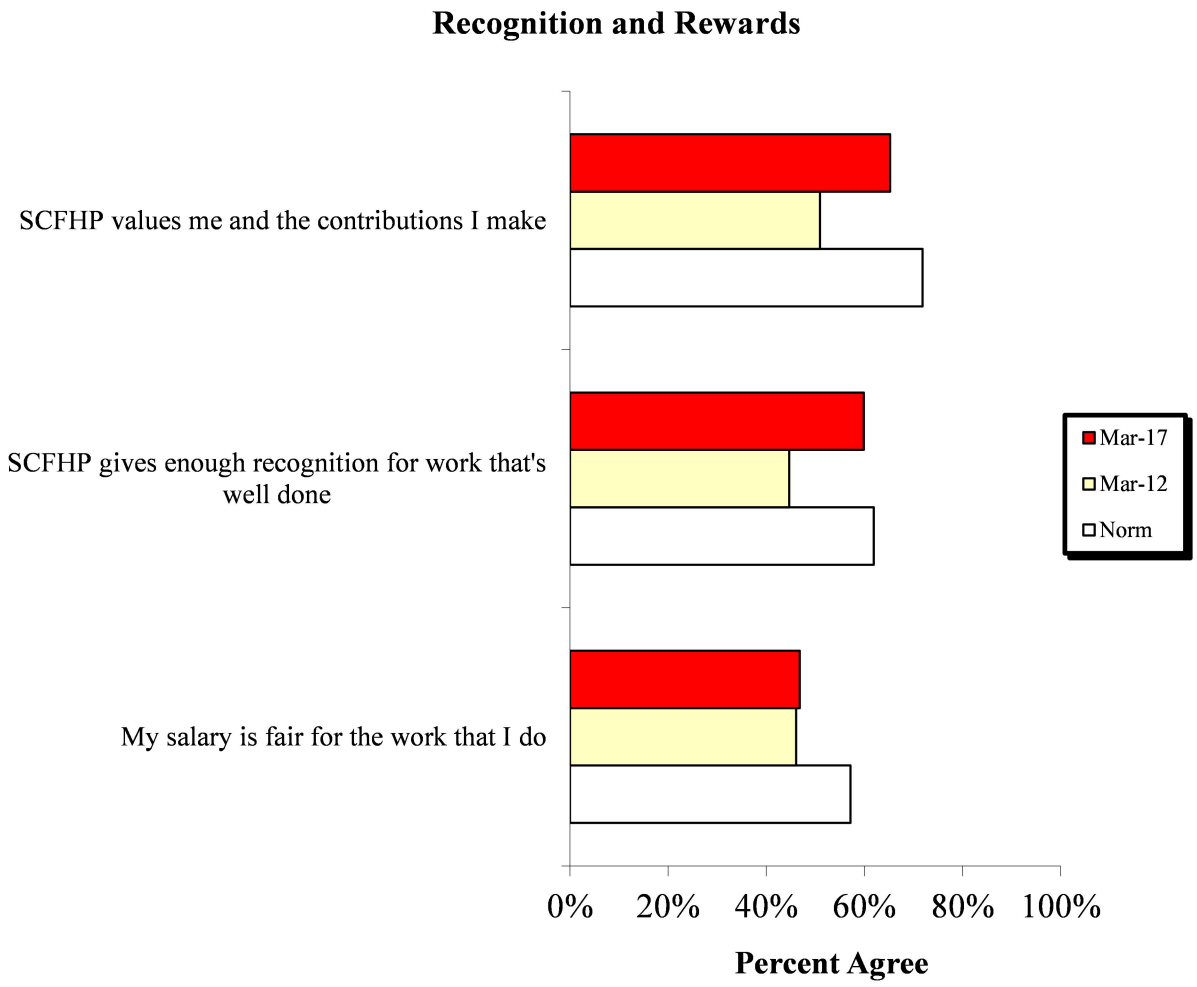


Table 15

Recognition and Rewards

	Norm	SCFHP Mar-12	SCFHP Mar-17
SCFHP values me and the contributions I make	72%	51%	65%
SCFHP gives enough recognition for work that's well done	62%	45%	60%
My salary is fair for the work that I do	57%	46%	47% *
Base		102 - 103	187 - 188

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in red are key items in need of improvement,

11. Teamwork and Cooperation

Teamwork and cooperation scores are at about norm levels on the three items for which we have norms. Perceptions that politics are kept to a minimum and everyone "pulls their own weight" improved significantly, but both are key items in need of improvement.

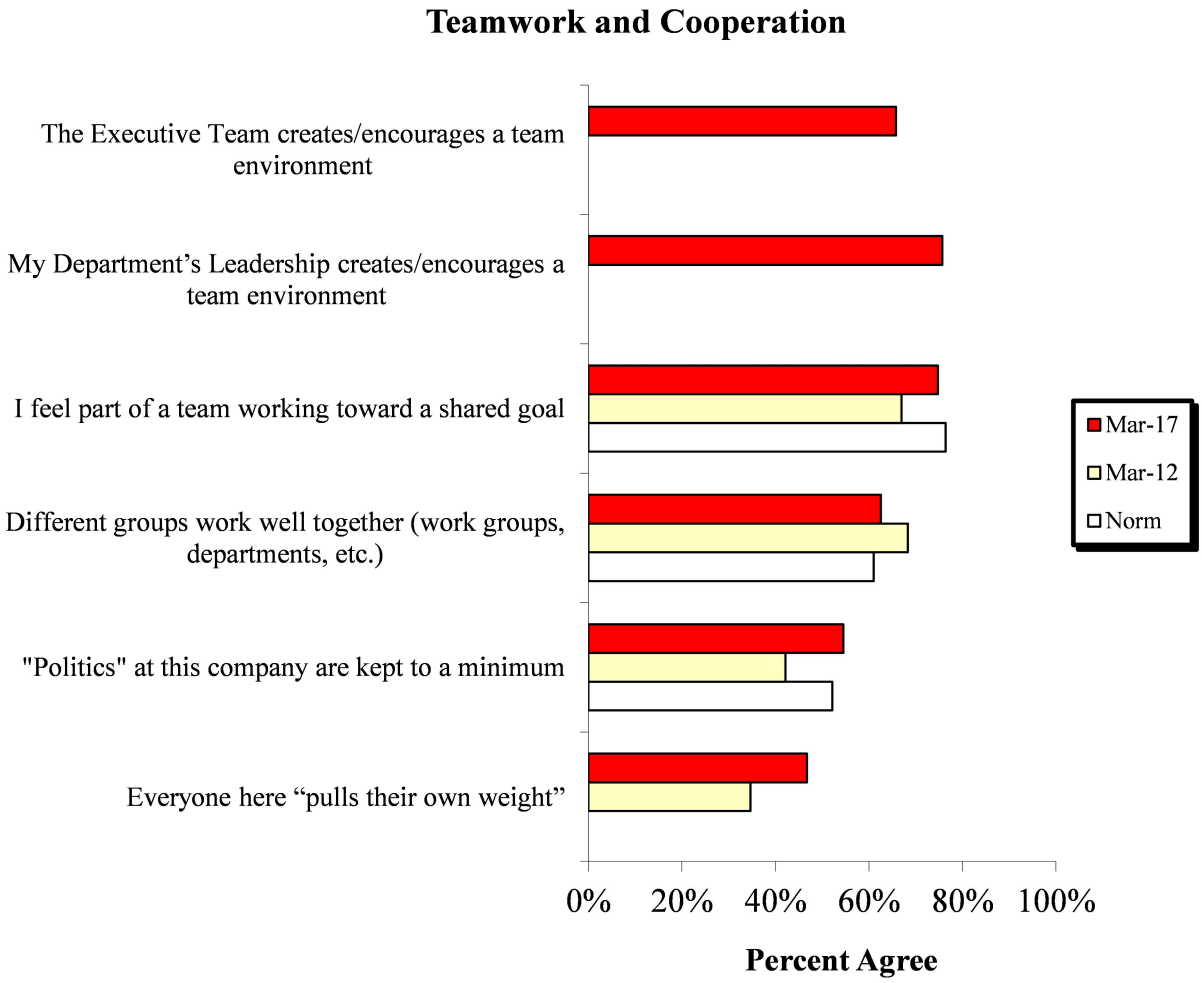


Table 16

Teamwork and Cooperation

	Norm	SCFHP Mar-12	SCFHP Mar-17
The Executive Team creates/encourages a team environment	NA	NA	66%
My Department's Leadership creates/encourages a team environment	NA	NA	76%
I feel part of a team working toward a shared goal	76%	67%	75%
Different groups work well together (work groups, departments, etc.)	61%	68%	63%
"Politics" at this company are kept to a minimum	52%	42%	55%
Everyone here "pulls their own weight"	NA	35%	47%
Base		0 - 103	184 - 187

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in red are key items in need of improvement,

11. Working Conditions

Perceptions of job security improved significantly and now are at norm levels. Changes in the other items were small. SCFHP is not significantly different from norm on any item, but is several percentage points lower on realistic deadlines and reasonable workload. “Reasonable workload” is a key item in need of improvement.

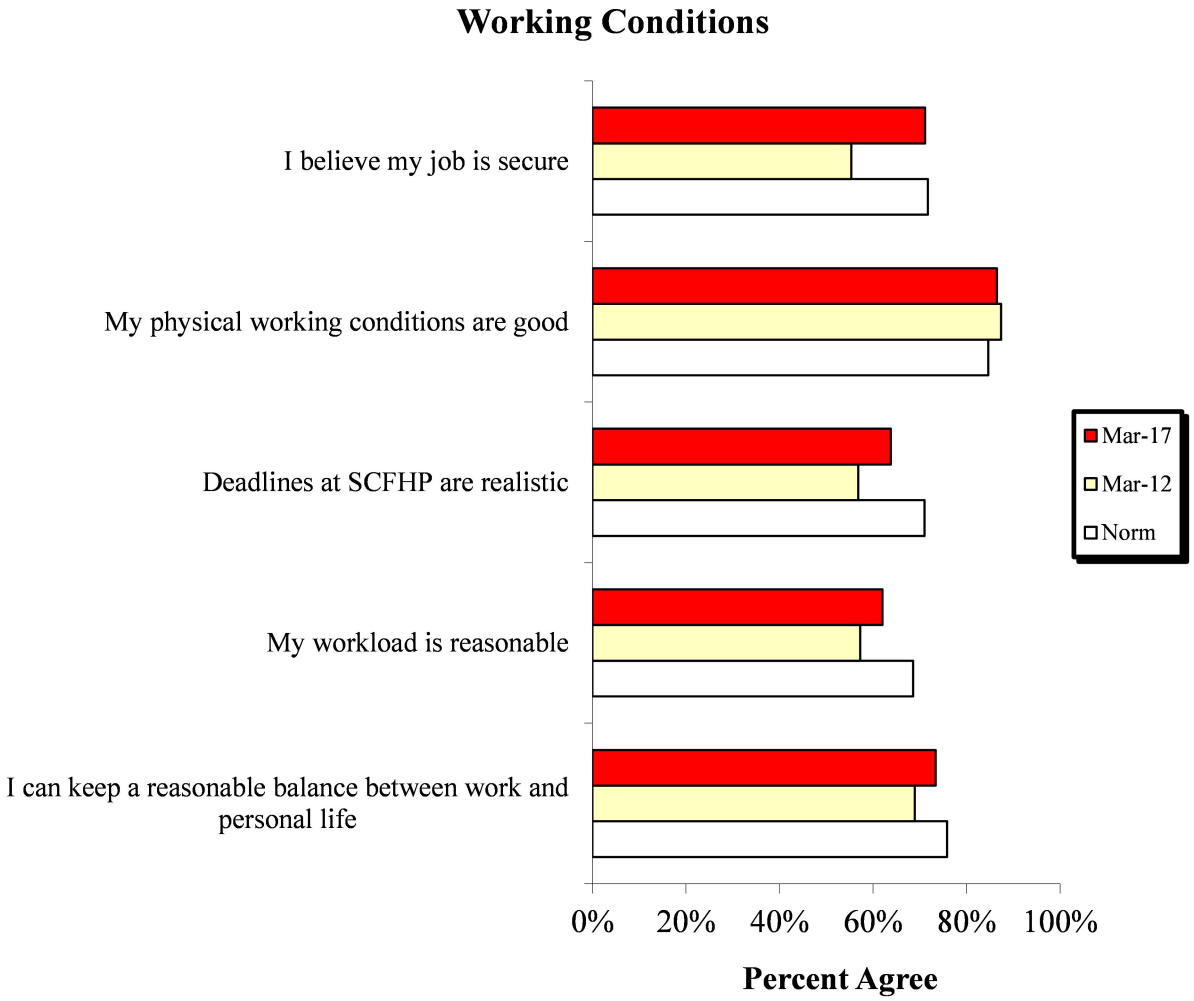


Table 17

Working Conditions

	Norm	SCFHP Mar-12	SCFHP Mar-17
I believe my job is secure	72%	55%	71%
My physical working conditions are good	85%	87%	86%
Deadlines at SCFHP are realistic	71%	57%	64%
My workload is reasonable	69%	57%	62%
I can keep a reasonable balance between work and personal life	76%	69%	73%
Base		102 - 103	185 - 188

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in red are key items in need of improvement,

11. Ethics

At least 75% of employees agree with each ethics statement. Never feeling pressure to violate ethics or values is a key strength.

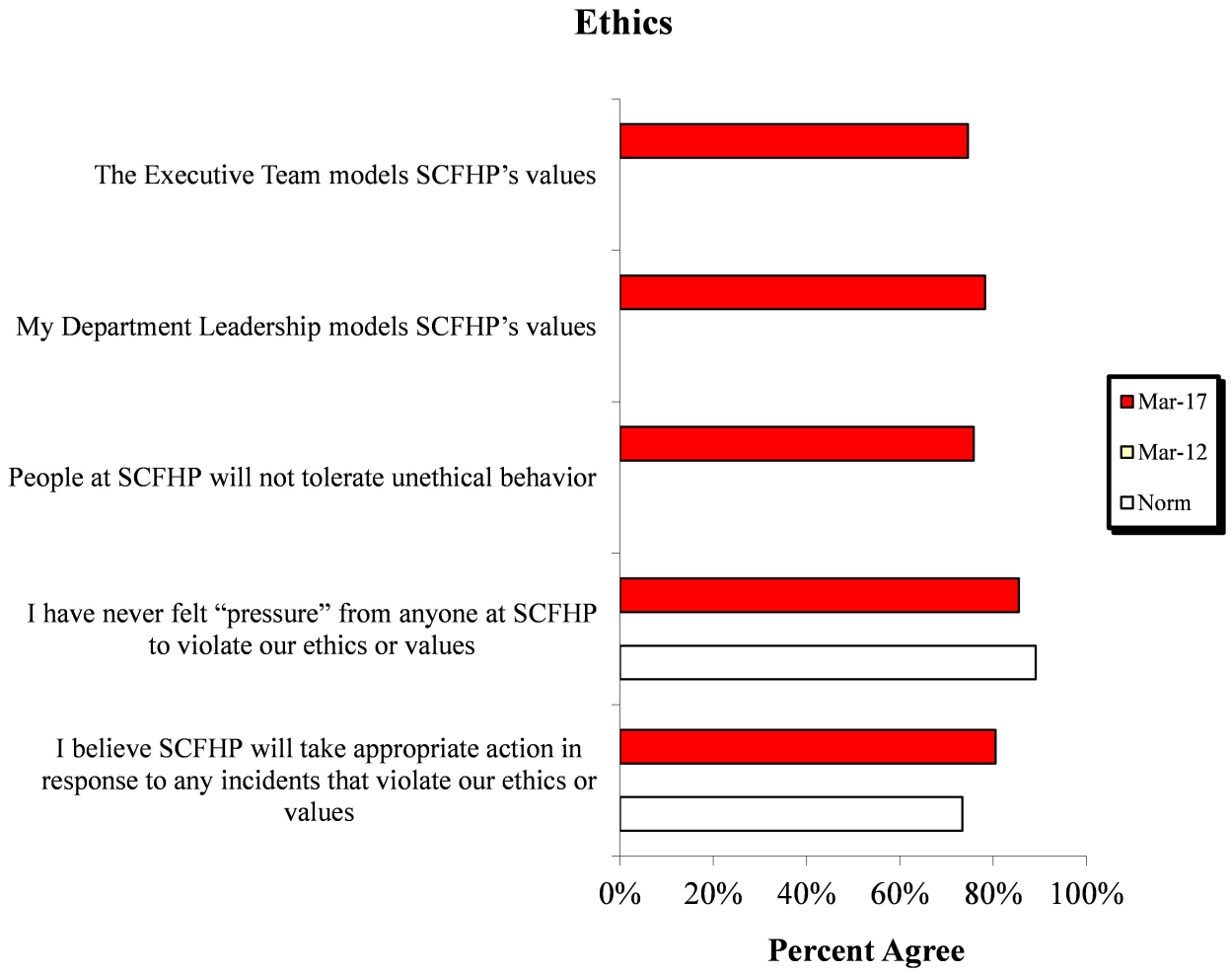


Table 18

Ethics

	Norm	SCFHP	
		Mar-12	Mar-17
The Executive Team models SCFHP's values	NA	NA	75%
My Department Leadership models SCFHP's values	NA	NA	78%
People at SCFHP will not tolerate unethical behavior	NA	NA	76%
I have never felt "pressure" from anyone at SCFHP to violate our ethics or values	89%	NA	85%
I believe SCFHP will take appropriate action in response to any incidents that violate our ethics or values	73%	NA	81%
Base		0 - 0	184 - 186

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

Items in blue are key strengths.

11. Benefits

Overall satisfaction with benefits and understanding of the benefits package is about the same as in 2012; both measures are higher than norm.

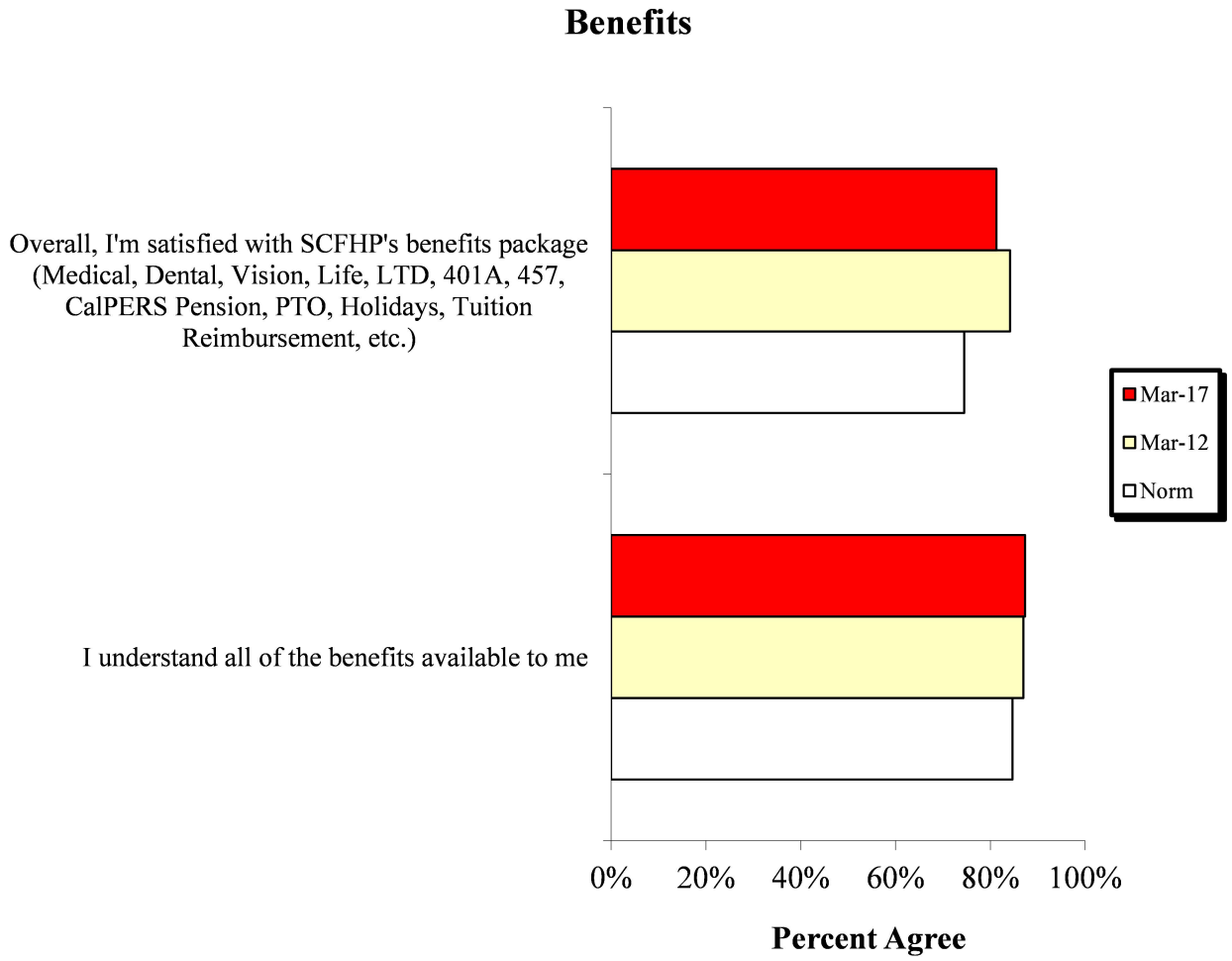


Table 19

Benefits

	Norm	SCFHP Mar-12	SCFHP Mar-17
Overall, I'm satisfied with SCFHP's benefits package (Medical, Dental, Vision, Life, LTD, 401A, 457, CalPERS Pension, PTO, Holidays, Tuition Reimbursement, etc.)	74%	84%	81%
I understand all of the benefits available to me	85%	87%	87%
Base		100 - 101	174 - 187

☐ = Mar-17 significantly different from Mar-12

* = Mar-17 significantly different from Norm

C. DIAGNOSTIC MEASURE: LEVERAGE ANALYSIS

1. Leverage Analysis

In the preceding sections we have reviewed employee ratings in various areas. That review shows where you stand in employee satisfaction in each separate area, but it does not show which ones should be the focus of attention.

Leverage analysis provides a way of selecting areas to focus on, by calculating each area's leverage on a "bottom line" measure — overall satisfaction. The high priority targets identified by leverage analysis are those areas that meet two criteria:

1. They need improvement, and
2. Their improvement will strongly leverage the bottom line — overall satisfaction.

Interpretation of a leverage analysis table

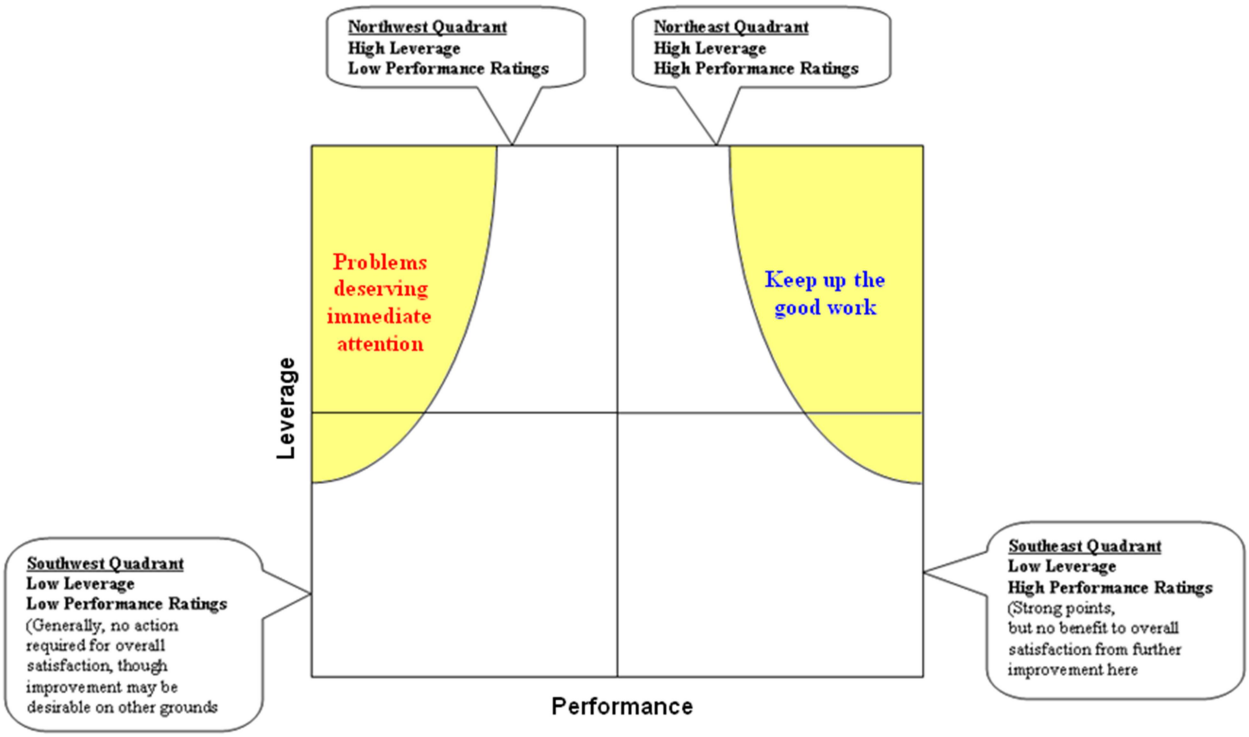
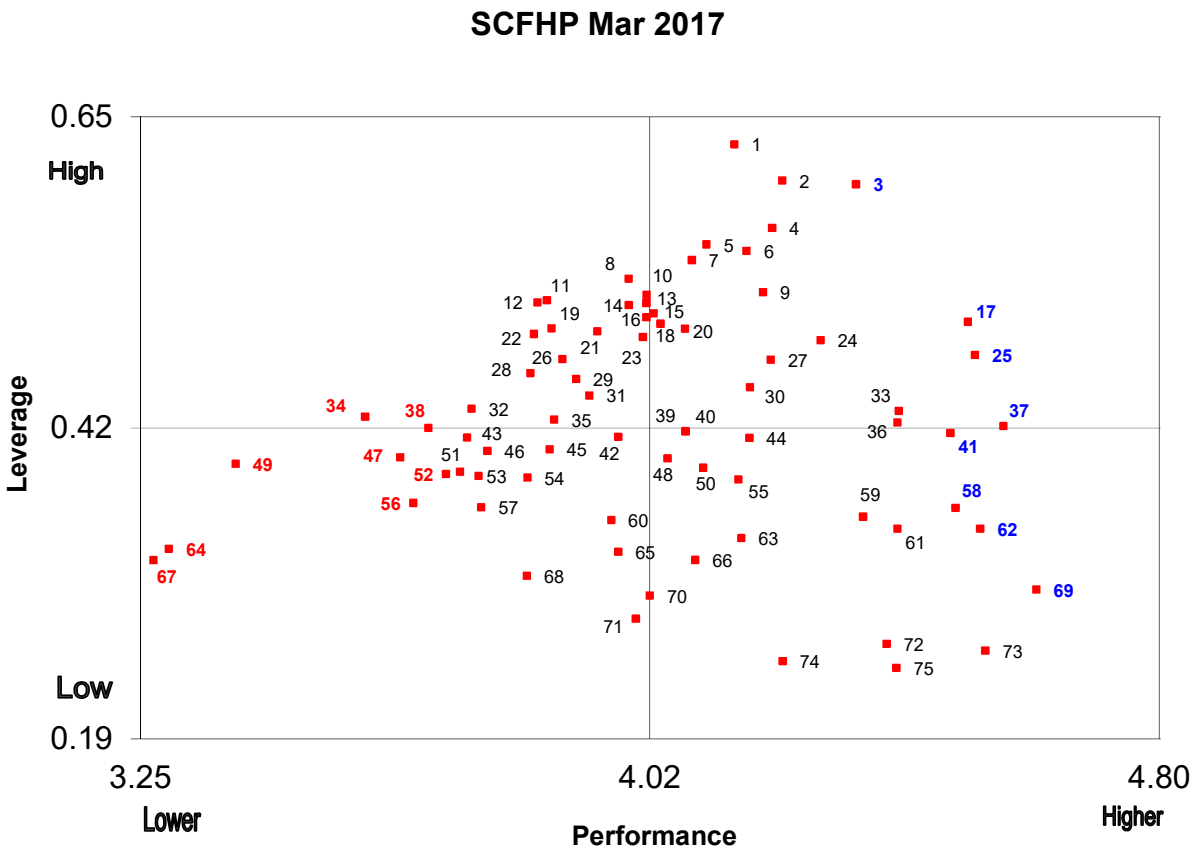


Table 20

Leverage Analysis Details



Note: In the list that follows, key strengths are printed in blue, key areas for improvement in red.

Label	Attribute
3	My work gives me a sense of personal accomplishment
17	I understand how my work supports my department's objectives
25	I understand how my work supports SCFHP's strategic objectives
37	My supervisor treats me with respect
41	I have never felt "pressure" from anyone at SCFHP to violate our ethics or values
58	My supervisor treats me fairly
62	I know what is expected of me at work
69	I understand how my work directly contributes to the overall success of the organization and its mission

34	**"Politics" at this company are kept to a minimum**
38	**SCFHP gives enough recognition for work that's well done**
47	**My workload is reasonable**
49	**Everyone here "pulls their own weight"**
52	**People at SCFHP are held accountable for their actions**
56	**The performance appraisal system is fair**
64	**There is adequate communication between departments**
67	**My salary is fair for the work that I do**

1	SCFHP is an enjoyable place to work
2	My Department Leadership models SCFHP's values
4	SCFHP Leadership respects its employees
5	My Department Leadership listens to what employees have to say
6	I agree with the direction SCFHP is headed
7	I have confidence in the leadership of SCFHP
8	My Department Leadership creates positive, upbeat work environment
9	People at SCFHP will not tolerate unethical behavior
10	My Department Leadership does not "say one thing and do another"
11	My Department Leadership carefully considers the impact of changes before implementing them
12	There is adequate planning of departmental objectives
13	The morale is good among the people with whom I work
14	I can keep a reasonable balance between work and personal life
15	My Department Leadership does not play favorites
16	My Department Leadership leads by example
18	Individual initiative is encouraged at SCFHP
19	The Executive Team creates positive, upbeat work environment
20	My Department Leadership clearly communicates department strategies and objectives
21	There is someone at work who encourages my development
22	I have opportunities to learn and grow
23	My Department communications keep me up to date on SCFHP
24	I believe SCFHP will take appropriate action in response to any incidents that violate our ethics or values
26	SCFHP's Leadership communicates an inspiring vision
27	I feel I can trust what my Department's Leadership tells me
28	SCFHP values me and the contributions I make
29	There is adequate planning of SCFHP objectives
30	I am given enough authority to make decisions I need to make
31	The Executive Team does not "say one thing and do another"
32	The Executive Team carefully considers the impact of changes before implementing them
33	My physical working conditions are good
35	There is adequate communication within my department
36	I feel comfortable telling my supervisor about any questions, concerns, or ideas I have
39	My Department's Leadership creates/encourages a team environment
40	My Department Leadership creates/encourages a team environment
42	The Executive Team creates/encourages a team environment
43	Different groups work well together (work groups, departments, etc.)
44	The Executive Team models SCFHP's values
45	The Executive Team leads by example
46	I have had the training I need to do my work well

48	I feel part of a team working toward a shared goal
50	Employees here treat each other with respect
51	The Executive Team does not play favorites
53	Deadlines at SCFHP are realistic
54	I usually hear about important information through formal company communications, rather than rumors
55	I feel I can trust what the Executive Team tells me
57	In the last six months, someone at work has talked to me about my progress
59	My supervisor tells me when I do my work well
60	The Executive Team listens to what employees have to say
61	My supervisor handles my work-related issues satisfactorily
63	Overall, I'm satisfied with SCFHP's benefits package (Medical, Dental, Vision, Life, LTD, 401A, 457, CalPERS Pension, PTO, Holidays, Tuition Reimbursement, etc.)
65	I believe my job is secure
66	I have the materials and equipment I need to do my job well
68	The Executive Team creates/encourages a team environment
70	Quality is a top priority with SCFHP
71	My last scheduled performance evaluation accurately reflected my performance
72	My supervisor tells me when my work needs improvement
73	I understand the mission and goals of SCFHP
74	SCFHP’s company communications are frequent enough (staff meetings, emails, etc.)
75	I understand all of the benefits available to me

D. EMPLOYEES COMMENTS AND SUGGESTIONS

The most frequently-requested change to the benefits package was a change to the dental benefits, followed by retirement plan comments and changes to the PTO policy.

Desired Changes to Benefits Package

	Mentioned by
Dental benefits mentions	26%
Retirement plan comments	17%
PTO comments	17%
Base	53

Note: The only comment categories shown are those mentioned by at least 10% of those responding to this question

When asked what would increase their employee satisfaction, the most common responses were improvements to training, increased compensation, and better communication.

How to Increase Employee Satisfaction

	Mentioned by
Training/Education	17%
Increase compensation	16%
Communication (not between departments)	15%
Positive comments	11%
Career growth/promotional opportunities/ job enrichment	10%
Fair/equal treatment/ reduce favoritism	10%
Social/teambuilding events	10%
Base	82

Note: The only comment categories shown are those mentioned by at least 10% of those responding to this question

E. SUBGROUP DIFFERENCES

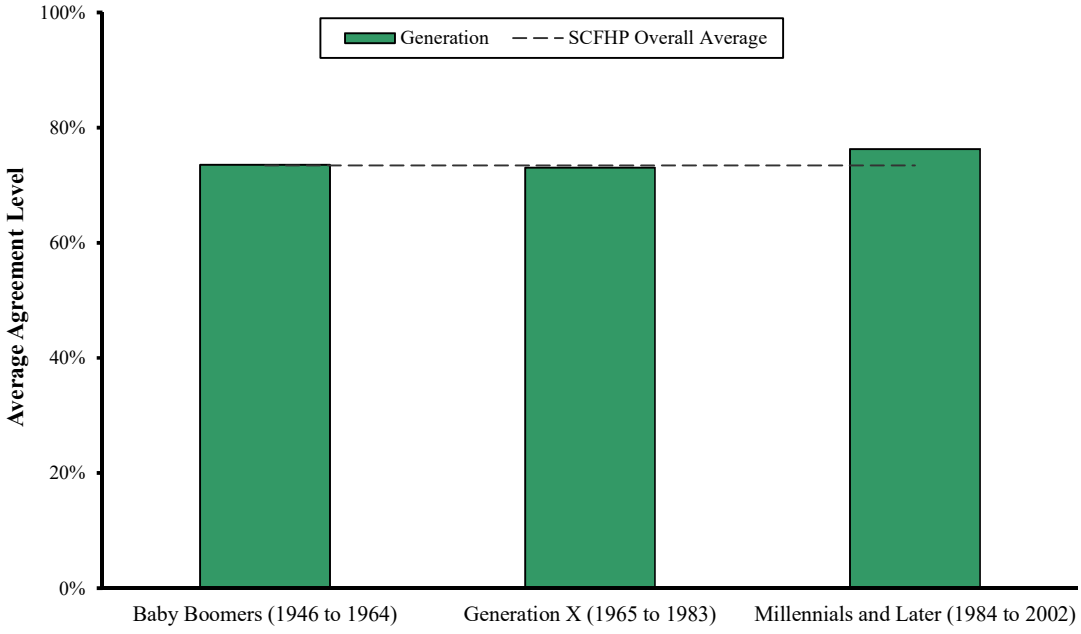
Note: Average Rating Level for a group is calculated by adding together all of their "agree" ratings, and dividing by the number of ratings, producing an average level of agreement. This is different from, overall satisfaction, which is based on a single rating, "Overall, how satisfied are you with SCFHP as an employer?"

1. Generation

On average, there is hardly any difference in the scores for the three major generations at SCFHP. Those born between 1984 and 2002 have the highest average agreement scores by a slight margin.

There are some differences worth noting on the individual questions. Boomers' scores are relatively low on departmental planning, accountability, having the training they need, physical working conditions, and realistic deadlines. Generation X's scores are relatively low on Leadership communicating an inspiring vision, the Executive Team encouraging a team environment, minimizing rumors, and fairness of the performance appraisal system.

Average Agreement Level of Items Measured, by Generation



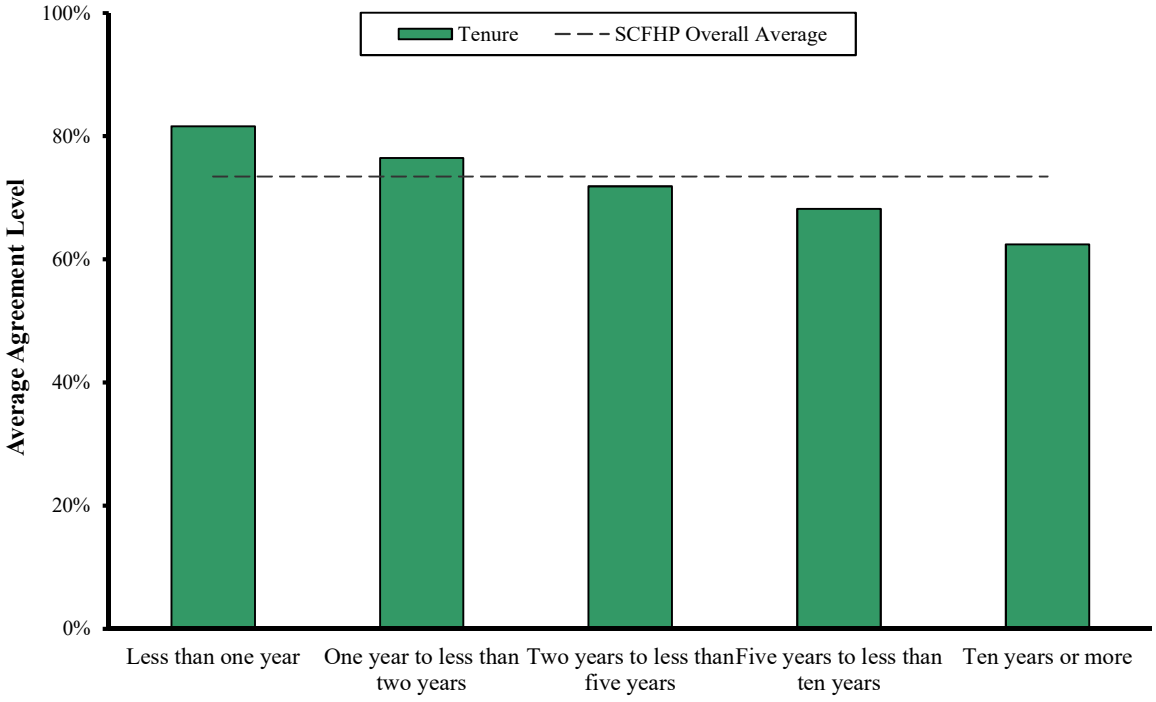
2. Tenure

The longer employees have worked for SCFHP, the less likely they are to give high ratings. This is by no means a normal pattern. Usually, scores begin high, gradually drop, and then improve as tenure increases.

The five-to-ten-year group's scores are low on three Executive Team items – not playing favorites, creating/encouraging a team environment, an creating a positive, upbeat work environment, as well as on having an opportunity to learn and grow and having a reasonable workload.

Those who have been with SCFHP for at least ten years have low scores on rumor minimization, everyone "pulling their own weight," and on three Working Conditions items – realistic deadlines, reasonable workload, and reasonable work-life balance.

Average Agreement Level of Items Measured, by Tenure



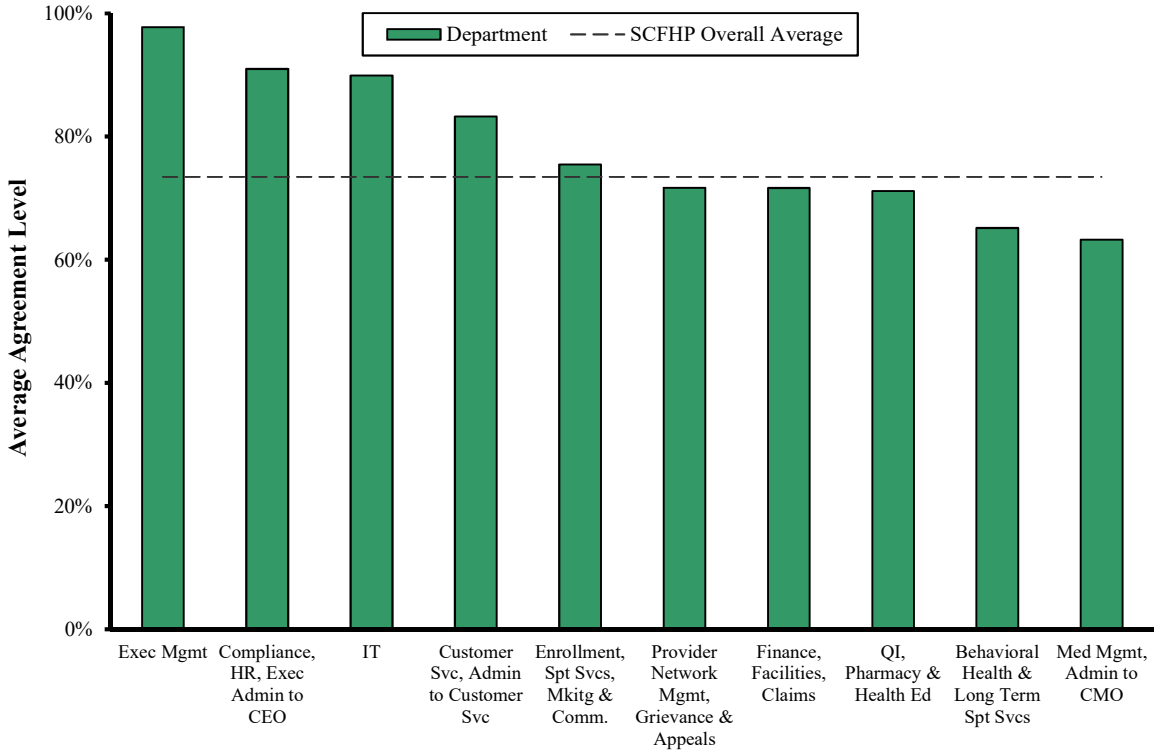
3. Department

The highest-scoring departments are Executive, Compliance/HR, and Customer Service. The lowest scores are in Behavioral Health/Long Term Support Services and Medical Management.

Low scores in Behavioral Health/Long Term Support Services include employees knowing what is expected of them, understanding the mission/goals and how their work contributes to the success of SCFHP, communication between departments, and understanding of benefits.

Medical Management employees' scores are low on the Executive Team listening and not "saying one thing and doing another, Department Leadership decision-making and creating a team environment, and comfort level in communicating ideas to the supervisor.

Average Agreement Level of Items Measured, by Department



Santa Clara
Family Health Plan
The Spirit of Care

www.scfhp.com

SCFHP Employee Satisfaction Survey
March 20 – April 4, 2017

HIGHLIGHTS

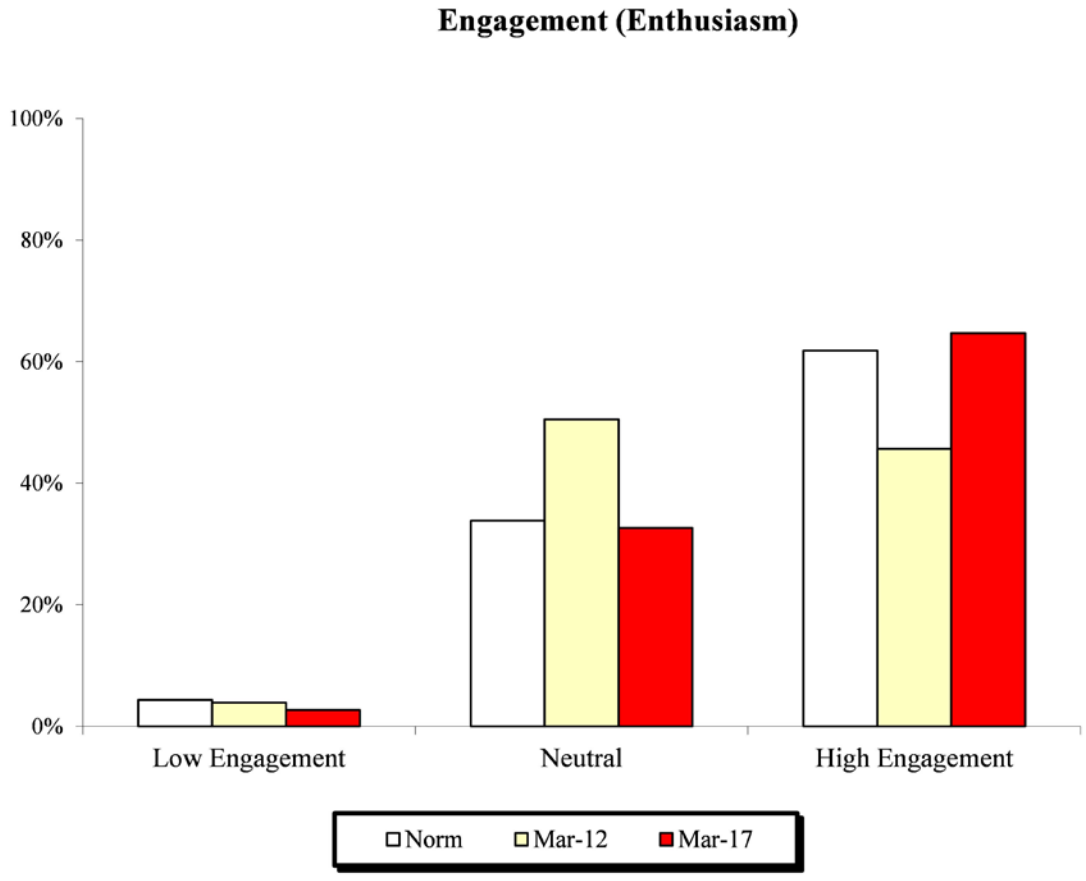
- 92% response rate (188 responses/204 employees)
- Respondent Tenure:
  - 5+ years – 27%
  - 1-5 years – 43%
  - <1 year – 30%
- Out of 49 questions asked in 2012:
  - Improvement on 45 (92%)
  - Significant improvement on 31 (63%)
- Out of 43 questions for which there is norm data:
  - Exceeded the norm on 27 (63%)
  - Significantly above norm on 3 (7%)

THE FINDINGS IN DETAIL

A. OVERALL SATISFACTION RATINGS

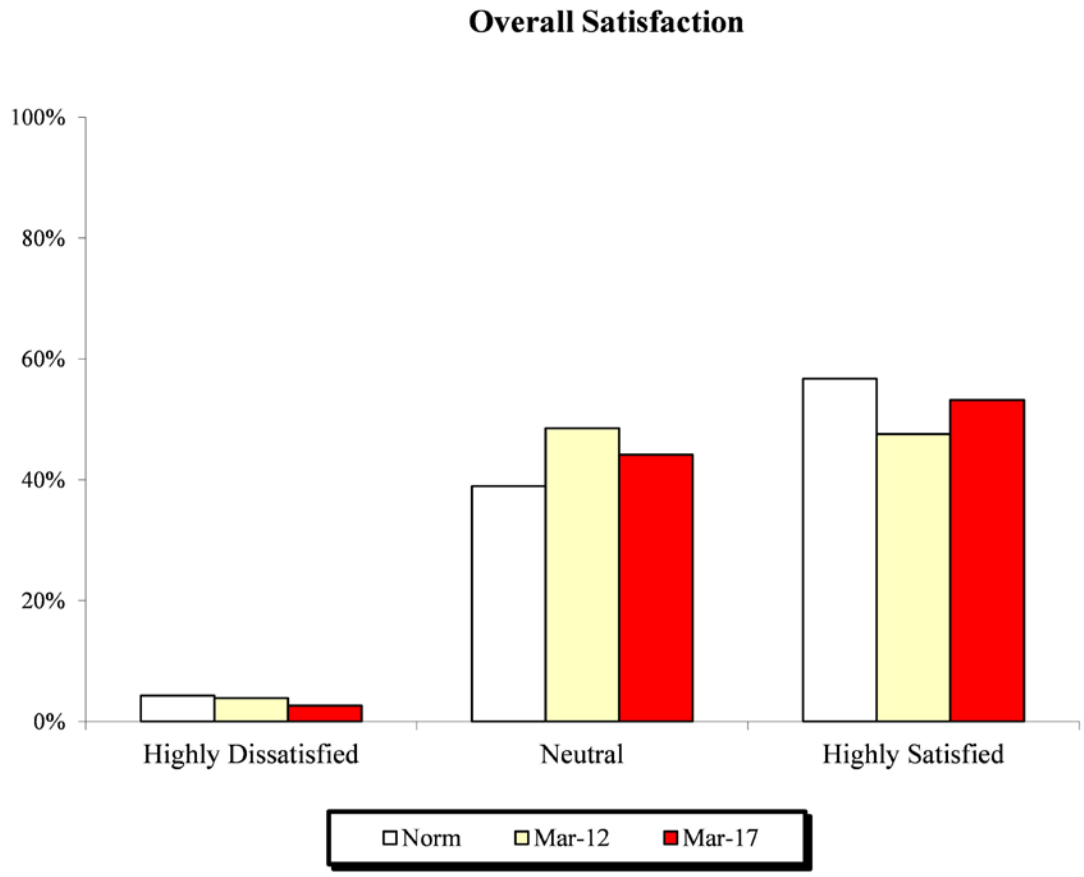
1. Engagement (Enthusiasm)

Engagement, as measured by enthusiasm, had a large statistically significant increase since the 2012 measurement. Almost two thirds of employees feel highly enthusiastic about coming to work and doing their best each day. This slightly exceeds the norm.



2. Overall Satisfaction

The percentage of highly satisfied employees increased five percentage points to 53%, and now is slightly below norm.



3. Willingness to Recommend SCFHP to a Friend

Slightly more than three-fourths of employees say they would be willing to recommend SCFHP to a friend, a significant increase of 13 percentage points. This is slightly higher than norm.

Willingness to Recommend SCFHP to a Friend Seeking Employment

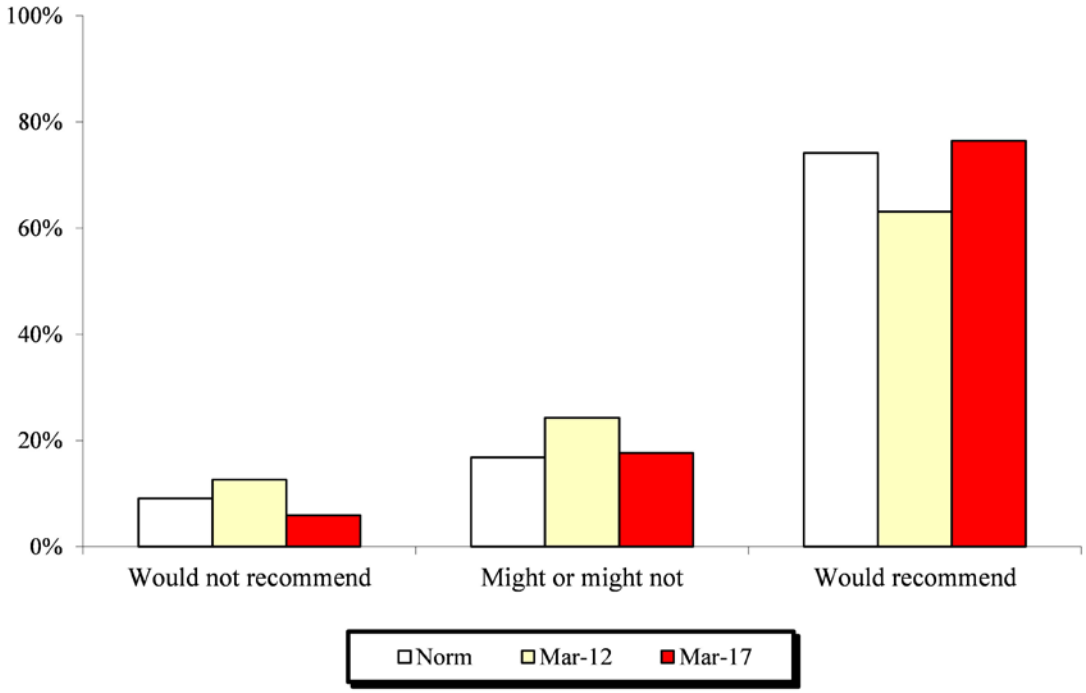


Table 1

Key Strengths
My work gives me a sense of personal accomplishment
I understand how my work supports my department's objectives
I understand how my work supports SCFHP's strategic objectives
My supervisor treats me with respect
I have never felt "pressure" from anyone at SCFHP to violate our ethics or values
My supervisor treats me fairly
I know what is expected of me at work
I understand how my work directly contributes to the overall success of the organization and its mission

Table 2

Key Opportunities for Improvement
"Politics" at this company are kept to a minimum
SCFHP gives enough recognition for work that's well done
My workload is reasonable
Everyone here “pulls their own weight
People at SCFHP are held accountable for their actions
The performance appraisal system is fair
There is adequate communication between departments
My salary is fair for the work that I do

Network Detection and Prevention Report

May 2017

SCCHA Governing Board Meeting

Santa Clara Family Health Plan

Firewall Background

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

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

The attempts have been categorized in three severity levels:

High

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

Medium

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

Low

These attacks are characterized more as informational events, such as various Scans (port and IP internet protocol address), RPC(Remote Procedure Call), and SMTP(Simple Mail Transfer Protocol) attacks.

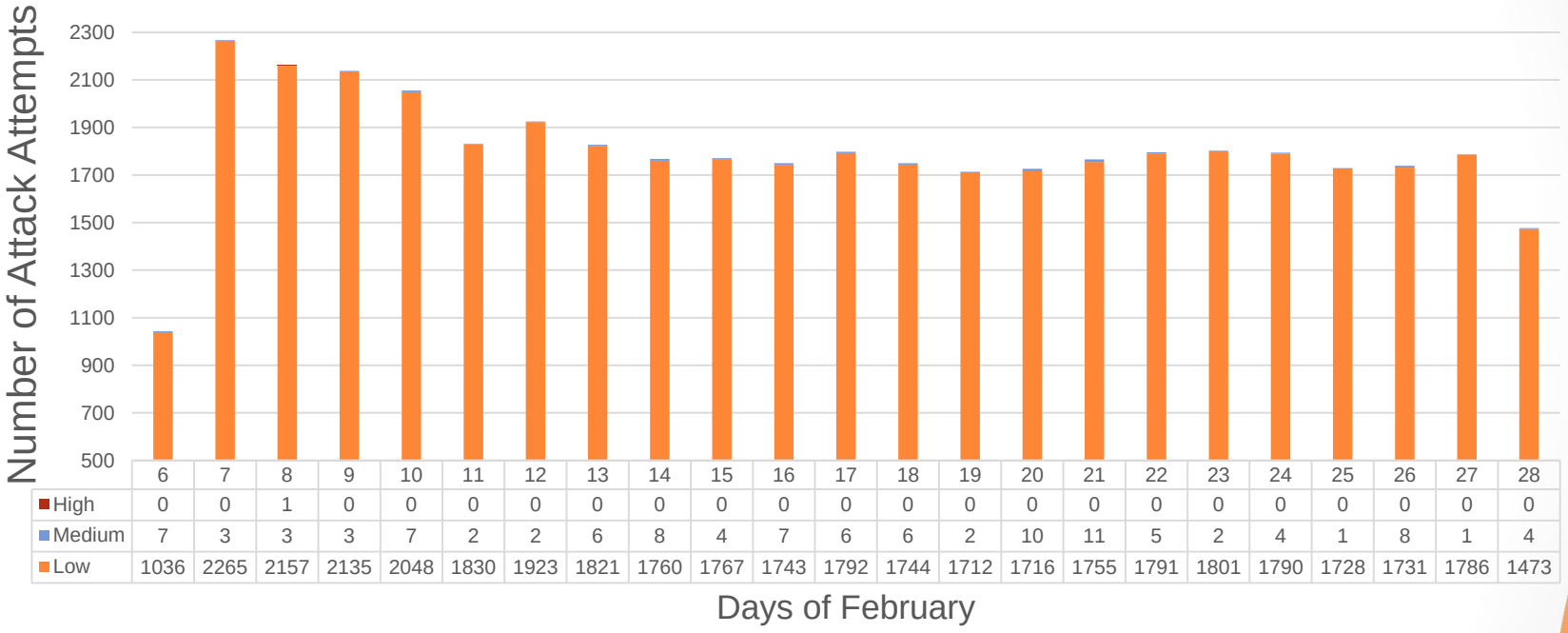
Attack Statistics Combined

February/March/April/May

Severity Level	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
	FEB	MAR	APR	MAY	FEB	MAR	APR	MAY	FEB	MAR	APR	MAY
High	4	1	0	5	22	4	0	2381	.05	.01	.00	5.93
Medium	9	9	9	11	100	173	203	776	.24	.36	.41	1.93
Low	17	17	22	19	41312	45253	49114	37007	99.71	99.63	99.59	92.14

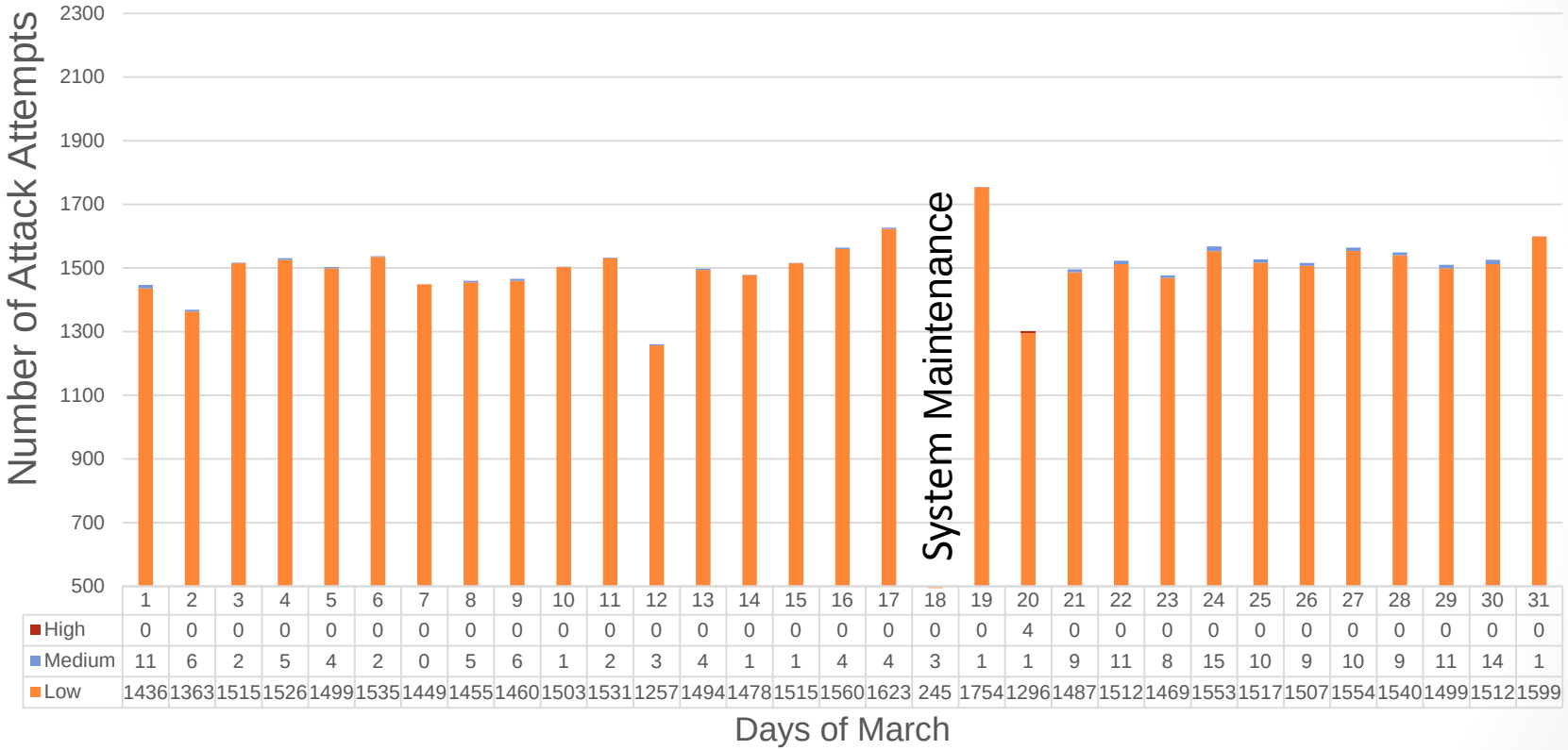
* Month of May shows increased High and Medium detections. This was due to new IPS Rules 41978 and 42340 were automatically downloaded by Sophos in April that mitigated new exploits for the month of May. Part of this new rule was to block packets for the "wannacry" malware that was not seen until the weekend of May 12th.

Daily Attack Attempts



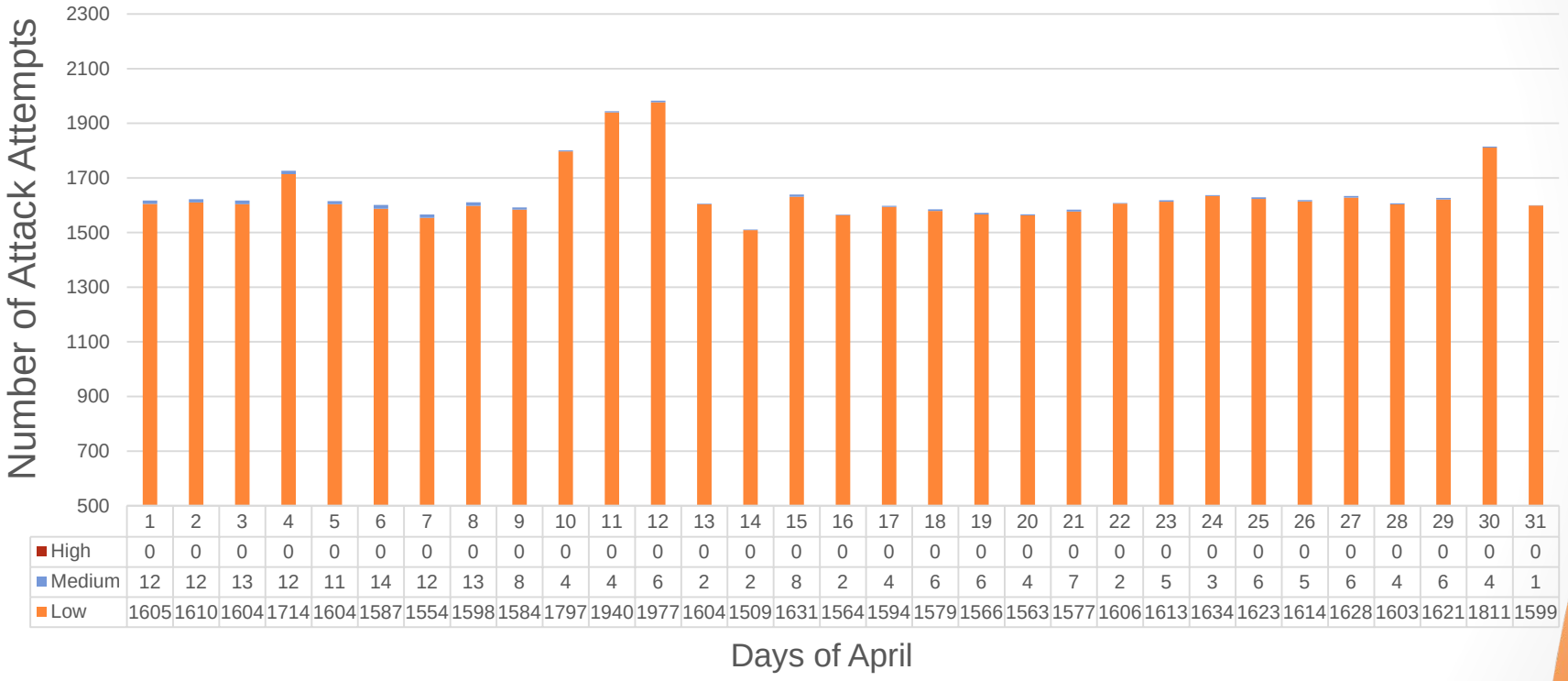
	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
High	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medium	7	3	3	3	7	2	2	6	8	4	7	6	6	2	10	11	5	2	4	1	8	1	4
Low	1036	2265	2157	2135	2048	1830	1923	1821	1760	1767	1743	1792	1744	1712	1716	1755	1791	1801	1790	1728	1731	1786	1473

Daily Attack Attempts



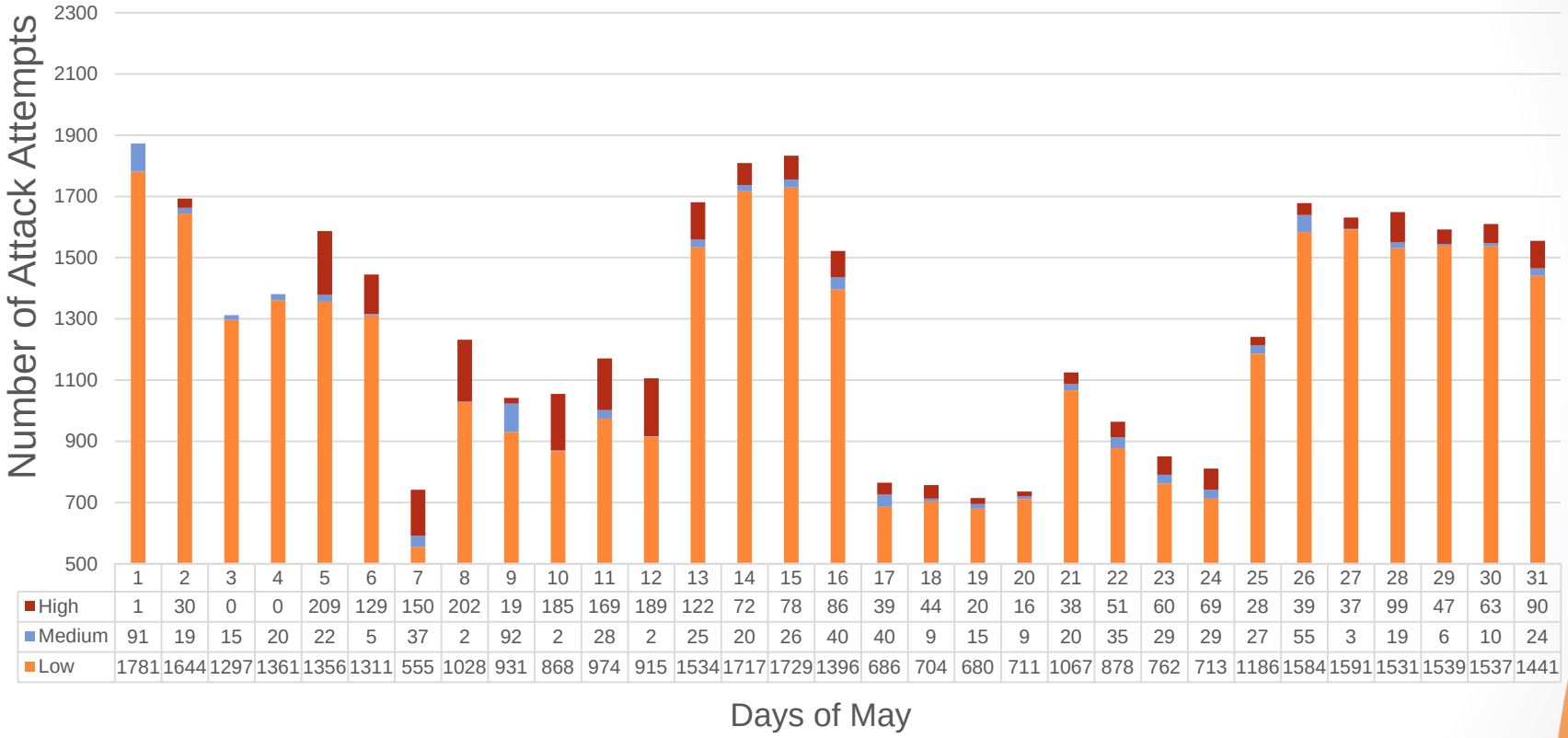
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
High	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0
Medium	11	6	2	5	4	2	0	5	6	1	2	3	4	1	1	4	4	3	1	1	9	11	8	15	10	9	10	9	11	14	1
Low	1436	1363	1515	1526	1499	1535	1449	1455	1460	1503	1531	1257	1494	1478	1515	1560	1623	245	1754	1296	1487	1512	1469	1553	1517	1507	1554	1540	1499	1512	1599

Daily Attack Attempts



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
High	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medium	12	12	13	12	11	14	12	13	8	4	4	6	2	2	8	2	4	6	6	4	7	2	5	3	6	5	6	4	6	4	1
Low	1605	1610	1604	1714	1604	1587	1554	1598	1584	1797	1940	1977	1604	1509	1631	1564	1594	1579	1566	1563	1577	1606	1613	1634	1623	1614	1628	1603	1621	1811	1599

Daily Attack Attempts



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
High	1	30	0	0	209	129	150	202	19	185	169	189	122	72	78	86	39	44	20	16	38	51	60	69	28	39	37	99	47	63	90
Medium	91	19	15	20	22	5	37	2	92	2	28	2	25	20	26	40	40	9	15	9	20	35	29	29	27	55	3	19	6	10	24
Low	1781	1644	1297	1361	1356	1311	555	1028	931	868	974	915	1534	1717	1729	1396	686	704	680	711	1067	878	762	713	1186	1584	1591	1531	1539	1537	1441

Santa Clara
Family Health Plan

Email Background

For email protection SCFHP utilizes software that intercepts every incoming email and scans them for suspicious content, attachments or URLs (Uniform Resource Locator or address to the World Wide Web). The software has anti-malware and phishing-detection technology that is constantly being updated to detect the latest threats. It is configured to detect phishing attempts as well SPF (Sender Policy Framework) anti-spoofing. SPF is a simple technology that detects spoofing by providing a mechanism to validate the incoming mail against the sender's domain name. The software can check those records to make sure mail is coming from legitimate email addresses.

Email Security – Daily Statistics

Top Email Senders

Total number of messages: 2 768

Total email traffic: 233.4 MB

	Email address	#	Size
1	reply@healthplanalliance.info	124	739.6 kB
2	hpms@cms.hhs.gov	115	16.5 MB
3	delivery@b2b-mail.net	87	2.2 MB
4	onq-scfhp-ha4@alerts.onqcentra	71	143.3 kB
5	kizzyelizabeth.nickerson@cogni	62	16.7 MB
6	prvs=4331bcd45e=courtney.boyle	54	3.5 MB
7	onq-scfhp-ha2@alerts.onqcentra	51	152.9 kB
8	cxemail@trizetto.com	50	187.8 kB
9	info@healthplanalliance.org	48	1.4 MB
10	notifications@basecamp.com	37	535.5 kB

Top Senders to SCFHP

Email Security - Daily Statistics

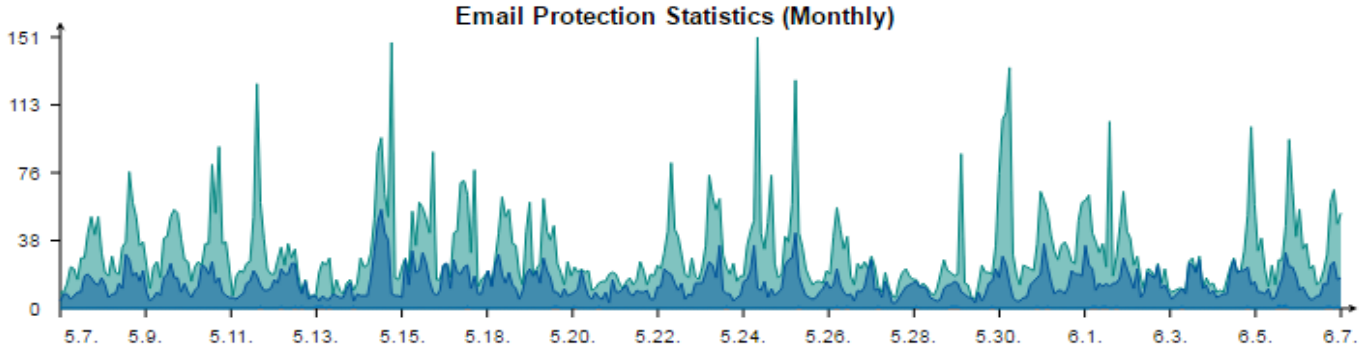
Top Spam Countries

Total number of spams: 1 333

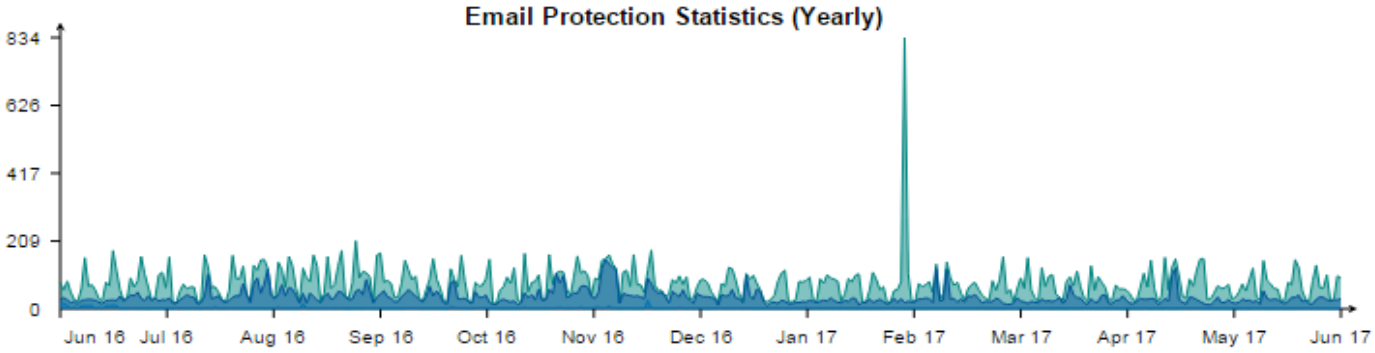
Total spam mail size: 74.5 MB

		Spams	Traffic
1	United States	711	62.0 MB
2	Germany	105	929.3 kB
3	Honduras	76	0
4	Canada	75	960.8 kB
5	Spain	47	261.6 kB
6	India	43	48.2 kB
7	Moldova, Republic of	29	217.5 kB
8	United Kingdom	28	363.7 kB
9	Viet Nam	25	0
10	Korea, Republic of	22	0

Email Protection Statistics by Month and Year



	Maximum	Minimum	Average	Last
Mail total	151	5	31.90	53
AV blocked	2	0	0.11	0
Spam blocked	55	3	13.88	17



	Maximum	Minimum	Average	Last
Mail total	834	17	79.53	94
AV blocked	26	0	1.61	2
Spam blocked	151	10	35.57	31

SCFHP Phishing Attacks

	INCIDENT 4 – 4/5/2017	INCIDENT 5 – 4/12/2017	INCIDENT 6 – 04/21/2017
TYPE OF ATTACK	Phishing attack	Phishing attack	Phishing
SUMMARY	4 Employees affected	24 Employees affected	1 Employee
RESPONSE	**Step 1.** blocked the subject "expand mailbox storage"	**Step 1.** blocked the subject "Help Desk Reset Your Mail"	**Step 1.** Analyze email and take appropriate action.
	Step 2. Block 1 source IP address from the properties of the email, blocked the web link and the domain the email referenced,	**Step 2.** Block 1 source IP address from the properties of the email, blocked the web link and the domain the email referenced,	**Step 2.** Block FW from Source email and IP. Add expression for Subject line Keyword "UPS Parcel Delivery".
	Step 3. Visited each of the 4 people to delete the email.	**Step 3.** Visited each of the 24 people to delete the email. and sent an IT Announcement email to all employees	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Instructed employees to delete the email.	**Step 4.** Instructed employees to delete the email.	**Step 4.** Monitor email and user
	Step 5. Continue to monitor email and firewall	**Step 5.** Continue to monitor email and firewall	**Step 5.** Continue to monitor email and firewall

SCFHP Phishing Attacks

	INCIDENT 7 – 5/1/2017	INCIDENT 8 – 5/3/2017	INCIDENT 9 – 5/10/2017	INCIDENT – 10 5/12/2017
TYPE OF ATTACK	Phishing	Phishing	Phishing	Ransomware attack (WannaCry)
SUMMARY	4 Employees	5 Employees	1 Employee	0 employees affected
RESPONSE	**Step 1.** Analyzed email and took appropriate action	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Email was Deleted. Analyzed what was sent and take appropriate action.	**Step 1.** Our firewall vendor were prepared for the WannaCry and applied the patches that week.
	Step 2. Block FW from Source email address and IP. Add expression for Subject Line keyword, “Security Alert”.	**Step 2.** Block FW from Sources email address and IP address. Add expression for Subject line keyword, “Re: payment”	**Step 2.** Block FW from Source email address. Added Expression for Subject Line keyword. “Isaac N Reed”.	**Step 2.** Updated firmware on SonicWall and Sophos. Updated Antivirus definitions.
	Step 3. Removed threat by permanently deleting email.	**Step 3.** Removed threat by permanently deleting email.	**Step 3.** Removed threat by permanently deleting email.	**Step 3.** Applied windows patches on all workstations and servers.
	Step 4. Monitor emails and users.	**Step 4.** Monitor emails and users.	**Step 4.** Monitor emails and Users	**Step 4.** Verified that emails are scanned by SonicWall for the ransomware before delivery to mailbox

Questions