Santa Clara
Family Health Plan
*The Spirit of Care*

www.scfhp.com

**Regular Meeting of the**
# Santa Clara County Health Authority Governing Board

**Thursday, September 22, 2016**
**2:30 PM - 5:00 PM**
**210 E. Hacienda Avenue**
**Campbell, CA 95008**

# AGENDA

| | | | | |
|---|---|---|---|---|
| **1.** | **Roll Call** | Mr. Brownstein | 2:30 | 5 min. |
| **2.** | **Public Comment**<br>Members of the public may speak to any item not on the agenda; two minutes per speaker. The Board reserves the right to limit the duration of public comment period to 30 minutes. | Mr. Brownstein | 2:35 | 5 min. |
| **3.** | **Announcement Prior to Recessing into Closed Session**<br>Announcement that the Governing Board will recess into closed session to discuss Item No. 4(a) below. | | | |
| **4.** | **Adjourn to Closed Session**<br>a. **Anticipated Litigation** (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 the receipt of an administrative claim for damages received pursuant to the Government Claims Act. The claim was submitted by Mark S. Renner of Wylie, McBride, Platten & Renner on behalf of Kathleen King. A copy of the claim is attached to this agenda. | | 2:40 | |
| **5.** | **Report from Closed Session** | Mr. Brownstein | 2:55 | 5 min. |
| **6.** | **Approve Consent Calendar and Changes to the Agenda**<br>Items removed from the Consent Calendar will be considered as regular agenda items.<br>**Possible Action:** Approve Consent Calendar | Mr. Brownstein | 3:00 | 15 min. |

a. Approve minutes of the June 23, 2016 **Regular Board** Meeting

b. Accept minutes of the July, 28 2016 **Executive/Finance Committee** Meeting and: — Ms. Lew
   - Accept May 2016 Financial Statements

c. Accept minutes of the August 25, 2016 **Executive/Finance Committee** Meeting and: — Ms. Lew
   - Accept Annual Investment Policy Report
   - Review FY '15-'16 Donation/Sponosorship Report
   - Review Draft Provider Incentive Program
   - Appoint temporary, ad hoc subcommittee to conduct annual CEO Evaluation

d. Accept minutes of the August 10, 2016 **Quality Improvement Committee** Meeting and: — Dr. Robertson
   - Ratify eight Case Management Policies
   - Ratify three Health Education Policies
   - Ratify Case Management Program Description
   - Ratify Health Education Program Description
   - Ratify Health Education Work Plan
   - Accept Credentialing, P&T, & UM Committee Reports

e. Accept minutes of the July 27, 2016 **Provider Advisory Council** Meeting — Dr. Robertson

f. Accept minutes of the September 13, 2016 **Consumer Advisory Committee** Meeting — Dr. Wenner

**7. CEO Update** — Ms. Tomcala — 3:15 — 10 min.

Discuss status of current topics and initiatives.

**Possible Action:** Accept CEO Update

**8. Election of Officers** — Mr. Brownstein — 3:25 — 10 min.

Elect offices of Chairperson, Vice-Chairperson, Treasurer, and Secretary.

**Possible Action:** Elect nominees for the offices of Chairperson, Vice-Chairperson, Treasurer, and Secretary

**9. Consumer Advisory Committee Charter** — Ms. Tomcala — 3:35 — 5 min.

Consider and approve Consumer Advisory Committee Charter.

**Possible Action:** Approve Consumer Advisory Committee Charter

**10. Compliance Report** — Ms. Paige — 3:40 — 10 min.

Review and discuss quarterly compliance activities and notifications.

**Possible Action:** Accept Compliance Report

**11. Fiscal Year 2015-2016 Unaudited Financials** — Mr. Cameron — 3:50 — 10 min.

Discuss FY 2015-16 financial performance.

**Possible Action:** Approve Unaudited FY15-16 statements

| | | | | |
|---|---|---|---|---|
| **12.** | **July 2016 Financial Statements**<br>Review recent organizational financial performance and related variables.<br>**Possible Action:** Approve July 2016 Financial Statements | Mr. Cameron | 4:00 | 10 min. |
| **13.** | **Reserve & Liquidity Strategies**<br>Discuss reserve strategy, TNE, and cash flow.<br>**Possible Action:** Approve Reserve & Liquidity Methodology | Mr. Cameron | 4:10 | 15 min. |
| **14.** | **Fiscal Year 2015-2016 Year in Review**<br>Review performance on FY 2015-16 Plan Objectives.<br>**Possible Action:** Accept FY 2015-16 Plan Objective Performance Report | Ms. Tomcala | 4:25 | 10 min. |
| **15.** | **Fiscal Year 2016-2017 Plan Objectives**<br>Consider approval of FY 2016-17 Plan Objectives.<br>**Possible Action:** Accept FY 2016-17 Plan Objectives | Ms. Tomcala | 4:35 | 10 min. |
| **16.** | **Fiscal Year 2015-2016 Team Incentive Compensation**<br>Review performance on FY 2015-16 Team Incentive metrics.<br>**Possible Action:** Approve Team Incentive Payout | Ms. Tomcala | 4:45 | 5 min. |
| **17.** | **Credentialing System RFP**<br>Discuss Credentialing System RFP and expenditure.<br>**Possible Action:** Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected credentialing system vendor in an amount not to exceed a projected expenditure for licensing and implementation | Mr. Tamayo | 4:50 | 5 min. |
| **18.** | **Publicly Available Salary Schedule Ranges**<br>Consider changes to the Publicly Available Salary Schedule and delegation of salary range re-benchmarking approval to Executive/ Finance Committee.<br>**Possible Action:** Approve Publicly Available Salary Schedule<br>**Possible Action:** Delegate approval of salary range re-benchmarking to Executive/Finance Committee | Ms. Valdez | 4:55 | 5 min. |
| **19.** | **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 Melanie Sibayan 48 hours prior to the meeting at 408-874-1997.

To obtain a copy of any supporting document that is available, contact Melanie Sibayan at 408-874-1997. 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.

WYLIE, MCBRIDE, PLATTEN & RENNER
A Law Corporation

JOHN McBRIDE
CHRISTOPHER E. PLATTEN
MARK S. RENNER

CAROL L. KOENIG

RICHARD J. WYLIE, *Retired*

DIANE SIDD-CHAMPION, *of Counsel*

2125 CANOAS GARDEN AVENUE, SUITE 120
SAN JOSE, CALIFORNIA 95125

TELEPHONE: 408.979.2920
FACSIMILE: 408.979.2934

605 MARKET STREET, SUITE 1200
SAN FRANCISCO, CALIFORNIA 94105

TELEPHONE: 415.977.0904
FACSIMILE: 415.536.0906

August 11, 2016

Robert Brownstein
President
Board of Directors
Santa Clara Family Health Plan
210 East Hacienda Avenue
Campbell, CA 95008-6617

Via Certified Mail
Return Receipt Requested.

**Re: Administrative Claim for Damages**

Dear Mr. Brownstein:

This law firm represents Kathleen King, who was previously working under the auspices of the Santa Clara Family Health Plan, or under its prior title, Santa Clara County Health Authority.

On behalf of Ms. King, please consider this correspondence an administrative claim under California Government Code § 9 10 et seq.

The name and address of the claimant is as follows:

Kathleen King
Healthier Kids Foundation Of Sana Clara County
4010 Moorpark Avenue, Suite 118
San Jose, California 95117

The claimant wishes notices to be sent to the following address:

Mark S. Renner
Wylie, McBride Platten & Renner
2125 Canoas Garden Avenue, Suite 120
San Jose, California 95125

The transaction which gave rise to this claim was the denial on or about February 18, 2016, by Cal-PERS Board of Administration of Ms. King's appeal to that Board regarding a

decision by an Administrative Law Judge effectively denying her coverage under Cal-PERS for service years ostensibly earned.

Ms. King had a contract which called for her participation in Cal-PERS, both for pension and for health benefits, from 2008 through 2013. By the Cal-PERS' Board's denial of Ms. King's participation, the Santa Clara Family Health Plan aka Santa Clara County Health Authority failed to fulfill the terms of the contract, thereby denying her the monetary value of Cal-PERS participation, both for purposes of pension benefits and health benefits.

The name or names of public employee(s) causing this damage are the director of the Santa Clara County Health Authority, as well as its respective Board.

This claim exceeds $10,000.00 and would not be a "limited civil case" as referenced in Government Code § 910. This claim is meant to encompass all monetary consequences of Cal-PERS barring Ms. King from participation in Cal-PERS, subject to offset by amounts returned by Cal-PERS directly to her, if any.

Very truly yours,

WYLIE, McBRIDE, PLATTEN,
& RENNER

MARK S. RENNER

MSR/mjh
cc: Kathleen King
Christopher Platten
Alison Hightowner

l:\7000\72272\administrative claim\ltr to robert brownstein -santa clara family health plan.docx

WYLIE, MCBRIDE, PLATTEN & RENNER
A Law Corporation

2125 CANOAS GARDEN AVENUE, SUITE 120
SAN JOSE, CALIFORNIA 95125

TELEPHONE: 408.979.2920
FACSIMILE: 408.979.2934

JOHN McBRIDE
CHRISTOPHER E. PLATTEN
MARK S. RENNER

RICHARD J. WYLIE, *Retired*

CAROL L. KOENIG

DIANE SIDD-CHAMPION, *of Counsel*

605 MARKET STREET, SUITE 1200
SAN FRANCISCO, CALIFORNIA 94105

TELEPHONE: 415.977.0904
FACSIMILE: 415.536.0906

August 16, 2016

CalPERS Board of Directors
c/o Christopher Phillips
P.O. Box 942707
Sacramento, California 94229-2702

**Re: Administrative Claim for Damages**

Dear Mr. Phillips:

This law firm represents Kathleen King, who was previously working under the auspices of the Santa Clara Family Health Pan, or under its prior title Santa Clara County Health Authority.

On behalf of Ms. King, please consider this correspondence an administrative claim under California Government Code § 9 10 et seq.

The name and address of the claimant is as follows:

Kathleen King
Healthier Kids Foundation of Santa Clara County
4010 Moorpark Avenue, Suite 118
San Jose, California 95117

The claimant wishes notices to be sent to the following address:

Mark S. Renner
Wylie, McBride, Platten & Renner
2125 Canoas Garden Avenue, Suite 120
San Jose, California 95125

The transaction which gave rise to this claim was the denial on or about February 18, 2016, by CalPERS Board of Administration for Ms. King's appeal to that Board regarding a

decision by an Administrative Law Judge effectively denying her coverage under CalPERS for service years ostensibly earned.

Ms. King had a contact which called for her participation in in CalPERS, both for pension and for health benefits, from 2008 through 2013. By the CalPERS Board's denial of Ms. King's participation, the Santa Clara Family Health Plan aka Santa Clara County Health Authority filed to fulfill the terms of the contract, thereby denying her the monetary value of CalPERS participation, both for purposes of pension benefits and health benefits.

By this claim, Ms. King seeks all funds that were contributed on her behalf to CalPERS which CalPERS has not or does not intend to return to her former employer, including any earnings which are reasonably allocated to such contributions. The contracting agency Santa Clara Valley Health Authority.

The name or names of public employee(s) causing this damage are the director of the Santa Clara County Health Authority, as well as its respective Board, as well as the Board of Administration for CalPERS.

This claim exceeds $10,000.00 and would not be a "limited civil case" as referenced in Government Code § 910. This claim is meant to encompass all monetary consequences of CalPERS barring Ms. King from participation in CalPERS, subject to offset by amounts returned by CalPERS directly to the contracting agency, if any.

Very truly yours,

WYLIE, McBRIDE, PLATTEN,
& RENNER

MARK S. RENNER

MSR: mjh
cc: Kathleen King
Christopher Platten
Alison Hightower

I:\7000\72272\administrative claim\lt to calpers board of directors.docx

WYLIE, MCBRIDE, PLATTEN & RENNER
A Law Corporation

JOHN McBRIDE
CHRISTOPHER E. PLATTEN
MARK S. RENNER

CAROL L. KOENIG

RICHARD J. WYLIE, *Retired*

DIANE SIDD-CHAMPION, *of Counsel*

2125 CANOAS GARDEN AVENUE, SUITE 120
SAN JOSE, CALIFORNIA 95125

TELEPHONE: 408.979.2920
FACSIMILE: 408.979.2934

605 MARKET STREET, SUITE 1200
SAN FRANCISCO, CALIFORNIA 94105

TELEPHONE: 415.977.0904
FACSIMILE: 415.536.0906

September 14, 2016

Government Claims Program
Office of Risk and Insurance Management
Department of General Services
P.O. Box 989052, MS 414
West Sacramento, CA 95798-9052

**Re: Administrative Claim for Damages**

Dear Sir/Madam:

This law firm represents Kathleen King, who was previously working under the auspices of the Santa Clara Family Health Pan, or under its prior title Santa Clara County Health Authority.

On behalf of Ms. King, please consider this correspondence an administrative claim under California Government Code § 9 10 et seq.

The name and address of the claimant is as follows:

Kathleen King
Healthier Kids Foundation of Santa Clara County
4010 Moorpark Avenue, Suite 118
San Jose, California 95117

The claimant wishes notices to be sent to the following address:

Mark S. Renner
Wylie, McBride, Platten & Renner
2125 Canoas Garden Avenue, Suite 120
San Jose, California 95125

The transaction which gave rise to this claim was the denial on or about February 18, 2016, by CalPERS Board of Administration for Ms. King's appeal to that Board regarding a

decision by an Administrative Law Judge effectively denying her coverage under CalPERS for service years ostensibly earned.

Ms. King had a contact which called for her participation in in CalPERS, both for pension and for health benefits, from 2008 through 2013. By the CalPERS Board's denial of Ms. King's participation, the Santa Clara Family Health Plan aka Santa Clara County Health Authority filed to fulfill the terms of the contract, thereby denying her the monetary value of CalPERS participation, both for purposes of pension benefits and health benefits.

By this claim, Ms. King seeks all funds that were contributed on her behalf to CalPERS which CalPERS has not or does not intend to return to her former employer, including any earnings which are reasonably allocated to such contributions. The contracting agency Santa Clara Valley Health Authority.

The name or names of public employee(s) causing this damage are the director of the Santa Clara County Health Authority, as well as its respective Board, as well as the Board of Administration for CalPERS.

This claim exceeds $10,000.00 and would not be a "limited civil case" as referenced in Government Code § 910. This claim is meant to encompass all monetary consequences of CalPERS barring Ms. King from participation in CalPERS, subject to offset by amounts returned by CalPERS directly to the contracting agency, if any.

Very truly yours,

WYLIE, McBRIDE, PLATTEN,
& RENNER

MARK S. RENNER

MSR: mjh
cc: Kathleen King
Christopher Platten
Alison Hightower

l:\7000\72272\administrative claim\lt to calpers board of directors 2.docx

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 23, 2016**
**210 E. Hacienda Avenue**
**Campbell, CA 95008**

## Minutes - DRAFT

**Board Members Present**
Bob Brownstein, Chair
Brian Darrow
Kathleen King
Liz Kniss
Michele Lew
Brenda Taussig
Wally Wenner, M.D.
Linda Williams

**Staff Present**
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Jeff Robertson, M.D., Chief Medical Officer
Jonathan Tamayo, Chief Informational Officer
Gary Kaplan, VP Vendor Relations & Delegation Oversight
Sharon Valdez, VP Human Resources
Beth Paige, Compliance Officer
Rita Zambrano, Executive Assistant

**Board Members Absent**
Dolores Alvarado
Chris Dawes
Darryl Evora
Paul Murphy
Jolene Smith

**Others Present**
Elizabeth Pianca, Secretary
Stephen Babich, DMHC
Peter Goll, PMG
Tony Kalgain

**1. Roll Call**

Bob Brownstein, Chair, called the meeting to order at 2:40 pm. Roll call was taken and a quorum was established.

**2. Public Comment**

Peter Goll, CEO of Physicians Medical Group of San Jose (PMG), noted PMG has been in the marketplace since 1980 and is a safety net provider serving approximately 102,000 at-risk residents of Santa Clara County, which is approximately one-third of the County's Medi-Cal population. Mr. Goll respectfully requested the Board consider recognizing PMG's partnership with SCFHP by providing monthly default enrollment.

**3. Approve Consent Calendar and Changes to the Agenda**

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

**a.** Approve minutes of the April 28, 2016 **Regular Board** Meeting.

Mr. Brownstein noted two changes to the April 28, 2016 meeting minutes previously distributed. Kathleen King's name was corrected in item 4 and in item 15, a second clause was added to the policy that would authorize the CEO to approve health-related community programs within limits designated by the Board.

**b.** Accept minutes of the June 16, 2016 **Bylaws Committee** Meeting

Christine Tomcala reported the Bylaws Committee held an introductory meeting and agreed to reconvene to continue the process of reviewing and recommending revisions to the Bylaws before bringing them to the Board.

**c.** Accept minutes of the May 26, 2016 **Executive/Finance Committee** Meeting

Michele Lew presented the May 26, 2016 Executive/Finance Committee meeting minutes.

**d.** Accept minutes of the May 11, 2016 **Quality Improvement Committee** Meeting

Dr. Jeff Robertson noted the Quality Improvement Committee (QIC) is now a committee of the Board and Darryl Evora, Board member, would be joining the Committee. He also noted Ria Paul, M.D., Associate Professor at Stanford Senior Care, was appointed to replace Thad Padua, M.D., as Chair of the QIC. The Committee approved the 2015 Quality Improvement Program Evaluation, changes to the 2016 Quality Improvement Program, and six Quality Improvement policies.

**e.** Accept minutes of the April 7, 2016 **Provider Advisory Council** Meeting

Dr. Robertson reported the Provider Advisory Council (PAC) Charter was approved and a description of the MLTSS and program was provided.

**f.** Accept minutes of the June 14, 2016 **Consumer Affairs Committee** Meeting

Dr. Wally Wenner presented the June 14, 2016 Consumer Affairs Committee (CAC) meeting minutes and noted that additional Committee members were being sought, as regulations require diverse committee membership, either by members or member representatives.

**g.** Approve **Publicly Available Salary Schedule**

Sharon Valdez gave an update on the Publicly Available Salary Schedule for those positions that were added or removed since the last update to the SCCHA Board of Directors on April 28, 2016.

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

**4. CEO Update**

Ms. Tomcala reported that CMS approved continuation of the MCO tax, which provides critical funds to the State's budget for the CCI program. She noted that CCI Sustainability remains an organizational priority, and the State has withdrawn its proposal for a passive enrollment process in the fall. Staff continues to work on efforts to mitigate enrollment losses through messaging, and member and provider outreach. Health plans are sharing best practices and working collaboratively on opportunities. Also, the Department of Finance has expressed budgetary concerns regarding savings expectations of the CCI program. She further noted that health plan representatives were meeting with DHCS that afternoon to discuss the future of the CCI program.

Ms. Tomcala brought to the Board's attention the Federal Medicaid Managed Care Regulations, or CMS "Mega-Reg," which was released in April. Given the magnitude of the rule (1,400 pages), analysis continues by the health plan associations.

It was noted Beth Paige would be sharing results from the DHCS Exit Conference, from the joint DHCS/DMHC audit in April. Ms. Tomcala further noted two additional audits were underway; DMHC would be onsite for a Finance audit, and Moss Adams had begun work on the Fiscal 2015-16 External Audit.

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

**5. Compliance Report**

Ms. Paige highlighted three items from the Compliance Report.

The preliminary report of the 2016 Quality Withhold Performance Measure Validation Activity (PMV) was received and under review for Plan comments. This was a review of Core Measure 2.1 conducted by Health Services Advisory Group (HSAG) for the Medicare-Medicaid Capitated Financial Alignment Initiative. The report states the data measured is compliance with CMS specifications. A final report will be issued following the plan review timeframe.

Three Patient Safety Outlier notices were received on May 6, 2016. A file format error caused a significant drop in the 2016 Q1 patient medication adherence rates. The file format was corrected, and SCFHP anticipates a return to normal adherence rates on 2016 Q2 Patient Safety Reports.

Preliminary DHCS audit findings were provided at the audit exit conference. Ms. Paige noted there were 36 preliminary findings compared with 34 on SCFHP's prior audit. In 2015, the average results for audited California health plans was 34, with a range from 8 to 78 findings. There were six audit categories overall and the Plan improved in three, stayed the same in one, and had two areas of increased findings. The areas with increased findings were Access and Availability of Care and Member Rights.

Access and Availability of care findings included: 1) non-compliance with timely access monitoring and reporting; 2) denial reasons for Emergency Services and Family Planning claims; 3) claims processing timeframes; 4) misdirected claims; and 5) process to monitor and ensure provision of drugs prescribed in emergency circumstances.

Member Rights findings included: 1) frequency of Grievance Committee meetings; 2) grievance reporting to the QIC; 3) grievance categorization; 4) clear and concise grievance letters and letters in threshold languages; 5) exempt grievance tracking; 6) cultural and linguistics' training on threshold languages; 7) confidentiality breach notification timeframes.

There were four repeat findings from 2014; 1) misdirected claims, 2) grievance threshold language letter time frames; 3) exempt grievance tracking and 4) provider orientation within ten days of becoming a participating provider with the plan. We are assessing our corrective action that was ineffective.

The Plan has the opportunity to contest the preliminary report, within 15 days, by submitting information to DHCS with documentation and justification. If accepted, those finding would be removed from the final report, which should be provided to the plan within 30 days. The Plan then has 30 days from receipt of the final report to respond with corrective action plans. Once the State has accepted the corrective actions, they will be posted on the DHCS website.

Mr. Brownstein asked why the Plan failed to successfully take corrective action with the timely access survey findings in 2014. This will require follow up. Brenda Taussig asked if there were findings the plan was worried about not being able to correct. Ms. Paige responded that many corrections have already been put in place to correct deficiencies identified during the audit.

**It was moved, seconded, and approved** to accept the Compliance report as presented.

*Elizabeth Pianca arrived at 3:02 pm.*

**6. Unified Managed Care Committee Update**

Mr. Brownstein provided an update on the May 26, 2016 Unified Managed Care Strategy Meeting with the Board-appointed committee and County staff, and indicated discussions continue regarding a joint strategic planning process. It was noted that Bruce Butler, CEO of Valley Health Plan, and Ms. Tomcala continue to work well on administrative collaboration. The Board was

also informed that Ms. Tomcala was working with Mr. Butler and Rene Santiago on a Unified Managed Care update to the Santa Clara County Health & Hospital Committee.

Mr. Brownstein asked for volunteers to be part of a Joint Strategic Planning Committee. Liz Kniss urged Mr. Brownstein and committee members to have a conversation with their respective Supervisors regarding what Integrated Managed Care looks like, and to seek clarity on their expectations.

> **It was moved, seconded, and approved** to appoint Linda Williams, Kathleen King, Michele Lew, Bob Brownstein, and Dr. Wenner to participate on the Joint Strategic Planning Committee.

**7. Preliminary 2016-2020 Strategic Plan Framework**

Ms. Tomcala reported that SCFHP has engaged Pacific Health Consulting Group to assist the executive team in developing a strategic plan. She presented a draft Strategic Plan Framework for 2016-2020, which focuses on five areas: Quality Improvement, Complex Care Delivery, Growth, Value-Based Care, and internal Optimization. The foundational areas that need to be consistently maintained include Financial Strength, Culture of Compliance, Effective Workplace, and Positive County, State, and Federal Relationships.

Kathleen King suggested the Mission Statement be included on the document, and a focus on health education and promotion rather than just health care. Brian Darrow inquired if we should be exploring prevention initiatives to help members avoid the development of complex conditions. Dr. Robertson noted the first dot point, "Improvement Initiatives to increase patient access and care coordination among delegated entities" includes a focus on health education and developing new and improved health promotion, including the diabetes prevention pilot. He stated it is part of the intent of improving quality, rather than solely focusing on complex care.

> **It was moved, seconded, and** the Preliminary 2016-2020 Strategic Plan Framework was **approved,** with an amendment to include language regarding health promotion.

**8. Claims System RFQ**

Jonathan Tamayo presented an overview of the Core System Conversion, noting the 2015-16 Plan Objective to upgrade systems to meet operational needs of the plan. The recommendation is to transition to one Core Claims System. The benefits of transitioning to a single system include consolidated maintenance and configuration, increased opportunity for operational efficiencies, improved quality and efficiency of claim processing and payment, opportunities for process improvements across departments, and enhanced integration across lines of business.

SCFHP engaged InfoArch Consulting to assist with a Request for Quote (RFQ) process, and seek proposals from three vendors: HealthTrio – Monument, Health Solutions Plus (HSP), and Trizetto – QNXT.

Mr. Brownstein asked what could go wrong. Dave Cameron discussed cost estimates and timeline, and Ms. Tomcala highlighted the risk of not upgrading systems.

> **It was moved, seconded, and approved to** authorize the Chief Executive Officer to negotiate, execute, amend, and terminate a contract with the selected claims system vendor in an amount not to exceed a projected $7 million for licensing and implementation. An additional amendment was added that the Board and Executive/Finance Committee receive progress reports for the next two years.

**9. April 2016 Financial Statements**

Mr. Cameron reported on the financial statements for the month and fiscal year-to-date ended April 30, 2016.

For the month, enrollment is 3.7% favorable to budget, while for the year to-date, enrollment is 0.8% favorable to budget. Continued growth in the Medi-Cal Expansion population is partially offset by reductions in the CMC program.

While the Plan was received higher CMC passive enrollment in calendar year 2015, membership is trending downward due to increased opt-outs in calendar year 2016. We are increasing our efforts to retain CMC membership. Enrollment by network has been stable throughout the year.

For the month of April, the Plan showed a net surplus of $1.2 million and $12.2 million surplus for the year-to-date, which is $1.6 million unfavorable to budget.

LTC membership spiked in FY15, but we feel that enrollment has now stabilized. In the past 18 months, LTC expenses increased from almost zero to upwards of $10 million a month.

Administrative expenses are under budget, due to the required ramp-up time in personnel and short-term filling of staffing gaps with temporaries and consultants.

The recasting reconciliation with the State is still in progress; therefore, we have been conservative in our accruals without knowing what the final rates will be for FY15. The State is committed to recasting the rates by August or September 2016.

TNE is $84 million or 283% of the minimum DMHC requirement at April 30, 2016.

Ms. King requested a breakdown of the supporting schedule to address performance by aid category within of all lines of business.

**It was moved, seconded, and** the April 2016 Financial Statements were **approved** as presented.

**10. Fiscal Year 2016-2017 Budget**

Mr. Cameron presented the proposed Fiscal Year 2016-17 Budget. Although SCFHP has experienced substantial growth over the last three years driven by the Affordable Care Act (ACA), Medi–Cal expansion, and the Coordinated Care Initiative (CCI) pilot, it is projecting a modest growth of 2.4 percent for FY17, reaching 279,307 members by June 2017. Medi-Cal membership is projected to grow 3.8%, primarily in the Duals and Expansion category of aid. CMC membership is projected to decline by 5.2%. Healthy Kids enrollment is forecasted to decline substantially as undocumented transition to Medi-Cal (under SB75 legislation).

Revenue is expected to grow from $1.09 billion in FY16 to $1.14 billion in FY17 representing an annual growth of 5.3%. Medi-Cal (non-expansion and non-Duals) revenue assumes a 6% blended average rate increase while Medi-Cal expansion revenue reflected a 15.4% rate decrease based on the draft rates received from DHCS in April 2016. CMC revenue is based on 2016 rates from CMS, with the Medi-Cal component based on rates released in April, further adjusted for actual enrollment in the specified population cohorts. Healthy Kids revenue is expected to decline consistent with declining membership.

Health care costs are expected to grow from $1.04 billion in FY16 to $1.09 billion in FY17 representing and annual growth of 4.9% and 95.1% of revenue. Health care cost projections are based predominantly on current trends coupled with historical experience. In addition, adjustments were made to account for known changes to program structure, expected provider increases, and/or actuarial estimates.

General and Administrative costs are expected to grow from $36 million in FY16 to $43 million in FY17 representing an annual increase of 20%. The primary drivers are increased staffing (35 new positions) to accommodate recent growth and significant opportunities in health services, compliance, policies & procedures, audit outcomes, and NCQA accreditation readiness. Projected administrative expenses of 3.8% of revenue are comparatively low by industry standards.

Overall, a net operating surplus of $11.7 million or 1.0% of revenue is projected.

SCFHP is financially stable with fund balance (or TNE) growth from $32.6 million in FY2013 to $96.9 million in FY2017. However, as a per cent of minimum required TNE, the ratio has fallen from 420% in FY13 to 290% in FY17 due to a rapid rise in the minimum required TNE from $7.8 million to $33.1 million in the same period caused by higher medical expenses.

The proposed Fiscal Year 2016-17 Budget includes a forecast of $10.4 million for capital expenditures. Of the total request, $6.8 million is for a new claims processing system to consolidate two systems processing Medi-Cal and Medicare claims separately. The capital budget includes plans for capacity expansion in the existing facility or a new building to accommodate the projected personnel growth, if needed.

**It was moved, seconded, and** the Fiscal Year 2016-17 Budget was **approved**.

**11. Benefits for Non-Bargaining Unit Staff**

Sharon Valdez reminded the Board that the SEIU MOU was ratified at the April 28, 2016 Board meeting, and included enhanced benefits for represented employees. She stated it is now respectfully requested that the Board extend the same benefits to non-represented employees. Those benefits include three additional days of PTO after ten years of service, increased bereavement leave from three to four days if travel is 500 miles or more, and educational reimbursement up to $2,000 per fiscal year if the approved course(s) are satisfactorily completed with a grade of "C" rather than a grade of "B".

**It was moved, seconded, and approved** to offer non-represented staff the same benefits as staff represented by SEIU.

**12. Adjournment**

The meeting was adjourned at 4:37 pm.

_____

Elizabeth Pianca, Secretary to the Board

Santa Clara
Family Health Plan
*The Spirit of Care*

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

Thursday, July 28, 2016
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**
Linda Williams
Wally Wenner, M.D.
Liz Kniss (via phone)

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

**Members Absent**
Bob Brownstein
Michele Lew

1. **Roll Call**

   Linda Williams, Committee Member, called the meeting to order at 8:30 am. Roll call was taken and a quorum was not established.

2. **Introduce Neal Jarecki, Controller**

   Dave Cameron, Chief Financial Officer, introduced Neal Jarecki as the new Controller for Santa Clara Family Health Plan. Mr. Jarecki noted his recent experience at Alameda Alliance for Health and indicated this is his 13th year in Medi-Cal Managed Care. Mr. Jarecki, a CPA, explained the role of a Controller, who has primary responsibility for accounting, compared to the CFO, who has a more forward-looking, strategic focus.

3. **Public Comment**

   There were no public comments.

**4. May 2016 Financial Statements**

Mr. Cameron reported on the May and May YTD 2016 Financials.

As of May, the Plan recorded a YTD surplus of $12.3 million, $2.5 million unfavorable to budget. The variance is primarily related to higher than anticipated long-term care (LTC) expenses that have increased rapidly this fiscal year.

*Liz Kniss joined the meeting via phone and a quorum was established.*

SCFHP has cash on hand of $226 million, of which $121 million is available to the Plan after pass-through liabilities of $105 million are excluded. With Tangible Net Equity (TNE) of $85 million, the Plan has 284% of the minimum TNE required by the Department of Managed Health Care (DMHC).

Dr. Wenner indicated he has been asked by other physicians why so much money is placed in reserves. Mr. Cameron explained it is not excessive for an organization with annual revenues of approximately $1 billion, as evidenced by the fact that SCFHP has the lowest TNE percentage of all local initiative plans in the state. Mr. Jarecki noted the Plan has cash available of less than a month and half of expenses.

**It was moved, seconded, and approved** to accept the May 2016 Financial Statements as presented.

**5. Fiscal 2015-16 Year-End Update**

Mr. Cameron provided a Fiscal 2015-16 year-end update. He indicated the Plan has been working with DHCS to confirm anticipated retrospective rate adjustments for multiple programs, both positive and negative, that amount to tens of millions of dollars. Mr. Cameron also noted the Plan received a mid-year CMC risk adjustment of approximately $6 million for January to July 2016. In summary, there are several different year-end adjustments which are anticipated to have a favorable impact on year-end performance.

Moss-Adams is actively underway with the annual year-end audit, and DMHC was on-site for a Knox-Keene audit.

**6. Reserve Methodology**

Mr. Cameron presented an overview of Reserve & Liquidity Strategies. He noted the Board set an initial reserve target in December 2011. In June 2015, the Board requested a review of the reserve policy, and subsequently requested review of Tangible Net Equity (TNE) options for the reserve target, with incorporation of a liquidity target.

SCFHP needs reserves to meet regulatory requirements for TNE, to provide financial solvency to mitigate volatility, to provide liquidity to sustain SCFHP and its providers during periods of insufficient or delayed revenue, and financial solvency and liquidity for future membership growth and infrastructure investments. Mr. Jarecki indicated the average rate payment lag is between 18-24 months and it is critical that the Plan be able to absorb retroactive rate changes, whether they are positive or negative. Mr. Cameron noted that reserves allow the Plan to pursue pilot programs like CMC, undertake necessary facilities expansion, and invest in new IT systems, such as the QNXT implementation approved last month.

The current reserve policy is two months of Medi-Cal premium revenue. SCFHP has not met this target since it was established in December 2011. The Plan currently has approximately 1.1 months of premium revenue in

reserves. Options for a TNE or Reserves Policy include a multiple of capitation revenue, a multiple of medical + administrative expenses, or a multiple of required minimum TNE.

A graph of Public Plan TNE % as of 3/31/16 was provided, which showed SCFHP at 284% TNE, the lowest percentage of the 16 public plans. Mr. Cameron discussed the impact of Medi-Cal Expansion funding and SCFHP passing much of the funding on to the Safety Net. Plans having ≤200% of minimum are placed on a DMHC "Watch List" and require monthly reporting, while plans having ≤130% of the minimum are considered to be in financial jeopardy and DMHC can take control of the health plan.

Mr. Cameron noted it is reasonable for SCFHP to set a Reserve Target at 350-500% of minimum required TNE. That represents a reserve target of $105-$150 million.

Ms. Williams inquired if when all the year-end reconciliations are complete, might the Plan's TNE percentage be higher. Mr. Cameron responded that may be likely.

It was noted there is no liquidity requirement in the Plan's contract with the State. DMHC requires plans to have a "Current Ratio" of at least 1.0, and SCFHP is at 1.2. However, while the Current Ratio is designed to provide a measure of a plan's ability to meet short-term financial obligations, due to inclusion of premiums receivable in assets and pass-through amounts in liabilities, it is not a true measure of liquidity since only cash can pay expenses.

Mr. Cameron suggested SCFHP establish a Liquidity Target of 45-60 days of expenses. He noted that for ease of monitoring, "Liquidity" would be defined as Net Cash Available to SCFHP. Mr. Cameron indicated this currently represents a Liquidity Target of $138-184 million.

Mr. Cameron further recommended that staff provide an annual discussion of the Reserve Policy to the Board concurrent with approval of the Annual Operating Budget.

It was noted SCFHP is $20-65 million below the recommended Reserve Target and $18-64 million below the recommended Liquidity Target. Mr. Cameron indicated the Plan should be able to reach the targets in 2-5 years with sustained profitability at a 1-1 ½ % margin. Staff will add a chart to the monthly financials to monitor progress toward the targets.

> **It was moved, seconded, and approved** to recommend Board approval of the proposed TNE and liquidity targets.

**7. Meeting Minutes**

The minutes of the May 26, 2016 Executive Committee Meeting were reviewed.

> **It was moved, seconded, and** the May 26, 2016 meeting minutes were **approved** as presented.
>
> *Liz Kniss left the meeting.*

**8. CEO Update**

Christine Tomcala reported that DMHC auditors were on-site for a routine Knox-Keene audit, which focuses on Finance and Claims. The audit went smoothly and there were nine exceptions to report, and four exceptions to

discuss, in the preliminary report presented at the exit conference on Friday.

Ms. Tomcala also noted that WeiserMazars has been conducting a Finance & Accounting Department Risk Assessment & Policy Analysis, which included review of policies and procedures, the last DMHC filing, and procurement and vendor contracting processes. The consultants gauged SCFHP's overall risk level as moderate, with eight risk areas identified in the assessment.

**9. Adjournment**

The meeting was adjourned at 9:38 am.

_____
Elizabeth Pianca, Secretary to the Board

Santa Clara
Family Health Plan

*The Spirit of Care*

# Financial Statements
## For Eleven Months Ended May 2016
(Unaudited)

# Table of Contents

# Santa Clara Family Health Plan
# CFO Finance Report
# For the Month and Year to Date Ended May 31, 2016

## Summary of Financial Results (*Revised Budget*)

For the month of May 2016, SCFHP recorded a net surplus of $0.1 million compared to a budgeted net surplus of $1.0 million resulting in an unfavorable variance from budget of $0.9 million. For year to date May 2016, SCFHP recorded a net surplus of $12.3 million compared to a budgeted net surplus of $14.8 million resulting in a unfavorable variance from budget of $2.5 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 – May 2016

Favorable/ (Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 92,351,188 | $ 89,184,168 | $ 3,167,020 | 3.6% | Revenue | $991,188,058 | $980,417,562 | $ 10,770,495 | 1.1% |
| 89,092,379 | 83,960,833 | (5,131,546) | -6.1% | Medical Expense | 946,093,883 | 928,567,643 | (17,526,241) | -1.9% |
| 3,258,809 | 5,223,335 | (1,964,525) | -37.6% | Gross Margin | 45,094,174 | 51,849,919 | (6,755,745) | -13.0% |
| 3,015,708 | 4,033,604 | 1,017,896 | 25.2% | Administrative Expense | 31,822,472 | 35,678,534 | 3,856,062 | 10.8% |
| 243,101 | 1,189,731 | (946,630) | -79.6% | Net Operating Income | 13,271,702 | 16,171,385 | (2,899,683) | -17.9% |
| (93,675) | (139,752) | 46,077 | 33.0% | Non-Operating Income/Exp | (952,099) | (1,332,500) | 380,401 | 28.5% |
| $ 149,426 | $ 1,049,979 | $ (900,553) | -85.8% | Net Surplus/ (Loss) | $ 12,319,603 | $ 14,838,885 | $ (2,519,282) | -17.0% |

## Revenue

The Health Plan recorded net revenue of $92.4 million for the month of May 2016, compared to budgeted revenue of $89.2 million, resulting in a favorable variance from budget of $3.2 million, or 3.6%. For year to date May 2016, the Plan recorded net revenue of $991.2 million, compared to budgeted revenue of $980.4 million, resulting in a favorable variance from budget of $10.8 million, or 1.1%, which was primarily driven by higher Medi-Cal membership, higher In Home Support Services (IHSS) revenue, increased Abortion capitation rate, and higher number of Hep C eligible users. The Plan received Long Term Care (LTC) prior year revenue and also recorded partial LTC rate adjustment revenue reflecting the more expensive MLTSS mix than originally projected by the state during the rate setting. The positive variance was partially offset by unfavorable variance in Medicare and Maternity Kick revenue.

A statistical and financial summary for all lines of business is included on page 9 of this report.

## Member months

For the month of May 2016, overall member months were higher than budget by 13,935 (+5.4%). For year to date May 2016, overall member months were higher than budget by 35,943 (+1.2%).

In the eleven months since the end of the prior fiscal year, 6/30/2015, membership in Medi-Cal increased by 10.5%, membership in the Healthy Kids program decreased by 3.7%, and membership in the Agnews program decreased by 1.8%.

In January 2015, we started enrolling members in Cal MediConnect (CMC). For the month of May 2016, membership in the CMC program was lower than the budget by 792 member months (- 8.6%). For year to date May 2016, membership in the CMC program was lower than the budget by 2,167 member months (- 2.3%). In the eleven months since the end of the prior fiscal year, 6/30/2015, membership in CMC program increased by 16.4%.

Member months, and changes from prior year, are summarized on Page 11.

## Medical Expenses

For the month of May 2016, medical expense was $89.1 million compared to budget of $84.0 million, resulting in an unfavorable budget variance of $5.1 million, or -6.1%. For year to date May 2016, medical expense was $946.1 million compared to budget of $928.6 million, resulting in an unfavorable budget variance of $17.5 million, or -1.9%. The increased medical expenses year to date are primarily attributable to Long term care ($13.6 million or 17.2%), Pharmacy ($4.5 million or 3.6%), and IHSS expense ($4.6 million or 3.2%) over budget.

## Administrative Expenses

Overall administrative costs were under budget by $1.0 million (25.2%) for the month of May 2016, and under budget by $3.9 million (10.8%) for year to date May 2016. Both Salaries/Benefits and Consulting expenses were under budget due to the longer than expected ramp up time to hire/engage additional resources approved at the mid-year budget review. Printing and Reproduction and Contracted Services expenses were lower due to the printing/mailing of the materials being deferred to a later date. Some of this favorability is offset by higher than budgeted Information systems and Temporary help expenses.

Overall administrative expenses were 3.2% of revenues for year to date May 2016.

## Balance Sheet (Page 6)

Current assets at May 31, 2016 totaled $469.7 million compared to current liabilities of $378.2 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 as of May 31, 2016. Working capital increased by $13.0 million for the eleven months year to date ended May 31, 2016.

Cash as of May 31, 2016, increased by $115.8 million compared to the cash balance as of year-end June 30, 2015. Net receivables increased by $63.4 million during the same eleven month period ended May 31, 2016. The cash position increased largely due to the continued overpayment of Medi-Cal expansion premium revenues by the DHCS. It also increased due to the receipt of both April and May capitation in the month of May. Commencing in January, DHCS started to recoup the over payments and completion of the payback is anticipated by February 2017. However, DHCS has still not implemented the substantially reduced FY16 rate, so this liability amount is likely to continue growing despite partial recoupment.

Liabilities increased by a net amount of $167.5 million during the eleven months ended May 2016. This was primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State, an increase in medical cost reserves largely as a result of the rapid growth of long term care claims, and an increase in the IHSS liability. The plan also recorded a Premium Deficiency Reserve ($18.0 million) for the Cal MediConnect contract period ending December 31, 2016. Additionally, the Health Plan recorded the unfunded Pension Liability of $5.7 million as required by GASB 68, as of May 31, 2016.

Capital Expenses increased by $1.4 million for the eleven months ended May 31, 2016.

# Tangible Net Equity

Tangible Net Equity (TNE) was $85.0 million at May 31, 2016 compared to the minimum TNE required by the Department of Managed Health Care (DMHC) of $30.0 million. A chart showing TNE trends is shown on page 14 of this report.

At the December 2011 Board of Director's meeting, a policy was adopted for targeting the organization's capital reserves to equal two months of Medi-Cal capitation revenue.

As of May 31, 2016, the Plan's reserves are below this reserves target by about $66.9 million (see calculation below).

Calculation of targeted reserves as of May 31, 2016

| | |
|---|---|
| Estimate of two months' capitation based on May 2016 (rounded) $146,949,000<br>(May 2016 Medi-Cal capitation of $73,474,130 x 2 = $146,948,260) | |
| Less: Unrestricted Net Equity per balance sheet (rounded) | $ 80,028,000 |
| Approximate reserves below target | $ 66,921,000 |

**Santa Clara County Health Authority**
**Balance Sheet**

| | MAY 16 | APR 16 | MAR 16 | JUN 15 |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Cash and Marketable Securities | $ 226,333,649 | $ 143,160,175 | $ 126,021,360 | $ 110,520,927 |
| Premiums Receivable | 240,947,195 | 317,887,525 | 303,384,171 | 177,531,031 |
| Due from Santa Clara Family Health Foundation - net | | | | 3,612 |
| Prepaid Expenses and Other Current Assets | 2,445,165 | 2,796,167 | 3,019,935 | 1,917,101 |
| Total Current Assets | 469,726,008 | 463,843,868 | 432,425,467 | 289,972,670 |
| **Long Term Assets** | | | | |
| Equipment | 13,249,656 | 13,165,506 | 12,493,431 | 11,879,173 |
| Less: Accumulated Depreciation | (8,632,945) | (8,491,534) | (8,352,033) | (7,363,871) |
| Total Long Term Assets | 4,616,711 | 4,673,972 | 4,141,398 | 4,515,302 |
| **Total Assets** | $ 474,342,719 | $ 468,517,839 | $ 436,566,865 | $ 294,487,972 |
| **Deferred Outflow of Resources** | $ 1,367,331 | $ 1,367,331 | 1,367,331 | 1,367,331 |
| **Total Deferred Outflows and Assets** | 475,710,050 | 469,885,170 | 437,934,196 | 295,855,303 |
| **Liabilities and Net Position** | | | | |
| **Current Liabilities** | | | | |
| Trade Payables | $ 4,583,300 | $ 3,658,195 | $ 7,214,335 | $ 4,924,038 |
| Deferred Rent | 144,469 | 146,529 | 148,590 | 167,134 |
| Employee Benefits | 1,046,300 | 1,026,662 | 1,079,171 | 973,066 |
| Retirement Obligation per GASB 45 | 556,515 | 505,923 | 455,330 | |
| Advance Premium - Healthy Kids | 64,791 | 66,999 | 63,041 | 64,127 |
| Deferred Revenue - Medicare | | 8,006,172 | | 0 |
| Liability for ACA 1202 | 503,985 | 516,561 | 516,500 | 5,069,225 |
| Payable to Hospitals (SB208) | (35,535) | (35,535) | (35,535) | (35,535) |
| Payable to Hospitals (AB 85) | 1,691,053 | 1,733,119 | 1,647,982 | 4,615,251 |
| Due to Santa Clara County Valley Health Plan | 2,829,030 | 2,568,192 | 2,375,009 | 11,230,305 |
| MCO Tax Payable - State Board of Equalization | 11,304,960 | 11,082,866 | 10,212,271 | 8,909,559 |
| Due to DHCS | 89,161,901 | 80,751,901 | 73,135,234 | 22,173,221 |
| Liability for In Home Support Services (IHSS) | 181,522,714 | 170,791,594 | 160,352,374 | 69,537,810 |
| Premium Deficiency Reserve (PDR) | 13,088,054 | 13,088,054 | 13,088,054 | 13,088,054 |
| Medical Cost Reserves | 71,784,407 | 78,738,257 | 71,681,738 | 70,819,543 |
| Total Current Liabilities | 378,245,943 | 372,645,488 | 341,934,094 | 211,535,798 |
| **Non-Current Liabilities** | | | | |
| Noncurrent Premium Deficiency Reserve | 4,911,946 | 4,911,946 | 4,911,946 | 4,911,946 |
| Net Pension Liability GASB 68 | 5,708,971 | 5,633,971 | 5,558,971 | 4,883,971 |
| Total Liabilities | 388,866,860 | 383,191,405 | 352,405,011 | 221,331,715 |
| **Deferred Inflow of Resources** | 1,892,634 | 1,892,634 | 1,892,634 | 1,892,634 |
| **Net Position / Reserves** | | | | |
| Invested in Capital Assets | 4,616,711 | 4,673,972 | 4,141,398 | 4,515,302 |
| Restricted under Knox-Keene agreement | 305,350 | 305,350 | 305,350 | 305,350 |
| Unrestricted Net Equity | 67,708,893 | 67,651,632 | 68,184,206 | 30,416,972 |
| Current YTD Income (Loss) | 12,319,603 | 12,170,177 | 11,005,597 | 37,393,330 |
| Net Position / Reserves | 84,950,557 | 84,801,131 | 83,636,551 | 72,630,954 |
| **Total Liabilities, Deferred Inflows, and Net Assets** | $ 475,710,050 | $ 469,885,170 | $ 437,934,196 | $ 295,855,303 |
| **Solvency Ratios:** | | | | |
| Working Capital | $ 91,480,066 | $ 91,198,379 | $ 90,491,373 | $ 78,436,872 |
| Working Capital Ratio | 1.2 | 1.2 | 1.3 | 1.4 |
| Average Days Cash on Hand | 78 | 49 | 44 | 55 |

**Santa Clara County Health Authority**
**Income Statement for the Eleven Months Ending May 31, 2016**

| | For the Month of May 2016 | | | | | For Eleven Months Ending May 31, 2016 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | % of Revenue | Budget | % of Revenue | Variance | Actual | % of Revenue | Budget | % of Revenue | Variance |
| **REVENUES** | | | | | | | | | | |
| MEDI-CAL | $ 83,924,167 | 90.9% | $ 79,084,299 | 88.7% | $ 4,839,868 | $ 890,339,454 | 89.8% | $ 874,246,100 | 89.2% | $ 16,093,353 |
| HEALTHY KIDS | $ 386,021 | 0.4% | $ 350,162 | 0.4% | $ 35,859 | $ 4,144,902 | 0.4% | $ 4,078,977 | 0.4% | $ 65,925 |
| MEDICARE | $ 8,040,999 | 8.7% | $ 9,749,706 | 10.9% | $ (1,708,707) | $ 96,703,702 | 9.8% | $ 102,092,485 | 10.4% | $ (5,388,783) |
| **TOTAL REVENUE** | $ 92,351,188 | 100.0% | $ 89,184,168 | 100.0% | $ 3,167,020 | $ 991,188,058 | 100.0% | $ 980,417,562 | 100.0% | $ 10,770,495 |
| **MEDICAL EXPENSES** | | | | | | | | | | |
| MEDI-CAL | $ 80,843,809 | 87.5% | $ 75,303,195 | 84.4% | $ (5,540,614) | $ 853,913,822 | 86.2% | $ 833,278,833 | 85.0% | $ (20,634,989) |
| HEALTHY KIDS | $ 355,784 | 0.4% | $ 362,515 | 0.4% | $ 6,731 | $ 4,029,879 | 0.4% | $ 4,102,006 | 0.4% | $ 72,126 |
| MEDICARE | $ 7,857,008 | 8.5% | $ 8,257,348 | 9.3% | $ 400,341 | $ 87,741,056 | 8.9% | $ 90,771,159 | 9.3% | $ 3,030,103 |
| AGNEWS | $ 35,777 | 0.0% | $ 37,775 | 0.0% | $ 1,997 | $ 409,126 | 0.0% | $ 415,645 | 0.0% | $ 6,519 |
| **TOTAL MEDICAL EXPENSES** | $ 89,092,379 | 96.5% | $ 83,960,833 | 94.1% | $ (5,131,546) | $ 946,093,883 | 95.5% | $ 928,567,643 | 94.7% | $ (17,526,241) |
| **MEDICAL OPERATING MARGIN** | $ 3,258,809 | 3.5% | $ 5,223,335 | 5.9% | $ (1,964,525) | $ 45,094,174 | 4.5% | $ 51,849,919 | 5.3% | $ (6,755,745) |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | | | |
| SALARIES AND BENEFITS | $ 1,617,139 | 1.8% | $ 2,128,796 | 2.4% | $ 511,656 | $ 16,770,525 | 1.7% | $ 18,901,538 | 1.9% | $ 2,131,013 |
| RENTS AND UTILITIES | $ 107,166 | 0.1% | $ 109,064 | 0.1% | $ 1,898 | $ 1,176,062 | 0.1% | $ 1,203,487 | 0.1% | $ 27,425 |
| PRINTING AND ADVERTISING | $ 899 | 0.0% | $ 445,473 | 0.5% | $ 444,574 | $ 401,052 | 0.0% | $ 1,309,864 | 0.1% | $ 908,812 |
| INFORMATION SYSTEMS | $ 181,557 | 0.2% | $ 87,999 | 0.1% | $ (93,558) | $ 1,883,766 | 0.2% | $ 1,465,680 | 0.1% | $ (418,086) |
| PROF FEES / CONSULTING / TEMP STAFFING | $ 793,669 | 0.9% | $ 968,286 | 1.1% | $ 174,618 | $ 8,500,012 | 0.9% | $ 9,770,219 | 1.0% | $ 1,270,207 |
| DEPRECIATION / INSURANCE / EQUIPMENT | $ 171,468 | 0.2% | $ 164,089 | 0.2% | $ (7,378) | $ 1,630,983 | 0.2% | $ 1,559,896 | 0.2% | $ (71,086) |
| OFFICE SUPPLIES / POSTAGE / TELEPHONE | $ 56,000 | 0.1% | $ 66,684 | 0.1% | $ 10,684 | $ 671,465 | 0.1% | $ 711,959 | 0.1% | $ 40,495 |
| MEETINGS / TRAVEL / DUES | $ 73,270 | 0.1% | $ 56,136 | 0.1% | $ (17,134) | $ 719,581 | 0.1% | $ 689,929 | 0.1% | $ (29,652) |
| OTHER | $ 14,542 | 0.0% | $ 7,077 | 0.0% | $ (7,464) | $ 69,027 | 0.0% | $ 65,961 | 0.0% | $ (3,065) |
| **TOTAL ADMINISTRATIVE EXPENSES** | $ 3,015,708 | 3.3% | $ 4,033,604 | 4.5% | $ 1,017,896 | $ 31,822,472 | 3.2% | $ 35,678,534 | 3.6% | $ 3,856,062 |
| **OPERATING SURPLUS (LOSS)** | $ 243,101 | 0.3% | $ 1,189,731 | 1.3% | $ (946,630) | $ 13,271,702 | 1.3% | $ 16,171,385 | 1.6% | $ (2,899,683) |
| **GASB 45-POST EMPLOYMENT BENEFITS EXPENSE** | $ (50,592) | -0.1% | $ (80,007) | -0.1% | $ 29,415 | $ (556,515) | -0.1% | $ (703,590) | -0.1% | $ 147,075 |
| **GASB 68 - UNFUNDED PENSION LIABILITY** | $ (75,000) | -0.1% | $ (75,000) | -0.1% | $ - | $ (825,000) | -0.1% | $ (825,000) | -0.1% | $ - |
| **INTEREST & OTHER INCOME** | $ 31,917 | 0.0% | $ 15,255 | 0.0% | $ 16,662 | $ 429,416 | 0.0% | $ 196,090 | 0.0% | $ 233,326 |
| **NET SURPLUS (LOSS) FINAL** | $ 149,426 | 0% | $ 1,049,979 | 1.2% | $ (900,553) | $ 12,319,603 | 1.2% | $ 14,838,885 | 1.5% | $ (2,519,282) |

**Administrative Expense**

**Actual vs. Budget**

**For the Current Month & Fiscal Year to Date - May 2016**

Favorable/(Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 1,617,139 | $ 2,128,796 | $ 511,656 | 24.0% | Personnel | $ 16,770,525 | $ 18,901,538 | $ 2,131,013 | 11.3% |
| 1,398,569 | 1,904,808 | 506,239 | 26.6% | Non-Personnel | 15,051,947 | 16,776,996 | $ 1,725,049 | 10.3% |
| 3,015,708 | 4,033,604 | 1,017,896 | 25.2% | Total Administrative Expense | 31,822,472 | 35,678,534 | 3,856,062 | 10.8% |

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

**Eleven Months Ended May 31, 2016**

| | Medi-Cal (incl. Agnews) | CMC | Healthy Kids | **Grand Total** |
|---|---|---|---|---|
| **P&L (ALLOCATED BASIS)** | | | | |
| REVENUE | 865,705,410 | 121,337,745 | $4,144,902 | **$991,188,058** |
| MEDICAL EXPENSES | 823,298,269 | 118,765,735 | 4,029,879 | **$946,093,883** |
| (MLR) | 95.1% | 97.9% | 97.2% | **95.5%** |
| GROSS MARGIN | 42,407,141 | 2,572,011 | 115,023 | **45,094,174** |
| ADMINISTRATIVE EXPENSES | 27,456,723 | 3,895,595 | 470,154 | **31,822,472** |
| *(% MM allocation except CMC)* | | | | |
| OPERATING INCOME/(LOSS) | 14,950,417 | (1,323,584) | (355,131) | **13,271,702** |
| OTHER INCOME/(EXPENSE) | (831,565) | (116,553) | (3,981) | **(952,099)** |
| *(% of Revenue Allocation)* | | | | |
| NET INCOME/ (LOSS) | $14,118,852 | ($1,440,137) | ($359,112) | **$12,319,603** |
| **PMPM (ALLOCATED BASIS)** | | | | |
| REVENUE | $311.49 | $1,294.41 | $87.10 | **$339.38** |
| MEDICAL EXPENSES | 296.23 | 1,266.97 | 84.68 | **323.94** |
| GROSS MARGIN | 15.26 | 27.44 | 2.42 | **15.44** |
| ADMINISTRATIVE EXPENSES | 9.88 | 41.56 | 9.88 | **10.90** |
| OPERATING INCOME/(LOSS) | 5.38 | (14.12) | (7.46) | **4.54** |
| OTHER INCOME / (EXPENSE) | (0.30) | (1.24) | (0.08) | **(0.33)** |
| NET INCOME / (LOSS) | $5.08 | ($15.36) | ($7.55) | **$4.22** |
| **ALLOCATION BASIS:** | | | | |
| *MEMBER MONTHS - YTD* | *2,779,229* | *93,740* | *47,590* | ***2,920,559*** |
| *Member MONTHS by LOB* | *95.2%* | *3.2%* | *1.7%* | ***100%*** |
| *Revenue by LOB* | *87.3%* | *12.2%* | *0.4%* | ***100%*** |

**Santa Clara Family Health Plan**
**Statement of Cash Flows**
**For Eleven Months Ended May 31, 2016**

| | | |
|---|---|---|
| Cash flows from operating activities | | |
| Premiums received | $ | 997,159,586 |
| Medical expenses paid | $ | (841,545,392) |
| Administrative expenses paid | $ | (38,860,405) |
| Net cash from operating activities | $ | 116,753,790 |
| | | |
| Cash flows from capital and related financing activities | | |
| Purchases of capital assets | $ | (1,370,483) |
| | | |
| Cash flows from investing activities | | |
| Interest income and other income, net | $ | 429,416 |
| | | |
| Net (Decrease) increase in cash and cash equivalents | $ | 115,812,722 |
| | | |
| Cash and cash equivalents, beginning of year | $ | 110,520,927 |
| | | |
| Cash and cash equivalents at May 31, 2016 | $ | 226,333,649 |
| | | |
| Reconciliation of operating income to net cash from operating activities | | |
| Operating income (loss) | $ | 11,890,187 |
| Adjustments to reconcile operating income to net cash from operating activities | | |
| Depreciation | $ | 1,269,074 |
| Changes in operating assets and liabilities | | |
| Premiums receivable | $ | (63,416,165) |
| Due from Santa Clara Family Health Foundation | $ | 3,612 |
| Prepaids and other assets | $ | (528,063) |
| Deferred outflow of resources | $ | - |
| Accounts payable and accrued liabilities | $ | (7,222,428) |
| State payable | $ | 69,384,081 |
| Santa Clara Valley Health Plan payable | $ | (8,401,276) |
| Net Pension Liability | $ | 825,000 |
| Medical cost reserves and PDR | $ | 964,864 |
| Deferred inflow of resources | $ | - |
| Total adjustments | $ | 104,863,602 |
| Net cash from operating activities | $ | 116,753,790 |

## Santa Clara Family Health Plan Enrollment Summary

| | For the Month of May 2016 | | | Eleven Months Ending May 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Prior Year Actual** | **Change FY16 vs. FY15** |
| Medi-Cal | 259,076 | 244,682 | 5.9% | 2,778,019 | 2,740,442 | 1.4% | 2,349,726 | 18.2% |
| Healthy Kids | 4,375 | 4,038 | 8.4% | 47,590 | 47,035 | 1.2% | 52,797 | ( 9.9%) |
| Medicare | 8,367 | 9,159 | ( 8.6%) | 93,740 | 95,907 | ( 2.3%) | 32,329 | 190.0% |
| Agnews | 110 | 114 | ( 3.5%) | 1,210 | 1,232 | ( 1.8%) | 1,246 | ( 2.9%) |
| Total | 271,928 | 257,993 | 5.4% | 2,920,559 | 2,884,616 | 1.2% | 2,436,098 | 19.9% |

**Santa Clara County Health Authority**
**May 2016**

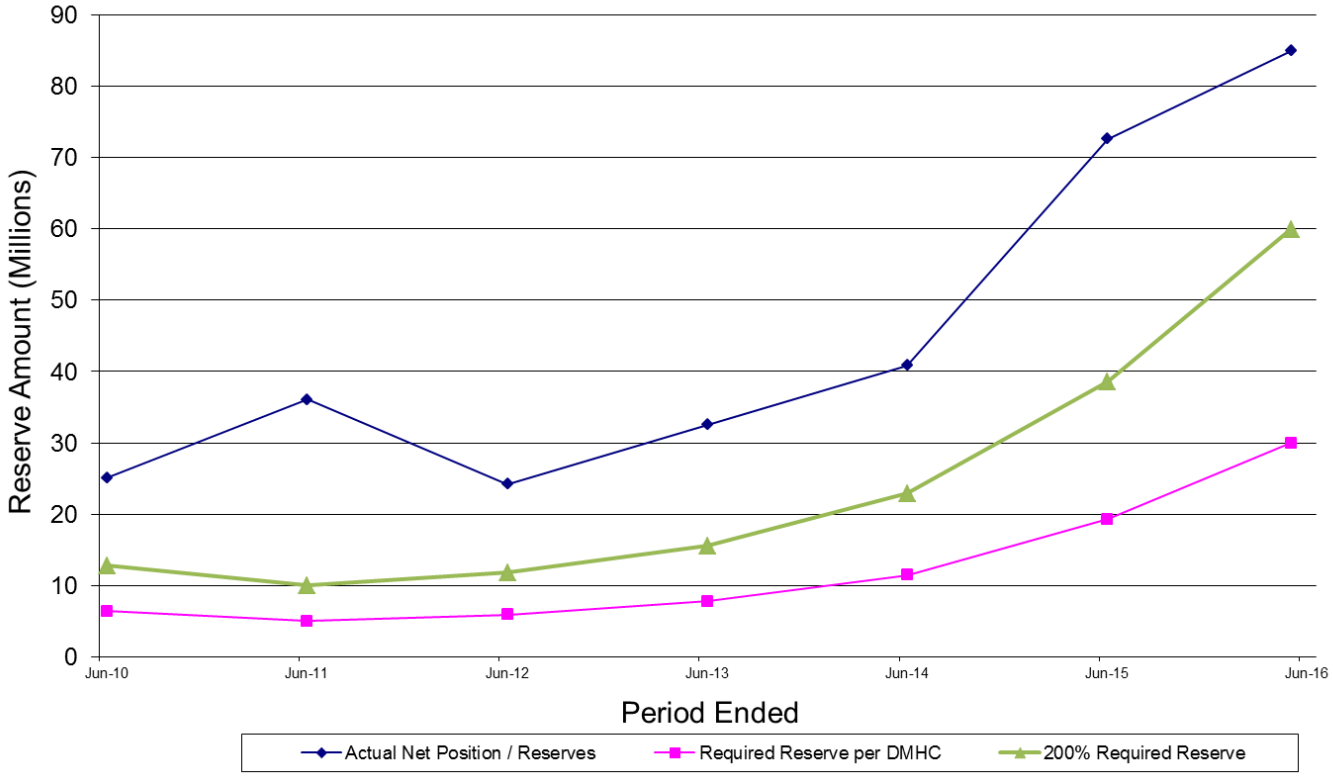
| | Medi-Cal | | Healthy Kids | | CMC | | AG | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contract Physicians | 22,848 | 9% | 227 | 5% | 8,367 | 100% | 110 | 100% | 31,552 | 12% |
| SCVHHS, Safety Net Clinics, FQHC Clinics | 139,012 | 54% | 2,920 | 67% | 0 | 0% | 0 | 0% | 141,932 | 52% |
| Palo Alto Medical Foundation | 7,428 | 3% | 34 | 1% | 0 | 0% | 0 | 0% | 7,462 | 3% |
| Physicians Medical Group | 46,658 | 18% | 1,041 | 24% | 0 | 0% | 0 | 0% | 47,699 | 18% |
| Premier Care | 15,890 | 6% | 153 | 3% | 0 | 0% | 0 | 0% | 16,043 | 6% |
| Kaiser | 27,240 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 27,240 | 10% |
| Total | 259,076 | 100% | 4,375 | 100% | 8,367 | 100% | 110 | 100% | 271,928 | 100% |
| Enrollment @ 6-30-15 | 234,497 | | 4,541 | | 7,187 | | 112 | | 246,337 | |
| Net % Change from Beginning of FY | 10.5% | | -3.7% | | 16.4% | | -1.8% | | 10.4% | |

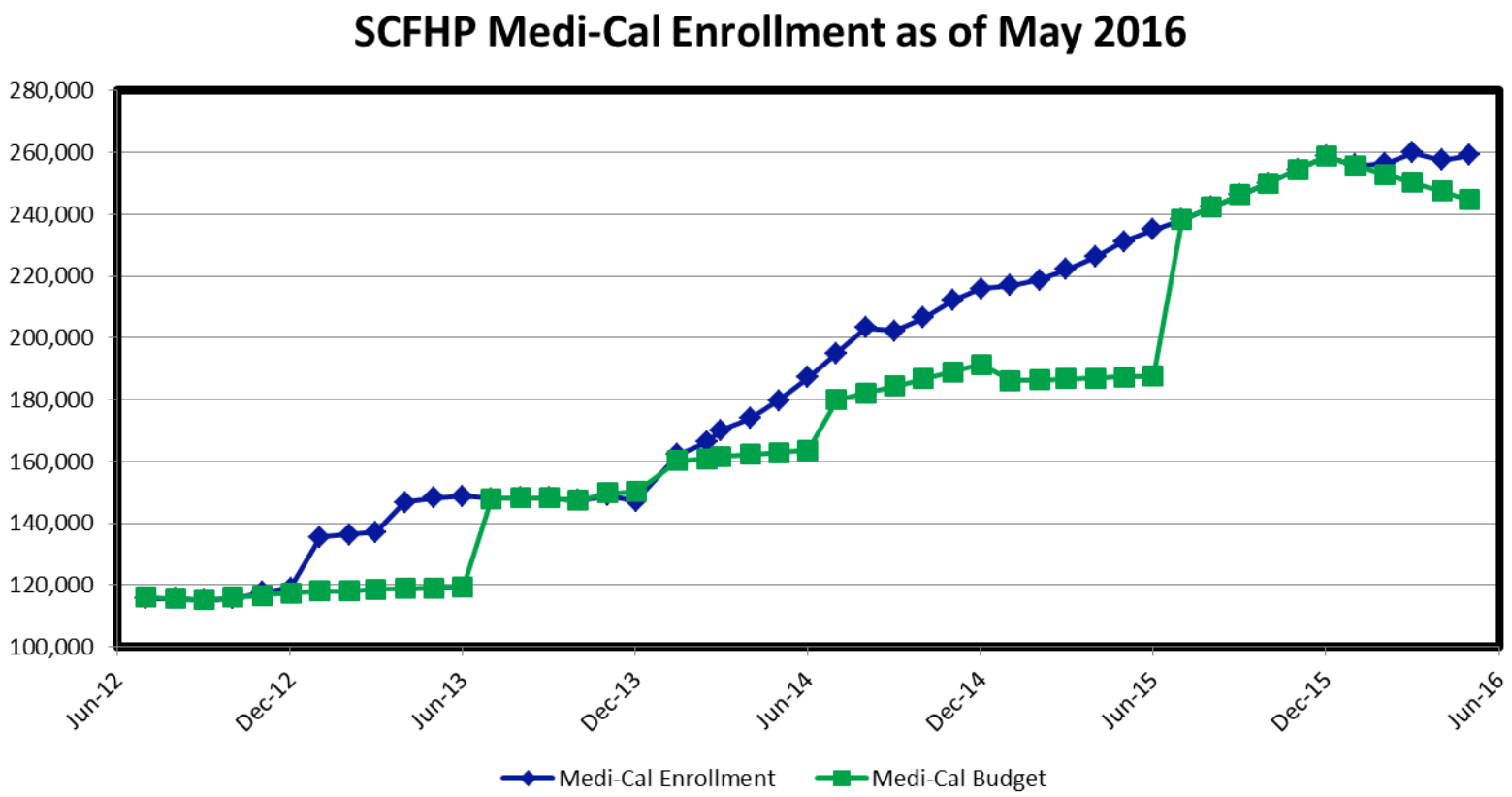
# Santa Clara Family Health Plan
# Enrollment by Aid-Category

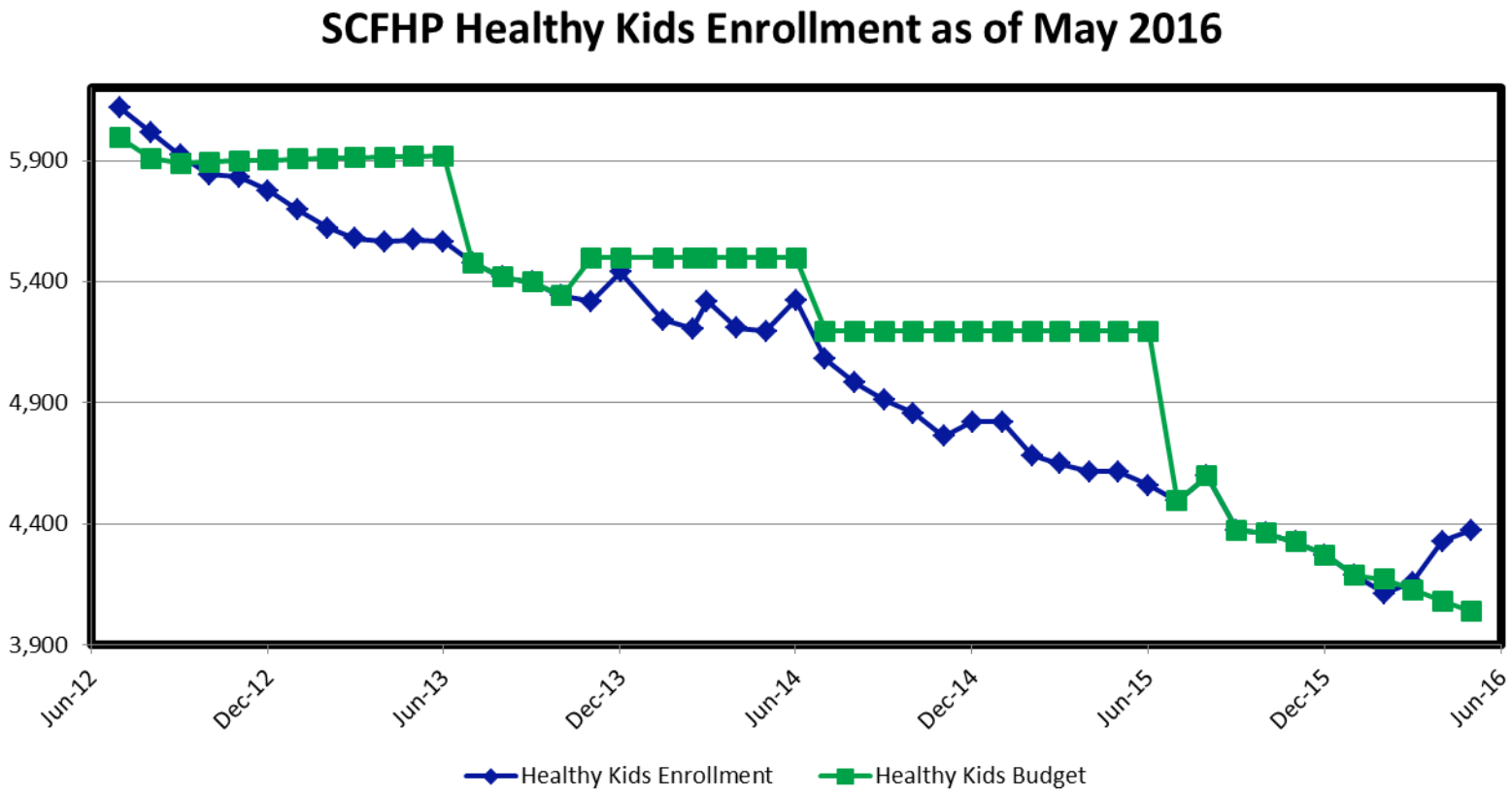
| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 2015-07 | 2015-08 | 2015-09 | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 27,844 | 27,331 | 27,080 | 27,148 | 27,229 | 27,493 | 27,509 | 27,485 | 27,857 | 27,436 | 27,431 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 8,642 | 8,730 | 8,858 | 8,909 | 9,103 | 9,235 | 9,241 | 9,158 | 9,150 | 9,145 | 9,144 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 9,541 | 7,791 | 6,032 | 4,575 | 3,837 | 3,461 | 3,211 | 2,863 | 2,556 | 2,301 | 2,045 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 |
| | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 4,727 | 4,932 | 5,235 | 5,544 | 5,852 | 6,042 | 6,049 | 6,070 | 6,058 | 6,050 | 6,018 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 1,238 | 1,303 | 1,370 | 1,458 | 1,483 | 1,638 | 1,638 | 1,654 | 1,701 | 1,711 | 1,787 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 16,612 | 17,635 | 19,002 | 20,332 | 21,698 | 22,779 | 22,819 | 23,008 | 23,106 | 23,068 | 23,223 |
| | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 |
| | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 4,496 | 4,598 | 4,375 | 4,362 | 4,325 | 4,273 | 4,186 | 4,114 | 4,158 | 4,328 | 4,375 |
| | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 7,543 | 7,698 | 7,912 | 8,354 | 8,906 | 9,699 | 9,159 | 8,886 | 8,728 | 8,488 | 8,367 |
| | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** |

**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 | 5/31/2016 |
|---|---|---|---|---|---|---|---|
| **Actual Net Position / Reserves** | 25,103,011 | 36,093,769 | 24,208,576 | 32,551,161 | 40,872,580 | 72,630,954 | 84,950,557 |
| **Required Reserve per DMHC** | 6,388,000 | 4,996,000 | 5,901,000 | 7,778,000 | 11,434,000 | 19,269,000 | 29,952,000 |
| **200% of Required Reserve** | 12,776,000 | 9,992,000 | 11,802,000 | 15,556,000 | 22,868,000 | 38,538,000 | 59,904,000 |




SCFHP Medi-Cal Enrollment as of May 2016
280,000
260,000
240,000
220,000
200,000
180,000
160,000
140,000
120,000
100,000
Jun-12
Dec-12
Jun-13
Dec-13
Jun-14
Dec-14
Jun-15
Dec-15
Jun-16
Medi-Cal Enrollment
Medi-Cal Budget


SCFHP Healthy Kids Enrollment as of May 2016
5,900
5,400
4,900
4,400
3,900
Jun-12
Dec-12
Jun-13
Dec-13
Jun-14
Dec-14
Jun-15
Dec-15
Jun-16
Healthy Kids Enrollment
Healthy Kids Budget

# May 2016
# Financial Summary

SCCHA Executive Committee Meeting

July 28, 2016

# Fiscal Year 2015-16 Highlights (*Revised Budget*)

- **Net Surplus (loss) –** May $0.1m surplus and YTD $12.3m surplus ($2.5m) unfavorable to budget
  - The variance is primarily related to long -term care expenses (LTC) that have increased rapidly this fiscal year (note expense growth on page 6 chart).
- **Revenue –** over budget by $10.8 m (+1.1%)
  - Increase is due to higher Medi-Cal membership, higher In Home Support Services (IHSS) revenue, higher Abortion capitation rate, higher number of Hep C users, and LTC rate adjustment. However, CMC revenue is lower than budget.
- **Medical Expenses –** over budget by $17.5m (-1.9%)
  - Primarily due to higher than budgeted LTC, Pharmacy, and IHSS expense.
- **Administrative Expenses –** under budget by $3.9m (10.8%)
  - Slower hiring personnel (FTE and Consultants) ramp up than budgeted. Printing/Reproduction/Contracted costs deferred to a later date.
- **Other Expenses –** under budget by $0.4m; due to higher interest earned and lower post-employment benefits expense.
- **Enrollment**
  - May 2016 membership: 271,928 (5.4% favorable to budget)
  - May YTD: 2,920,559 member months (1.2% favorable to budget and 20% higher than May YTD last year)
  - Continued growth in Medi-Cal Expansion membership. CMC membership has been trending downward since January.
- **Balance Sheet**
  - May capitation received early improving cash position and reducing capitation receivable.
  - Net receivables due from DHCS have increased $40m primarily because of CCI and CMC rate recasting delays.
  - Medi-Cal Expansion rate overpayment: State recouped most of the FY15 overpayments; however, FY16 overpayments continue to grow.

# Consolidated Performance
# May 2016 and Year to Date

| | Month of May | FYTD through May |
|---|---|---|
| **Revenue** | $92.4 million | $991.2 million |
| **Medical Costs** | $89.1 million | $946.1 million |
| **Medical Loss Ratio** | 96.5% | 95.5% |
| **Administrative Costs** | $3 million (3.3%) | $31.8 million (3.2%) |
| **Other Income/ Expense** | ($93,675) | ($952,099) |
| **Net Surplus (Loss)** | $149,426 | $12,319,603 |

| | | |
|---|---|---|
| Cash on Hand | (78 Days) | $226.3 million |
| Net Cash Available to SCFHP | (42 Days) | $120.9 million |
| Receivables | | $240.9 million |
| Current Liabilities | | $378.2 million |
| Tangible Net Equity | | $85 million |
| Pct. Of Min. Requirement | | **284%** |

# Consolidated Performance

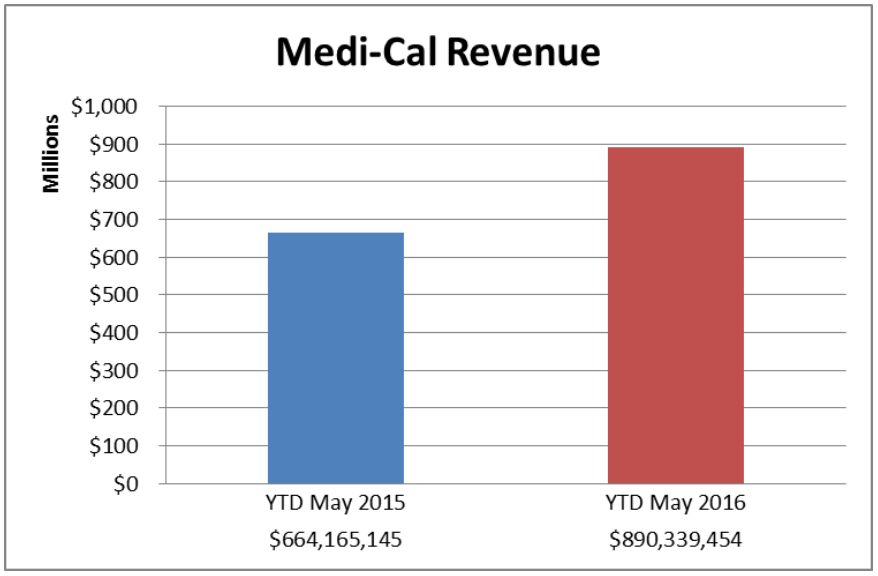
**Summary Operating Results - Actual vs. Budget**
**For the Current Month & Fiscal Year to Date - May 2016**

Favorable/(Unfavorable)

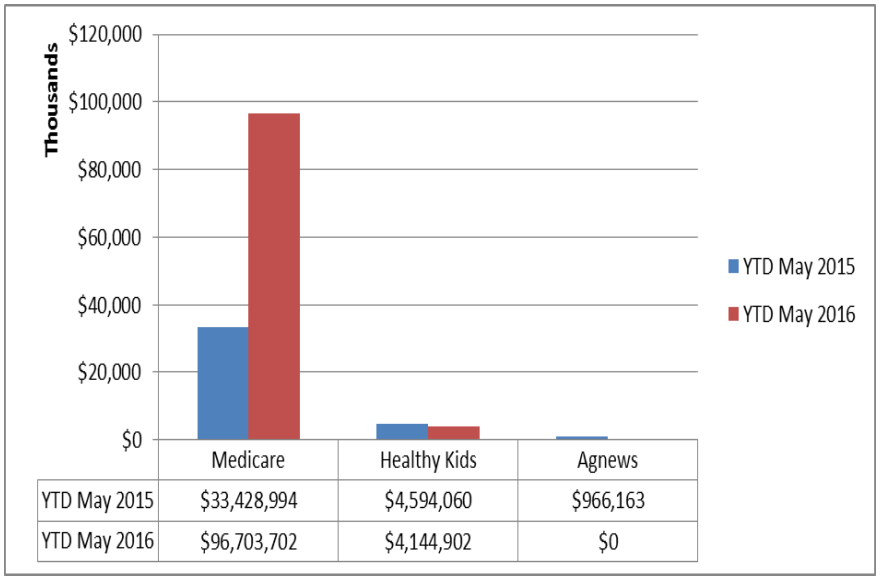
| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 92,351,188 | $ 89,184,168 | $ 3,167,020 | 3.6% | Revenue | $991,188,058 | $980,417,562 | $ 10,770,495 | 1.1% |
| 89,092,379 | 83,960,833 | (5,131,546) | -6.1% | Medical Expense | 946,093,883 | 928,567,643 | (17,526,241) | -1.9% |
| 3,258,809 | 5,223,335 | (1,964,525) | -37.6% | Gross Margin | 45,094,174 | 51,849,919 | (6,755,745) | -13.0% |
| 3,015,708 | 4,033,604 | 1,017,896 | 25.2% | Administrative Expense | 31,822,472 | 35,678,534 | 3,856,062 | 10.8% |
| 243,101 | 1,189,731 | (946,630) | -79.6% | Net Operating Income | 13,271,702 | 16,171,385 | (2,899,683) | -17.9% |
| (93,675) | (139,752) | 46,077 | 33.0% | Non-Operating Income/Exp | (952,099) | (1,332,500) | 380,401 | 28.5% |
| $ 149,426 | $ 1,049,979 | $ (900,553) | -85.8% | Net Surplus/ (Loss) | $ 12,319,603 | $ 14,838,885 | $ (2,519,282) | -17.0% |

# Revenue Trend

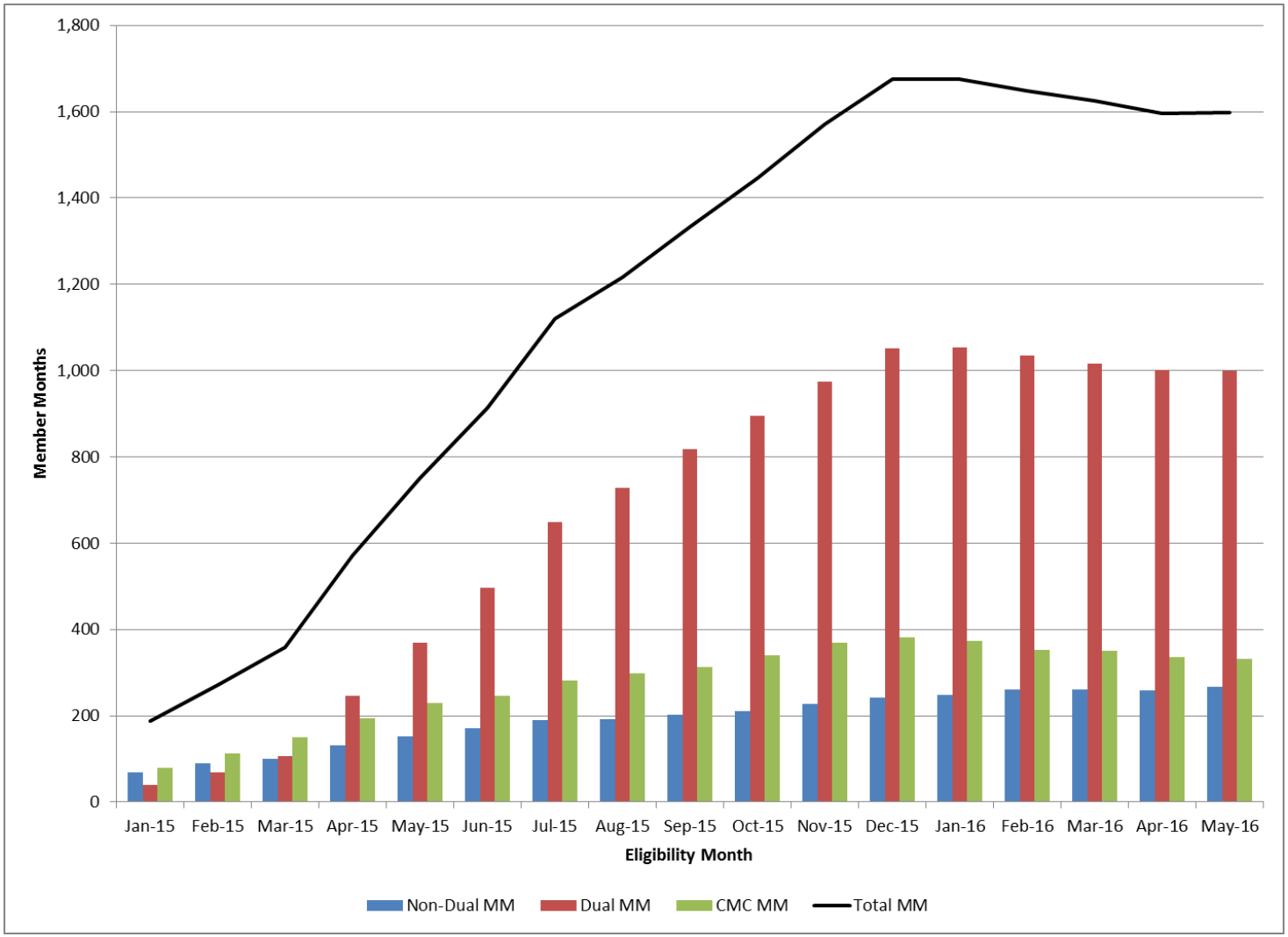
*Graph 1: Portrays current YTD Medi-Cal revenue vs. previous year. Increase of 34%.*



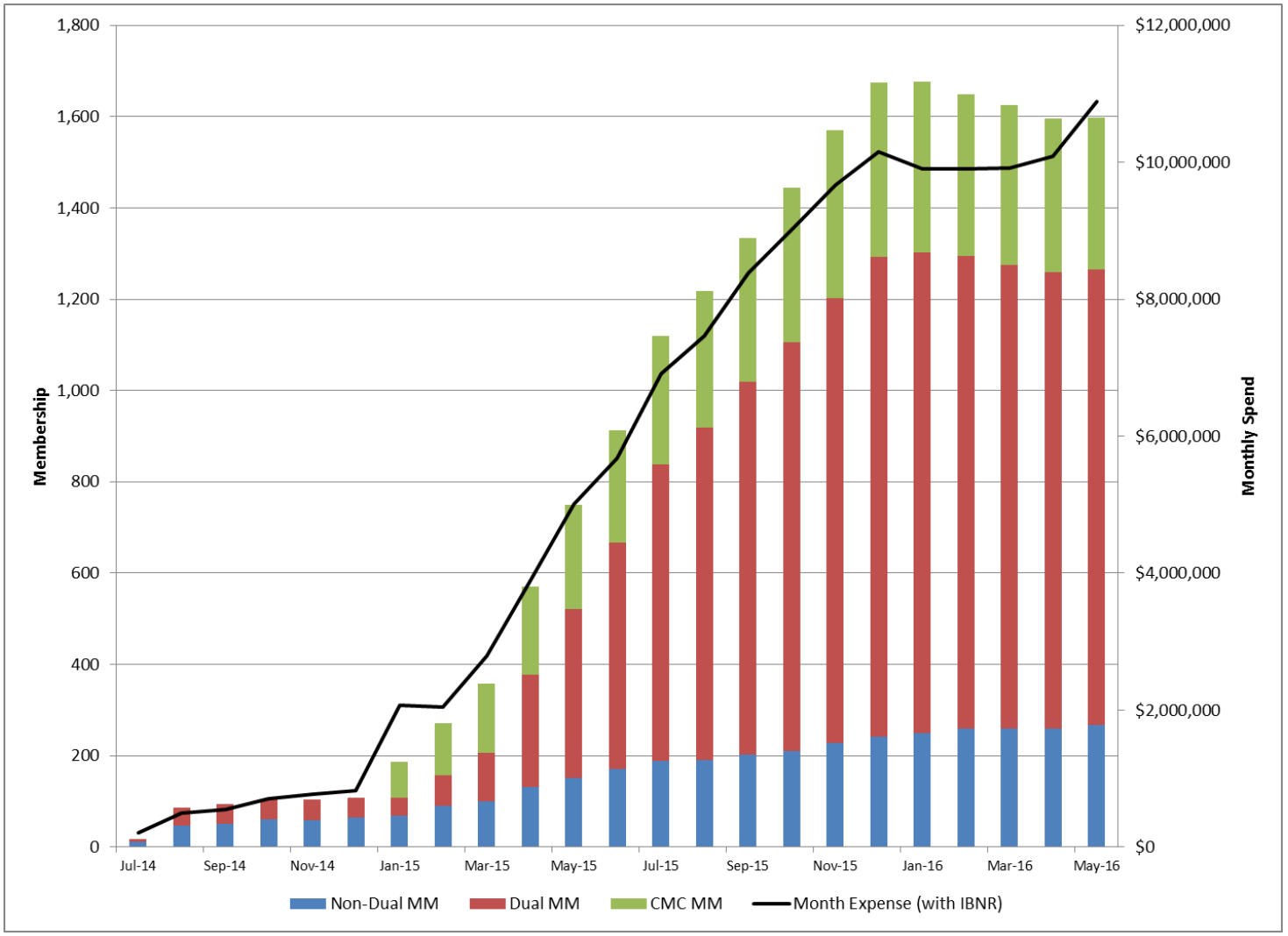

*Graph 2: Represents all other operating revenue YTD compared to previous year. Increase of 159%.*



# Long Term Care Membership
# Medi-Cal and CMC



# Medi-Cal Long Term Care Experience
# July 2014 – May 2016



# Enrollment Summary
# May and YTD

**Santa Clara Family Health Plan Enrollment Summary**

| | For the Month of May 2016 | | | Eleven Months Ending May 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Prior Year Actual** | **Change FY16 vs. FY15** |
| Medi-Cal | 259,076 | 244,682 | 5.9% | 2,778,019 | 2,740,442 | 1.4% | 2,349,726 | 18.2% |
| Healthy Kids | 4,375 | 4,038 | 8.4% | 47,590 | 47,035 | 1.2% | 52,797 | ( 9.9%) |
| Medicare | 8,367 | 9,159 | ( 8.6%) | 93,740 | 95,907 | ( 2.3%) | 32,329 | 190.0% |
| Agnews | 110 | 114 | ( 3.5%) | 1,210 | 1,232 | ( 1.8%) | 1,246 | ( 2.9%) |
| Total | 271,928 | 257,993 | 5.4% | 2,920,559 | 2,884,616 | 1.2% | 2,436,098 | 19.9% |

# Enrollment by Network - YTD

**Santa Clara County Health Authority**
**May 2016**

| | Medi-Cal | | Healthy Kids | | CMC | | AG | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contract Physicians | 22,848 | 9% | 227 | 5% | 8,367 | 100% | 110 | 100% | 31,552 | 12% |
| SCVHHS, Safety Net Clinics, FQHC Clinics | 139,012 | 54% | 2,920 | 67% | 0 | 0% | 0 | 0% | 141,932 | 52% |
| Palo Alto Medical Foundation | 7,428 | 3% | 34 | 1% | 0 | 0% | 0 | 0% | 7,462 | 3% |
| Physicians Medical Group | 46,658 | 18% | 1,041 | 24% | 0 | 0% | 0 | 0% | 47,699 | 18% |
| Premier Care | 15,890 | 6% | 153 | 3% | 0 | 0% | 0 | 0% | 16,043 | 6% |
| Kaiser | 27,240 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 27,240 | 10% |
| Total | 259,076 | 100% | 4,375 | 100% | 8,367 | 100% | 110 | 100% | 271,928 | 100% |
| Enrollment @ 6-30-15 | 234,497 | | 4,541 | | 7,187 | | 112 | | 246,337 | |
| Net % Change from Beginning of FY | 10.5% | | -3.7% | | 16.4% | | -1.8% | | 10.4% | |

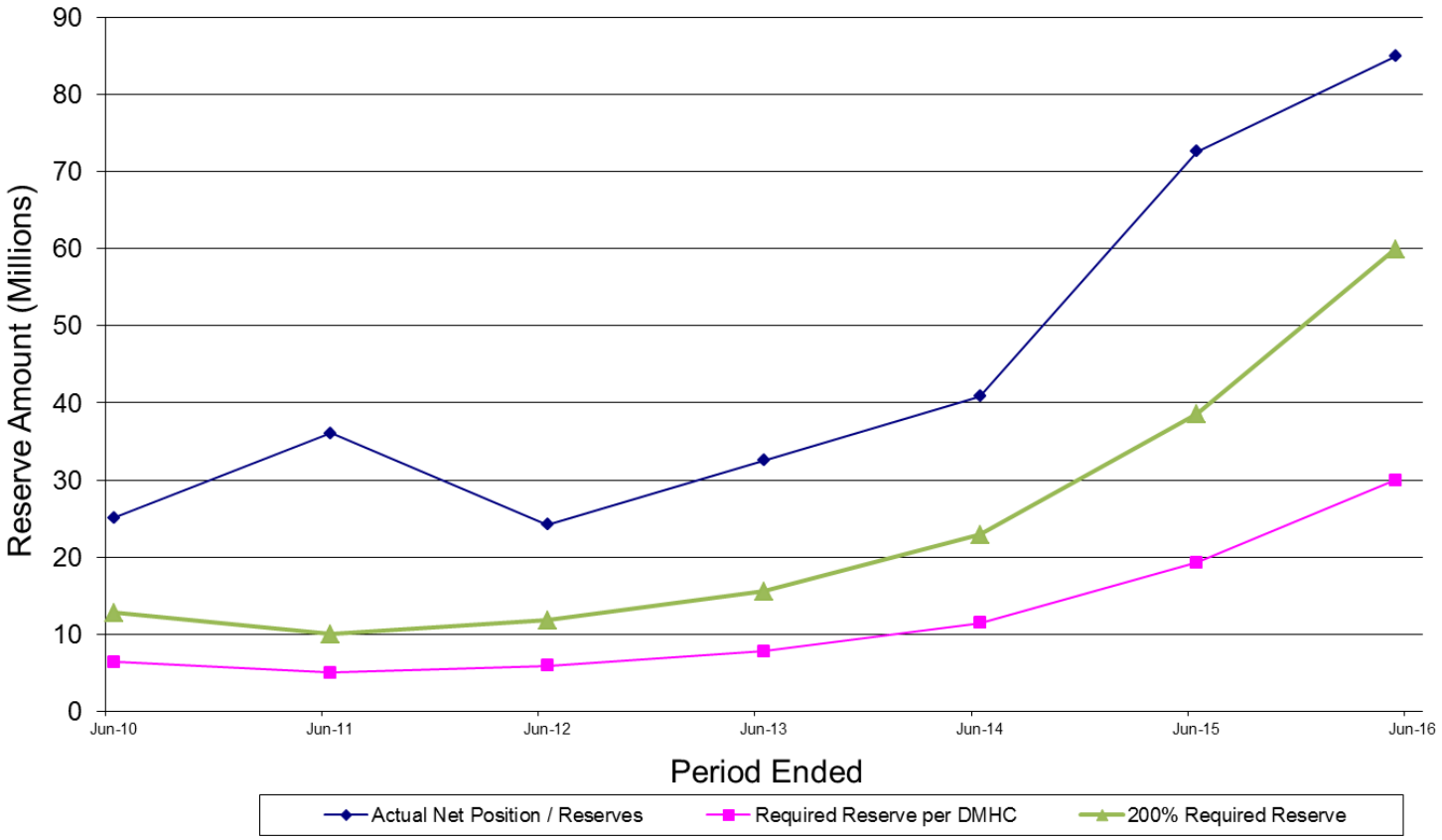
Membership has increased 10.4% since the beginning of the Fiscal Year, primarily as a result of Medi-Cal Expansion, which started January 1, 2014 and has grown to 82,294 members.

# Enrollment by Aid Category

| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 2015-07 | 2015-08 | 2015-09 | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 27,844 | 27,331 | 27,080 | 27,148 | 27,229 | 27,493 | 27,509 | 27,485 | 27,857 | 27,436 | 27,431 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 8,642 | 8,730 | 8,858 | 8,909 | 9,103 | 9,235 | 9,241 | 9,158 | 9,150 | 9,145 | 9,144 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 9,541 | 7,791 | 6,032 | 4,575 | 3,837 | 3,461 | 3,211 | 2,863 | 2,556 | 2,301 | 2,045 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 |
| | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 4,727 | 4,932 | 5,235 | 5,544 | 5,852 | 6,042 | 6,049 | 6,070 | 6,058 | 6,050 | 6,018 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 1,238 | 1,303 | 1,370 | 1,458 | 1,483 | 1,638 | 1,638 | 1,654 | 1,701 | 1,711 | 1,787 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 16,612 | 17,635 | 19,002 | 20,332 | 21,698 | 22,779 | 22,819 | 23,008 | 23,106 | 23,068 | 23,223 |
| | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 |
| | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 4,496 | 4,598 | 4,375 | 4,362 | 4,325 | 4,273 | 4,186 | 4,114 | 4,158 | 4,328 | 4,375 |
| | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 7,543 | 7,698 | 7,912 | 8,354 | 8,906 | 9,699 | 9,159 | 8,886 | 8,728 | 8,488 | 8,367 |
| | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** |

# Tangible Net Equity at May 31, 2016

TNE is $85.0 million or 2.84 times the minimum TNE required by the Department of Managed Health Care (DMHC). The Plans reserves are roughly $66.9 million below the reserves targeted by the Authority Board of two months' Medi-Cal capitation revenue.



Santa Clara
Family Health Plan
*The Spirit of Care*

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

Thursday, August 25, 2016
210 E. Hacienda Avenue
Campbell CA 95008

## Minutes - DRAFT

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

**Staff Present**
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Rita Zambrano, Executive Assistant

**Members Absent**
Bob Brownstein
Liz Kniss

1. **Roll Call**

   Michele Lew, Chair, called the meeting to order at 8:30am. Roll call was taken and a quorum was established.

2. **Meeting Minutes**

   The minutes of the July 28, 2016 Executive/Finance Committee Meeting were reviewed.

   **It was moved, seconded, and** the July 28, 2016 Executive/Finance Committee minutes were **approved** as presented.

3. **Public Comment**

   There were no public comments.

4. **Adjourn to Closed Session**
   a) **Anticipated Litigation** (Government Code Section 54956.9(d)(2)): The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding receipt of an administrative claim for

damages received pursuant to the Government Claims Act. The claim was submitted by Mark S. Renner of Wylie, McBride, Platten, & Renner on behalf of Kathleen King.

**5. Report from Closed Session**

No action was taken.

**6. Preliminary Fiscal Year 2015-16 Results**

Dave Cameron provided a verbal report on fiscal year financial results. He indicated there are a significant number of year-end adjustments (e.g., catch-up of retrospective rate adjustments in multiple programs, changes in estimates, additional year-end accruals, etc.). He indicated the Plan will exceed the budgeted year-end surplus of $15.5 million.

**7. Investment Activity and Policy Review**

Mr. Cameron reported on the review of our Investment Policy by Sperry Capital. The report from Sperry Capital recommended no changes to SCFHP Board-approved Investment Policy of April 23, 2015 at this time.

**It was moved, seconded, and approved** to accept the annual Investment Activity and Policy Report.

**8. Donation/Sponsorship Report**

Christine Tomcala presented a summary of the Donations/Sponsorships made by the Plan for FY 2015-2016 and year-to-date 2017.

**9. Finance and Accounting Department Risk Assessment & Policy Analysis**

Mr. Cameron gave an overview of the report issued by WeiserMazars (WM) representing a partial audit of SCFHP Finance and Accounting Department and a full audit of its late claims. Mr. Cameron noted the goal of the audit was to assess SCFHP's overall performance, compliance with regulatory requirements, and use of best practices. The issued report indicated areas of risk and classified them into low, moderate, or high risk. Each area had observations and recommendations. The report also proposed an Internal Audit Plan for the next twelve to eighteen months and suggested revisions and additions to the Finance and Accounting Department's Policies and Procedures. The Finance Department is in the process of implementing recommendations.

**10. Provider Incentive Program**

Ms. Tomcala presented an overview of a proposed Medi-Cal Provider Incentive Program for Fiscal Year 2016-17. She shared the Program Goals and Methodology, including eligibility criteria for program participation. Incentives would be based on five measures: 1) All Cause Readmissions, 2) Cervical Cancer Screening, 3) Initial Health Assessments, 4) Access to Primary Care Practitioners, and 5) Encounter Data Timeliness.

The Committee discussed the measures. With respect to conducting Initial Health Assessments within 120 days, it was noted the clinics only received new member eligibility on paper from Valley Health Network, which made it challenging to meet this compliance goal. Staff will seek to remove this barrier so clinics can receive timely and accurate eligibility electronically.

**11. CEO Update**

Ms. Tomcala updated the Committee on the DMHC routine audit preliminary report. She noted our Claims Director had resigned, and briefly discussed the assessment of options to provide adequate space for the Plan's growing staff needs.

**12. Annual CEO Evaluation Process**

Ms. Lew discussed the need to conduct an annual evaluation of the CEO, and proposed appointment of a subcommittee to lead the process, as has been done in the past.

> **It was moved, seconded, and approved** to appoint a temporary, ad hoc subcommittee, comprised of Chris Dawes as Chair, Dolores Alvarado, Michele Lew, and Linda Williams, to conduct the annual evaluation of the CEO.

**13. Adjournment**

The meeting was adjourned at 10:00 am.

_____
Elizabeth Pianca, Secretary to the Board

August 19, 2016

Dave Cameron
Santa Clara Family Health Plan
Chief Financial Officer
210 E. Hacienda Avenue
Campbell, CA 95008

Re: Annual Investment Policy Review

Dear Dave,

At your request I have reviewed the Santa Clara Family Health Plan's Annual Investment Policy, approved April 23, 2015 by the Governing Board, to determine any updates, clarifications or modifications that should be made.

Currently, available excess funds are deposited with the Santa Clara County Treasurer in the Commingled Investment Pool and remain subject to the County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposit and the County of Santa Clara Treasury Investment Policy, as adopted on June 21, 2016.

We have reviewed the County's 2016 Investment Policy and the Quarterly and Monthly Investment Reports from June 2015 through May 2016. These reports are prepared by the treasury staff of the County and published online on the County's website. These reports are in keeping with the reporting requirements of the County's Investment Policy. The County's stated benchmark for its investment performance is the State Treasurer's Local Agency Investment Fund (LAIF). Throughout this time period, the Commingled Investment Pool's yields exceeded those of LAIF (see page 2).

We have also reviewed the 2016 California Debt and Investment Advisory Commission's, Local Agency Investment Guidelines and find the County's 2016 Investment Policy reflects those guidelines. The County Treasury Oversight Committee, comprised of six members representing the County, school districts and other local government agencies whose funds are deposited in the County's commingled pool and other segregated investments, is required by statute to monitor and review the County Treasury's compliance with the investment policy and reporting provision of the Government Code through an annual audit. We recommend that this annual audit be reviewed by SCFHP financial staff when available.

Pursuant to our review with staff, we understand the County's withdrawal limitations from the Pool pose no issue for SCFHP in meeting six months' of cash flow needs (Code requirement). We also understand:

- There are no changes in the Plan's investment objectives,
- There are no other invested funds other than those previously described,
- No funds are borrowed from the County, and
- SCFHP staff is monitoring the monthly investment reports of the County's Commingled Pool.

Therefore, based upon this information, we recommend no changes to the SCFHP Annual Investment Policy at this time.

Sincerely,
Martha J. Vujovich
Principal

**Comparison of Investment Performance of Santa Clara Commingled Pool with LAIF**

| Period | Yield of Santa Clara County Pool (%) | Weighted Average Life (in days) | Yield of LAIF (%) | Weighted Average Life (in days) |
|---|---|---|---|---|
| **2015** | | | | |
| April | 0.585 | 466 | 0.283 | 220 |
| May | 0.610 | 471 | 0.290 | 222 |
| June | 0.620 | 469 | 0.299 | 239 |
| July | 0.676 | 496 | 0.320 | 240 |
| August | 0.704 | 494 | 0.330 | 216 |
| September | 0.680 | 463 | 0.337 | 210 |
| October | 0.773 | 500 | 0.357 | 200 |
| November | 0.766 | 482 | 0.374 | 183 |
| December | 0.720 | 402 | 0.400 | 179 |
| **2016** | | | | |
| January | 0.773 | 418 | 0.446 | 167 |
| February | 0.820 | 428 | 0.467 | 159 |
| March | 0.832 | 428 | 0.506 | 146 |
| April | 0.830 | 399 | 0.525 | 164 |
| May | 0.862 | 417 | 0.552 | 167 |

**SCFHP DONATIONS/SPONSORSHIPS**

| | | FY 2015 | | | FY 2016 | | | FY 2017 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Organization** | **Event Name** | **Check Date** | **Event Date** | **Amount** | **Check Date** | **Event Date** | **Amount** | **Check Date** | **Event Date** | **Amount** |
| Aging Services Collaborative | Annual Caregivers Conference | | | | 3/28/2016 | 4/16/2016 | $ 100 | | | |
| Alum Rock Counseling Center | Annual Luncheon | | | | 12/10/2015 | 4/7/2016 | $ 500 | | | |
| Asian Americans for Community Involvement | Annual Event | 5/1/2014 | 9/20/2014 | $ 5,000 | 5/14/2015 | 10/10/2015 | $ 5,000 | 6/22/2016 | 9/10/2016 | $ 5,000 |
| | Donation - Med Homes for Duals | | | | 7/1/2015 | | $ 5,000 | | | |
| California Association for Adult Day Services | N Calif Spring Conference: The Quality Imperative | | | | 3/17/2016 | 5/11/2016 | $ 250 | | | |
| Community Health Partnership | 21st Anniversary Celebration | 4/24/2014 | 9/10/2014 | $ 5,000 | | | | | | |
| Foundation for Mental Health | 2014 Shining Stars Event | 9/4/2014 | 10/16/2014 | $ 1,750 | | | | | | |
| Gardner Family Health | Annual Event | 8/14/2014 | 10/25/2014 | $ 5,000 | 3/17/2016 | 4/16/2016 | $ 2,000 | | | |
| Healthier Kids Foundation | Annual Symposium on Status of Children's Health in Santa Clara County | | | | 5/12/2016 | 5/13/2016 | $ 5,000 | | | |
| | Wine Tasting Benefit | | | | | | | 8/11/2016 | 9/16/2016 | $ 5,000 |
| Hospice of the Valley | Compassion in Action Conference | 2/5/2015 | 3/27/2015 | $ 1,000 | 2/25/2016 | 3/24/2016 | $ 1,000 | | | |
| | Annual Gala | 4/30/2015 | 6/13/2015 | $ 2,000 | | | | | | |
| Indian Health Center Santa Clara Valley | Annual Event | 8/21/2014 | 10/18/2014 | $ 5,000 | 8/21/2015 | 10/17/2015 | $ 5,000 | | | |
| Justice in Aging | Take a Stand Against Poverty | 2/12/2015 | 4/16/2015 | $ 500 | 3/3/2016 | 4/7/2016 | $ 2,500 | | | |
| March of Dimes | March of for Babies | 10/1/2014 | 4/25/2015 | $ 5,000 | 12/10/2015 | 5/1/2016 | $ 5,000 | | | |
| Momentum for Mental Health | Annual Shining Stars Benefit | | | | 10/22/2015 | 11/23/2016 | $ 1,500 | | | |
| Planned Parenthood | Contribution | 5/14/2015 | | $ 5,000 | 6/16/2016 | | $ 5,000 | | | |
| Silicon Valley Council of Non Profits | Be Our Guest Annual Luncheon; Housing Summit | 10/9/2014 | 10/30/2014 | $ 2,000 | 7/1/2015 | 11/16/2015 | $ 5,000 | 8/18/2016 | 10/27/2016 | $ 5,000 |
| Silicon Valley Independent Living Center | Disability Pride Parade | 4/24/2014 | 7/19/2014 | $ 500 | | | | | | |
| | CCT Program Presentation | 3/31/2016 | 4/16/2015 | $ 300 | | | | | | |
| United Way Silicon Valley | Annual Community Breakfast | 8/29/2014 | 9/10/2014 | $ 1,000 | | | | | | |
| VMC Foundation | Annual Gala | | | | 4/30/2015 | 10/10/2015 | $ 5,000 | 5/19/2016 | 9/24/2016 | $ 5,000 |
| Working Partnerships USA | 20 Years in Action | | | | 12/3/2015 | 12/10/2015 | $ 300 | | | |
| | **TOTAL** | | | **$ 39,050** | | | **$ 48,150** | | | **$ 20,000** |

**SANTA CLARA FAMILY HEALTH PLAN**
**WEISER MAZARS REPORT SUMMARY**
**REPORT DATED 08/10/16**

| Ref. | Risk Area | Description | Trajectory | Overall Risk | Key WM Observations | SCFHP Comment & Next Steps |
|---|---|---|---|---|---|---|
| **A** | **Financial** | **Vendor Payments & Fraud** | Increasing | High | No vendor management process until early 2016<br>Previously decentralized function.<br>Insufficient staff<br>Excludes claims processing | **Concur**<br>Expansion of Purchasing Function In Process |
| **B** | **Operational** | **IT Risk Management** | Increasing | Mod-High | Need to implement an IT risk management program<br>Open process of prioritization and systemic changes<br>Outside input to IT is limited<br>No routine reporting to Sr. Management | **Concur**<br>Improved IT Processes/Reporting Under Review |
| **C** | **Operational** | **Segregation of Duties** | Decreasing | Mod-High | Few documented Finance P&P<br>Few documented internal controls<br>Rapid expansion causes potential role conflicts<br>Broad systems access is a risk to the Plan | **Concur**<br>P&P documentation In Process<br>Systems Access Privileges Under Review |
| **D** | **Compliance** | **Delegate Oversight** | Flat | Moderate | Centralize delegate oversight<br>Interdisciplinary team | **Concur**<br>Improved Delegation Oversight in Development |
| **E** | **Financial** | **Management Reporting** | Flat | Moderate | Better document IBNP methodology<br>Use lookback as a feedback loop | **Concur**<br>Improved Documentation in Process |
| **F** | **Operational** | **Data Loss Prevention & Privacy** | Flat | Moderate | Evaluate What & Where.<br>Review data controls and privacy regulations | **Concur**<br>Improved IT Processes Under Review |
| **G** | **Operational** | **Business Continuity** | Increasing | Moderate | Invest in DR/BC<br>Document DR plan<br>Develop management succession plan | **Concur**<br>Improved IT Processes Under Review<br>Succession Planning Under Consideration |
| **H** | **Operational** | **Process Improvement** | Flat | Low | Rapid growth & insufficient resources<br>Need to document processes<br>Implement Process Management team | **Concur**<br>P&P documentation In Process<br>Process Management Under Consideration |

# SANTA CLARA FAMILY HEALTH PLAN
# FINANCE & ACCOUNTING DEPARTMENT
# RISK ASSESSMENT, PROPOSED INTERNAL AUDIT PLAN, & POLICY ANALYSIS

August 10, 2016

MAZARS

WeiserMazars
*Exactly Right.*

## Contents

## Executive Summary

In early 2016, Santa Clara Family Health Plan (SCFHP) retained WeiserMazars (WM) to perform a partial audit of its Finance and Accounting Department and a full audit of its late claims. The goal of the partial audit of the Finance and Accounting Department is to assess the SCFHP's overall performance, compliance with regulatory requirements, and use of best practices. The goal of the full audit of late claims is to determine SCFHP's overall level of compliance, as well as the accuracy of its application of interest and penalties.

The scope of the partial audit of the Finance and Accounting Department includes review of all policies, procedures, and documented processes, as well as review of SCFHP's last DMHC filing, and its current procurement and vendor contracting processes. The result of this review and analysis is this report which includes:

I. Risk Assessment of SCFHP's financial and accounting functions;
II. Proposed Internal Audit Plan for the next twelve to eighteen months; and
III. Suggested Revisions and Additions to the Finance and Accounting Department's Policies and Procedures.

Results from the full audit of late claims will be provided within a separate report.

The resulting risk assessment of SCFHP's financial and accounting functions is part of SCFHP's continuing effort to enhance performance and better document the functions of the Plan in order to accommodate the Plan's recent and continuing growth. This risk assessment provides SCFHP with a means to measure uncertainty related to manageable Plan functions and processes. For the purpose of this assessment, risk is defined as an uncertainty that could impair SCFHP's ability to achieve appropriate growth and meet regulatory compliance. Risk is measured by the probability of a negative event occurring, the significance of that events, and the impact such a negative event would likely have on SCFHP should it occur.

The process followed in the risk assessment consisted of three primary phases of work: 1) fact finding, 2) risk assessment, and 3) risk reporting. Fieldwork encompassed interviews with

staff and management, documentation review and research of issues. Analysis included evaluating the level of uncertainty associated with each factor, including the potential for impact on SCFHP's business. Reporting entailed the development of a formal draft.

The entire Finance and Accounting Department, as well as crossover functions from some related departments such as vendor oversight and procurement, have been evaluated within the risk assessment. This risk assessment serves as the basis for the proposed SCFHP Internal Audit Plan for the time period of July 1, 2016 through December 31, 2017. Fieldwork for this project was conducted from April through May of 2016. Input was obtained from over twelve employees, with representation from the Finance, Accounting, Vendor Operations, Delegation Oversight, and IT departments.

We have divided SCFHP's risk areas into three categories (Financial, Compliance, and Operational) as detailed below:

1. Financial Risk: The risk of financial loss, negative changes in financial position, negative response from external regulators grantors, etc.

2. Compliance Risk: The risk that processes and disclosures may not comply with laws and regulations resulting in monetary and non-monetary penalties and increased oversight by regulators.

3. Operational Risk: The risk of lost productivity, inefficiency and disruption to services as a result of inadequate or failed internal processes, people and systems, or from external events.

Within each risk area, the following four risk elements are evaluated:

- Risk Level – level of uncertainty
- Likelihood – probability of a negative event occurring
- Impact – level of significance should a negative event occur
- Risk Trajectory – direction of where risk is headed in the future

The risk assessment defines SCFHP's major risks and defines steps that need to be taken to lower the level of risk for SCFHP as a whole while improving overall performance. In aggregate, SCFHP's overall risk level is gauged as being "moderate." Three of the eight risk areas presented have been evaluated as moderate – high or high overall risk. Mitigation actions are defined within this risk assessment and include improvement to the processes in place or the development of new processes that allow SCFHP to improve performance delivery and reduce risk.

The following table identifies the eight risk areas identified within this assessment, along with the associated levels of risks in May 2016.

| Risk Area | Likelihood | Impact | Risk Trajectory | Overall Risk Level |
|---|---|---|---|---|
| A. Financial – Vendor Payments and Fraud | High | Moderate | Increasing | **High** |
| B. Operational – IT Risk Management | High | Moderate | Increasing | **Moderate – High** |
| C. Operational – Segregation of Duties/Internal Controls | Low – Moderate | Moderate | Decreasing | **Moderate – High** |
| D. Compliance – Delegated Entity Oversight | Moderate | High | Flat | **Moderate** |
| E. Financial – Management Reporting | Moderate | Moderate | Flat | **Moderate** |
| F. Operational – Data Loss Prevention and Privacy | Moderate | High | Flat | **Moderate** |
| G. Operational – Business Continuity | Low | High | Increasing | **Moderate** |
| H. Operational – Process Improvement | Low | Low | Flat | **Low** |
| **OVERALL RISK LEVEL** | | | | **Moderate** |

The remainder of this report contains the I. Risk Assessment results and recommendations for improvement, II. Proposed Internal Audit Plan, and III. Suggested Revisions and Additions to the Finance and Accounting Department's Policies and Procedures.

# I. Risk Assessment

| A. FINANCIAL – VENDOR PAYMENTS AND FRAUD | |
|---|---|
| Risk Level | High |
| Likelihood | High |
| Impact | Moderate |
| Risk Trajectory | Increasing |
| Condition | There were no separate controls or functions to support an effective vendor/provider management process until the beginning of 2016. At that time, the Vendor Management function was assigned to the Vendor Operations & Delegation Oversight Department. At the time of this report this functional area was understaffed with plans to add a Vendor Relations Manager and an Analyst.<br><br>Prior to 2016 the vendor management function was largely fulfilled by the various business units and was not centralized as a separate functional area. This led to SCFHP having a non-standard approach to vendors and created a situation where the area purchasing items had no oversight except for Senior Management approval.<br><br>WM is testing provider payments (claims) in another portion of the overall engagement with SCFHP and the results of that work are not yet known. This is an area of high exposure for any health plan, however in SCFHP's case the bulk of the provider payments are monthly capitation payments which have a lower potential for error and diversion. WM has also evaluated the Vendor level policies and procedures and interviewed management staff about their content. While the policies and procedures appear adequate, only about twenty percent (20%) of the vendor management activity is actually performed by the Vendor Management department at the time of this report. Additional staffing will be needed in this area to accommodate the workload and ensure there is an orderly structured process in place to assure vendor compliance and appropriate payment.<br><br>SCFHP currently has an open position for its Medicare Claims Auditor and has one claims auditor in place. This level of staffing does not appear adequate and efforts should be made to fill the open position and evaluate the need for additional staff.<br><br>Representative processes requiring significant attention and implementation of new processes include:<br>• Procurement and contract management<br>• Fraud detection and prevention<br>• Assurance of appropriate payment and contract compliance |

| | |
|---|---|
| Risk Mitigation | • Assure adequate staffing to implement Vendor Procedures<br>• Conduct “as-is” workflow evaluation |
| Potential Residual Risk (if risks are mitigated) | Low |

| B. OPERATIONAL – IT RISK MANAGEMENT | |
|---|---|
| Risk Level | High |
| Likelihood | High |
| Impact | Moderate |
| Risk Trajectory | Increasing |
| Condition | The IT risk for all companies is rapidly increasing because of external threats and as risks increase, companies need to change their mindset toward IT risk to address new threats. Senior management needs to fully address their organization's risk management level of due care, approach and preparedness, and to implement an IT risk management program that is adequate and effective in managing cyber risks.<br><br>It is critical that IT functions are able to effectively address the following questions:<br>1. Can SCFHP's IT Department articulate its strategy to identify, mitigate and monitor IT risks to all parties?<br>2. How does the IT area know that it has identified all key IT risks that would prevent SCFHP from achieving corporate strategies, objectives and initiatives?<br>3. How does IT make sure SCFHP's risk framework continues to be relevant and continues to identify pertinent risks to keep the company out of trouble?<br><br>One of the highest risk areas for IT is that it will not support the core functions of SCFHP. In order to assure that is not the case an open process of evaluation of priorities and systemic change needs to be in place for all of the end users of IT systems. SCFHP stakeholders expect the company to focus risk management activities and resources on areas with the greatest impact. Internal audit is uniquely positioned to help drive growth and create value to the company through reviewing IT risk management activities.<br><br>Staff interviews indicate that routine report requests that would enhance performance are often given lower priority than requests involving regulatory issues and compliance. IT has responded with new "project management meetings" but this process should be documented and should be collaborative in nature. It appears as if the perception of end users is that their input to the IT Department is limited. |

| | |
|---|---|
| Condition (continued) | SCFHP's IT Department prepares a number of reports (antivirus reports, entitlement reports, firewall reports, patching reports for vulnerability, penetration reports, vulnerability reports, system logs and inappropriate use reports). While these reports are reviewed by the IT Department, there is no indication that this activity is regularly summarized and reported to Senior Management. quiring significant attention and implementation of new processes include:<br><br>• Classify SCFHP data per IT also must respond to external threats. |
| Risk Mitigation | • Document distribution and response to listed reports.<br>• Conduct "as-is" workflow evaluation |
| Potential Residual Risk (if risks are mitigated) | Moderate |

| C. OPERATIONAL – SEGREGATION OF DUTIES/INTERNAL CONTROLS | |
|---|---|
| Risk Level | High |
| Likelihood | Low - Moderate |
| Impact | Moderate |
| Risk Trajectory | Decreasing |
| Condition | During a review of existing policies, procedures and internal controls for SCFHP's Finance & Accounting Department (completed as a part of this project), WM notes that there were few documented policies and procedures in this area.<br><br>While it appears as if the system of internal controls is in place for the Finance & Accounting Department based on the responses to the Internal Control Questionnaire, few controls have been otherwise documented The responses to the questionnaire along with WM's work in this area should serve as a guide as to what policies and procedures need to be documented. Without appropriate documentation internal control compliance is difficult to measure.<br><br>Additionally, SCFHP has instituted "Positive Pay" that both enhances security and streamlines the payment process. This function only allows for checks generated by the Finance & Accounting Department (as documented by a listing sent to the bank beforehand). Senior Management is also very involved with approvals on a day-to-day basis. This level of involvement may need to decrease in the future given the size and complexity of SCHFP's operations.<br><br>Segregation of Duties (SoD) is considered by many to be a fundamental control. SCFHP does not have well-documented policies and procedures that assure appropriate SoD. The complexity of SCFHP's systems and the immediate need for coverage may create role conflict for some key individuals. This was the case when an individual with control responsibilities performed incompatible functions with his control responsibilities because of a need for backup coverage in another functional area.<br><br>The underlying reason for SoD is based on the fact that those individuals should not have broad system access that enables them to execute transactions across an entire business process without checks and balances. Allowing this kind of access represents real risk to the business. Managing that risk in a pragmatic, effective way is more difficult than it seems. The complexity and variety of the systems that automate key business processes makes the process difficult. Additionally, the ownership and accountability for controlling those processes must be established. The rate of growth for SCFHP has made effective documentation difficult. |

| | |
|---|---|
| | Strengthening internal controls is a major focus of the Senior Management team. A lack of documentation should be easy to overcome.<br><br>Representative processes requiring significant attention and implementation of new processes include:<br><br>• Documentation of policies, procedures and internal controls in the Finance & Accounting Department<br>• Testing documented controls once they are documented. |
| Risk Mitigation | • Document Financed Department Policies, Procedures and Internal Controls for the Finance & Accounting Department to articulate current practices.<br>• Update documented Internal Controls in this area after an internal control review. |
| Potential Residual Risk (if risks are mitigated) | Moderate |

| D. COMPLIANCE – DELEGATED ENTITY OVERSIGHT | |
|---|---|
| Risk Level | Moderate |
| Likelihood | Moderate |
| Impact | High |
| Risk Trajectory | Flat |
| Condition | SCFHP operates as a health plan that delegates a variety of functions to delegated entities. Eighty-eight percent (88%) of enrollee's processional services are covered by delegated IPA's and health plans. The DMHC and good business practices require the health plan oversee the operations of delegated entities.<br><br>Until now, SCFHP has performed this function with a manager, an analyst and staff from the functional areas being overseen (Claims, Finance and Clinical for Quality Assurance/Utilization Management). New policies and procedures have been created for this area requiring extensive additional work.<br><br>Based on WM's experience, the function of oversight should be centralized. A complete review of a delegated entity is most effectively performed by an interdisciplinary team. Additionally, the use of dedicated resources allows the oversight work to occur when needed, not when resources become available.<br><br>This is an important function given the level of delegation at SCFHP. The Delegated Entity Oversight Department has requested additional staffing in this area in order to centralize the function. Additional claims auditors devoted to the oversight function have been requested as a part of the budget process. Given the robust level of delegation oversight envisioned in the new policies and procedures a centralized function is probably necessary. |
| Risk Mitigation | • Reorganize the Delegation Oversight function. |
| Potential Residual Risk (if risks are mitigated) | Low |

| E. FINANCIAL – MANAGEMENT REPORTING | |
|---|---|
| Risk Level | Moderate |
| Likelihood | Moderate |
| Impact | Moderate |
| Risk Trajectory | Flat |
| Condition | WM has conducted a review of the processes of the SCFHP Finance & Accounting Department. The basic financial statements were reviewed along with regulatory filings. We also reviewed the Incurred But Not Reported (IBNR) Process and other accounting processes. In our review of the system for IBNR claims we determined that SCFHP uses an accepted general model developed by Milliman & Associates. SCFHP employs the Milliman model's standard three percent (3%) margin, as well as a ten percent (10%) margin which is added to the cost for each month. The current ten percent (10%) margin is within norms for plans with similar business lines.<br><br>One component of the IBNR process is performing a lookback on total IBNR for the month which allows one to see what the overall impact of an over/under statement of IBNP is on the profitability for that month. This lookback is a necessary component of the IBNP feedback loop and ensures that an accurate margin percentage is employed moving forward. While SCFHP prepares a look back analysis which compares the initial estimate to actual paid claims for each month of service, the actual estimation methodology, and lookback procedure used to arrive at this ten percent (10%) margin is not well documented. Without a well-documented procedure, it is difficult for SCFHP to show how it calibrates its margin from month-to-month.<br><br>An over or under calculated margin can over or under state IBNR and have a significant impact on SCFHP's financial reporting. For this reason, it is essential that SCFHP thoroughly document and consistently perform the process used to calibrate any margin used in addition to the Milliman model.<br><br>(It should be noted that SCFHP uses an Incurred But Not Paid methodology (IBNP) to estimate claims cost based on payment rather than when the claim is received.) |
| Risk Mitigation | • Better document IBNP estimation methodology and look back feedback loop. |
| Potential Residual Risk (if risks are mitigated) | Moderate |

| F. OPERATIONAL – DATA LOSS PREVENTION AND PRIVACY | |
|---|---|
| Risk Level | High |
| Likelihood | Moderate |
| Impact | High |
| Risk Trajectory | Flat |
| Condition | Over the last few years, companies in every industry sector around the globe have seen their sensitive internal data lost, stolen or leaked to the outside world. A wide range of high-profile data loss incidents have cost organizations millions of dollars in direct and indirect costs and have resulted in tremendous damage to companies involved. The vast majority of these incidents resulted from the actions of internal users and trusted third parties, and most have been unintentional. Data is one of SCFHP's most valuable assets and one of the greatest exposures to financial loss, protecting it and keeping it out of the public domain is of paramount importance. To accomplish this, a number of data loss prevention (DLP) controls must be implemented, combining strategic, operational and tactical measures. However, before DLP controls can be effectively implemented, SCFHP must understand the answer to these three fundamental questions:<br>• What sensitive data does SCFHP hold?<br>• Where does SCFHP sensitive data reside, both internally and with third parties?<br>• Where is SCFHP data going?<br><br>Highly publicized incidents of data leaks or identity theft pose large potential financial risks for businesses. As a result, businesses are investing more money to protect the privacy of personal information — to respond to government regulation and enforcement. These risks still exist and it is important to expend money in the correct areas. Internal audit is well positioned to help the organization address this question.<br>Representative processes requiring significant attention and implementation of new processes include:<br>• Classify SCFHP data per the criteria above, review data controls in place.<br>• Evaluate Privacy Regulations that affect SCFHP and ensure appropriate policies are in place to protect Personal Information. |
| Risk Mitigation | • Develop additional Data Controls<br>• Perform organization wide education about Privacy procedures. |
| Potential Residual Risk (if risks are mitigated) | Moderate |

| G. OPERATIONAL – BUSINESS CONTINUITY | |
|---|---|
| Risk Level | Moderate |
| Likelihood | Low |
| Impact | High |
| Risk Trajectory | Increasing |
| Condition | As organizations grow in size and complexity, the impact of non-availability of any resources magnifies. Natural disasters and technology infrastructure failures have increased awareness of the need to develop, maintain and sustain business continuity programs. Although these large-scale events dramatically challenge the existence of some companies, there are smaller, less impactful but more frequent disruptions that cause many executives to question their organization's ability to react and recover. Replacement of key executives has become a major obstacle for some organizations.<br><br>SCFHP's management have demonstrated that they are able to manage SCFHP operations at low cost levels historically. Their relationships with the local medical community are valuable and not easily replaced.<br><br>As a result of the potential for disasters, as well as the issue of management succession, SCFHP should invest in effective business continuity management (BCM). While BCM should be viewed as an enterprise-wide risk and effort, the reality is that it is often IT that is asked to lead critical planning activities and serve as lead facilitator and this has been the case with SCFHP. While it appears as if a Disaster Recovery Plan is in place, it does not appear to be well documented. IT systems and disaster recovery procedures are a cornerstone of the broader BCM plan, and thus, IT audit is well positioned to evaluate broader BCM procedure for dealing with Disaster Recovery.<br><br>SCFHP should also develop a management succession plan. Examining the competencies that exist and identifying internal personnel resources to develop over the next few years is an appropriate safeguard in this area. |
| Risk Mitigation | • Document Disaster Recovery Plan<br>• Identify key positions that should be targeted for succession planning. |
| Potential Residual Risk (if risks are mitigated) | Moderate |

| H. OPERATIONAL – PROCESS IMPROVEMENT | |
|---|---|
| Risk Level | Low |
| Likelihood | Low |
| Impact | Low |
| Risk Trajectory | Flat |
| Condition | SCFHP has experienced explosive growth due to changes in coverage by DHCS actions moving the bulk of the Medi-Cal and the Medi-Connect enrollment to managed care systems. It has retained WM in order to assess operations in a number of areas and ensure the documentation of systems and processes.<br><br>New policy and procedure sets are being implemented across all departments of the organization because of this work. The reality is the expansion of the Medi-Connect line and additional Medi-Cal enrollment have caused so much financial growth that until now the organization has not had time to examine its core processes, how they have changed and document the systems created. The expansion has caused an increase in scope and complexity that does not allow for the reliance on manual and informal systems that could be tolerated at historic levels of enrollment.<br><br>SCFHP's program complexity is increasing and simply meeting the needs of day-to-day operations has prevented the analysis and documentation of the system. It is likely that SCFHP will continue to grow and that its operational complexity will continue to increase. Much of the work performed by WM has been oriented to putting systems in place to adapt to the growth that has taken place. SCFHP needs to provide sufficient resources to assure that new procedures are followed and produce the results expected.<br><br>As organizations continue to look for ways to take costs out of the business, they are undertaking significant initiatives to redesign and standardize business processes. SCFHP has invested significantly in increasing its knowledge and capabilities. It will need to form an internal team to ensure that all of the processes that are newly documented are actually taking place.<br><br>SCFHP may need temporary resources to complete it redesign of systems in a timely fashion. Internal audit can play an effective role in confirming the right processes are in place to manage programs and that those processes and controls are being executed appropriately. |
| Risk Mitigation | • Form a Process Management team to document necessary changes and monitor performance. |
| Potential Residual Risk (if risks are mitigated) | Moderate |

## II. Proposed Internal Audit Plan

Below is a Proposed Internal Audit Plan based on the Risk Assessment as detailed in the previous section of this report. Items within the Proposed Internal Audit Plan should be prioritized by Overall Risk Level and are listed in order from highest to lowest overall risk. For this reason, A. Financial – Vendor Payments and Fraud should be high priority as it is a high overall risk, whereas H. Operational – Process Improvement can be considered a lower priority as it is low overall risk. The risk levels and suggested timing of the proposed audits, within an eighteen month audit period, are summarized in the table below. Each proposed audit area is described in detail following this summary table.

| Risk Area | Overall Risk Level | Priority | Proposed Timing for Audit of Risk Area |
|---|---|---|---|
| A. Financial – Vendor Payments and Fraud | High | 1 | Months 1 – 3 |
| B. Operational – IT Risk Management | Moderate – High | 2 | Months 3 – 6 |
| C. Operational – Segregation of Duties/Internal Controls | Moderate – High | 2 | Months 3 – 6 |
| D. Compliance – Delegated Entity Oversight | Moderate | 3 | Months 6 – 9 |
| E. Financial – Management Reporting | Moderate | 3 | Months 6 – 9 |
| F. Operational – Data Loss Prevention and Privacy | Moderate | 4 | Months 9 – 12 |
| G. Operational – Business Continuity | Moderate | 5 | Months 12 – 15 |
| H. Operational – Process Improvement | Low | 6 | Months 15 – 18 |
| **OVERALL RISK LEVEL** | **Moderate** | | |

| A. FINANCIAL – VENDOR PAYMENTS AND FRAUD | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Supplier management review — Evaluate the process management has put in place to qualify and accept suppliers. The internal audit team will focus on the controls for ensuring that company policies and procedures are in place and being consistently followed. This will include a review of supplier acceptance and the periodic supplier continuance review process. | • What is the process for accepting new suppliers?<br>• Who is involved in the process and what are the controls in place?<br>• What is the process for validating continuing relationships with suppliers? |

| B. OPERATIONAL – IT RISK MANAGEMENT | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Threat and vulnerability management program assessment — Evaluate the organization's threat and vulnerability management (TVM) program, including threat intelligence, vulnerability identification, remediation, detection, response and countermeasure planning | • How comprehensive of a TVM program exists?<br>• Is the TVM program aligned with business strategy and the risk appetite of the organization?<br>• Are the components of TVM integrated with one another, as well as with other security and IT functions?<br>• Do processes exist to address that identified issues are appropriately addressed and remediation is effective? |
| Vulnerability assessment — Audit should perform, or make certain IT performs, a regular attack and penetration (A&P) review. These should not be basic A&Ps that only scan for vulnerabilities. Today we suggest risk-based and objective-driven penetration assessments tailored to measure the company's ability to complicate, detect and respond to the threats that the company is most concerned about. | • What mechanisms are in place to complicate attacks the organization is concerned about?<br>• What vulnerabilities exist and are exploits of these vulnerabilities detected?<br>• What is the organization's response time when intrusion is detected? |
| IT governance audit — Evaluate the processes IT has in place to govern capital allocation decisions, project approvals and other critical decisions. | • Do formalized processes to govern IT exist?<br>• What can be done to increase business confidence in IT governance?<br>• Are your IT governance processes and requirements applicable across all of IT? |
| IT risk assessment — As an advisory audit, participate in IT's own risk assessment (as opposed to the independent IT internal audit risk assessment). Evaluate the risks identified and provide insight given your unique perspective of the IT organization. | • Is there a comprehensive risk assessment performed to identify all IT risks?<br>• Is the IT risk assessment process effective? How can the process be enhanced?<br>• Is there an opportunity to coordinate the IT internal audit risk assessment with IT's own risk assessment? |

| C. OPERATIONAL – SEGREGATION OF DUTIES/INTERNAL CONTROL | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Systematic segregation of duties review audit — Evaluate the process and controls in place to effectively manage segregation of duties. Perform an assessment to determine where segregation of duties conflicts exist and compare to known conflicts communicated. Evaluate the controls in place to manage risk where conflicts exist. | • How does the business identify cross-application segregation of duties issues?<br>• While compensating controls identified for SoD conflicts may detect financial misstatement, would they truly detect fraud? |
| Role design audit — Evaluate the design of roles within each functional area to determine if inherent SoD issues are embedded within the roles. Provide role design, role cleanup or role redesign advisory assistance and pre- and post-implementation audits to solve identified SoD issues | • Does the organization design roles in a way that creates inherent SoD issues?<br>• Do business users understand the access being assigned to roles they are assigned ownership of? |
| General Internal Control review and testing | • Perform after implementation of Finance & Accounting Department Internal Control system documentation. |

| D. COMPLIANCE – DELEGATED ENTITY OVERSIGHT | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Delegation Oversight Audit – To be performed simultaneously with a review of a delegated organization. Ensure areas of delegation are being audited. Validate the testing performed to ensure viability of the administrative services performed. | • Was every area of delegated function audited?<br>• Did the SCFHP reviewers have sufficient technical background to perform the review in that area?<br>• Was the overall team organized to perform the audit on a cost effective basis? |

| E. FINANCIAL – MANAGEMENT REPORTING | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Analysis of the budgeting and forecasting process - Assess the annual budgeting and forecasting processes including the internal controls and potential process, improvement recommendations. Review the primary business segments of the organization, current state processes and root cause issues driving inaccuracies in the forecast. | • What is the current process for budgeting and forecasting and is it consistent across business units/locations?<br>• How do we monitor the accuracy of the budgeting and forecasting process?<br>• What are the controls in place to assess accuracy and completeness of the process?<br>• What actions would be required to address the gaps? |
| IBNP Test of Results – Perform a two year review of IBNP Systems. Perform variance analysis of actuals versus original estimates for total IBNP for the month. Perform the analysis with at least six months lag. | • What was the average variance between actual paid and original estimate?<br>• Was the margin amount used reasonable (less than 5% of total)? |

| F. OPERATIONAL – DATA LOSS PREVENTION AND PRIVACY | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| DLP control review — Audit the controls in place to manage privacy and data in motion, in use and at rest. Consider the following scope areas: perimeter security, network monitoring, use of instant messaging, privileged user monitoring, data sanitation, data redaction, export/save control, endpoint security, physical media control, disposal and destruction, and mobile device protection. | • What controls do we have in place to protect data?<br>• How well do these controls operate?<br>• Where do our vulnerabilities exist, and what must be done to manage these gaps? |
| Privacy regulation audit — Evaluate the privacy regulations that affect the organization, and assess management's response to these regulations through policy development, awareness and control procedures. | • How well do we understand the privacy regulations that affect our global business? For example, HIPAA is potentially a risk to all organizations, not just health care providers or payers<br>• Do we update and communicate policies in a timely manner?<br>• Do users follow control procedures to address regulations? |

| G. OPERATIONAL– BUSINESS CONTINUITY MANAGEMENT | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Business continuity program integration and governance audit — Evaluate the organization's overall business continuity plan, including program governance, policies, risk assessments, business impact analysis, vendor/third-party assessment, strategy/plan, testing, maintenance, change management and training/awareness. | • Does a holistic business continuity plan exist for the organization?<br>• How does the plan compare to leading practice?<br>• Is the plan tested? |
| Disaster recovery audit — Assess IT's ability to effectively recover systems and resume regular system performance in the event of a disruption or disaster | • Are disaster recovery plans aligned with broader business continuity plans?<br>• Do testing efforts provide confidence systems that can be effectively recovered?<br>• Are all critical systems included?<br>• Are critical systems defined? |

| H. OPERATIONAL– PROCESS IMPROVEMENT | |
|---|---|
| **AUDIT AREA** | **KEY ISSUES/QUESTIONS** |
| Determine what priority areas are, if sufficient resources are allocated to perform the changes or if added resources are necessary. Review of structure of process Management team and whether added individuals are necessary for specific areas. Review timeliness to ensure adequate time is devoted to each area and that SCFHP is able to meet its overall objective in a timely manner. | • Are key individuals involved?<br>• Has consideration been given to the order in which all tasks need to be completed in? Is there a need of Critical Path analysis (common timeline with all task listed)? |
| Assessment of Monitoring Process - Evaluate performance of monitoring systems. Overall review of functional department's progress in each area specified. Determination if initial time frames set are being met and if not, what feedback to the constituents of each functional rea receives. Determination as to whether monitoring results are being communicated to senior management in appropriate time frames. | • Are all items identified by the Process Improvement team being monitored?<br>• Are all monitoring results reported in a common timeframe (e.g. monthly, quarterly and annually)?<br>• Are areas without sufficient progress identified and remedial steps taken to improve response?<br>• Are feedback mechanisms adequate? Do they need to be modified or need to be redirected to other individuals? |

## III. Suggested Revisions and Additions to the Finance and Accounting Department's Policies and Procedures

WM performed a review of SCFHP's Finance and Accounting Department policies and procedures. The Department maintains some written policies and procedures; however, most have not been recently reviewed and updated. Additionally, none of the current policies and procedures is in a consistent format. While departmental staff regularly uses many procedures with effective internal controls, few are documented.

What follows are our recommendations for revisions and additions to the Department's policies and procedures. These policies and procedures should be documented and implemented as soon as possible to strengthen and evidence SCFHP's system of internal controls.

### General

Accounting Manual – SCFHP has a "Desk Manual" of basic procedures. While not yet in an appropriate format, these procedures could be easily converted into a formal Accounting Manual. This should be done as soon as possible. Without an Accounting Manual to document expected performance, it is impossible to evaluate SCFHP's overall accounting performance. The components of a best practice Accounting Manual are listed within Appendix A. Finance and Accounting Department management should consider these components when converting their current "Desk Manual" into a formal Accounting Manual.

### Cash-related

Cash Segregation of Duties and Systemic Controls (Policies and Procedures) need to be documented:

> **Cash Policy #1** – This policy should articulate the need to maintain secure cash balances and the need for cash handling to be a secure process with appropriate segregation of duties and an effective reconciliation process.

**Cash Procedure #1 – Use of Cash Logs:** This procedure should cover how deposits and wire transfers are recorded. The entry of the deposit amounts into a Cash Log as a control for bank reconciliations should be covered.

**Cash Procedure #2 – Positive Pay Procedure Description:** This procedure should deal with checks and outflows. The procedure should note that all checks require Positive Pay by Wells Fargo and describe the process by which checks are presented as a part of the positive pay list. It should be noted that invoice back-up is required and contract backup required where payment is by contract.

**Cash Procedure #3 – Cash Reconciliation Process:** This procedure should describe the reconciliation process for all cash accounts. This procedure should include the following steps:

- Reconciliation check off by Senior Accountant Cash logs and other .source documents (bank statements).
- Check off of Wire transfers by Accounting Manager against source documents and Bank Statements.

**Cash Procedure #4 – Accounts Payable:** A new procedure should be created to indicate that the requirement of attaching packing slips or other proof of delivery should be included in order to process the invoice for payment. Invoices for payment should be evaluated for compliance with the SCFHP's Contracting & Procurement Policy (detailed in subsequent section) to ensure that staff are making purchases in the most transparent and accountable manner.

## Accounting System Related

Great Plains access and segregation of function should be documented once SCFHP staff has set up the access restrictions. This will allow appropriate segregation of duties to be embedded within the design of the roles of accounting staff with system access.

**Accounting System Procedure #1 – Accounting Software Access:** This procedure should provide a determination of what subsystem access is optimal for each accounting position.

**Accounting Systems Procedure #2 – Segregation of Duties Using Access Controls:** This procedure should detail how the access restriction provides appropriate security controls for each position.

## Procurement & Contract Related

**Procurement Policy and Procedure #1** – Contracting and procurement policies go hand-in-hand but do have different roles. While the contracting policy delineates the SCFHP's authority to enter into contracts, designates when a contract is necessary, and provides the framework and parameters for contract development, the procurement policy details all of the means through which staff may make purchases, including contracts. For example, the procurement policy should explain when it is appropriate for staff to use a purchase order payable by invoice, or pay by a personal or corporate credit card to make a purchase, or when it is necessary to pursue the solicitation a contracting of a vendor. The procurement policy should also include documentation staff are required to gather and either maintain in their own files and/or submit to the Finance & Account Department upon request for payment or reimbursement. Finally, the procurement policy, like the contracting policy, should include SCFHP's conflict of interest code (or reference to it), required disclosures, reasons for disqualification, and best practice guidelines. As the areas of contracting and procurement overlap, each set of policy and procedure should refer to the other.

Under separate cover, WM will provide examples of contracting and procurement policy best practices and policy examples.

**Contract Policy and Procedure #1** – Policy and procedure for solicitation and award of contracts by SCFHP should include the following key elements:

1. SCFHP's authority to solicit and enter into contracts.
2. Conflict of interest, disclosure, disqualification, and ethical business standards. It is within this section of policy that SCFHP should prohibit split or segmented contracts whenever possible to allow for greater transparency and effective contract monitoring.
3. For which types of transactions or relationships are contracts required?

4. Means by which SCFHP will solicit contracts with vendors. For example, do projects with certain estimated expenditure amounts or durations require a competitive bidding process? What is the threshold for sole source vendor relationships? What are the criteria for emergency purchasing outside of a contract?
5. Contract approval levels defined by total amount of the expected expenditure, timing, and scope. Definition of contracts which require Board approval.
6. General contract parameters to be adhered to by SCFHP staff, such as no evergreen contracts, no contracts spanning multiple fiscal years, etc.
7. Identification of staff that is able to commit to and sign contracts on behalf of SCFHP.
8. Monitoring and reporting of contracts to management and/or the Board to assess total vendor load against thresholds, to detect fraud, waste, or abuse, and to promote transparency.

Under separate cover, WM will provide examples of contracting and procurement policy best practices and policy examples.

## Signatory Authority

The authority level of management to approve transactions and what level of transactions should be approved by the Board should be examined and documented. Management should set the signatory approval levels within the policy as it sees fit given the compensating controls that are currently in place for checks (positive pay), as well as the fact that the Board of Directors will review any policy which management develops. When developing approval levels, SCFHP should keep the levels for contract approval in mind. For instance, if contracts greater than $499,000 must be approved by the Board of Directors, than checks greater than $499,000 should not be able to be signed by the CFO alone.

## Reimbursable Expenses

The current Policy/Procedure for reimbursing expenses, dated 2008, should be reviewed and updated into the new template format. The list of expenses should be reviewed for adequacy based on current conditions. For example, SCFHP should determine whether or not it will reimburse for applicable professional license expense. SCFHP should

ensure that the Reimbursable Expenses agrees with its Accounts Payable policy (recommended as part of Cash Procedure #4) in regards to documentation required to receive reimbursement.

## IBNR Policy and Process

A minimal procedure is in place which details the accrual of IBNR. The current basic procedure needs to be replaced by a more detailed combined policy and procedure set that adheres to the new templates. The policy should be couched in terms of measurement of actual medical costs based on lag and actuarial analysis in order to fairly state such costs. The process should be identified as using IBNP methodology. Any margin typically added should be included in the documentation.

The procedure should include a look back process (where past IBNP estimates are compared to actual results with a sufficient lag should be documented). The look back process should include whether the medical expense for a month of service is over or under the original estimate. The look back process should also include the aggregate over or understatement of the IBNP at each measurement date in total for all months of service in order to directly state the impact on the profitability for each period measured.

## Budget Policy and Process

The budget process should be included as a policy and procedure set. The budget process starts in January of the current fiscal year and results in a final budget by June of each fiscal year for following fiscal year. The following processes need to be documented:

- How revenue is projected based on projected membership and the pmpm revenue yields for each service line and is developed by Senior Management with Mr. Jain's input.

- How expenses are evaluated by department, including how the current expense trends are used to project the following fiscal year budget. This process should be documented in detail.

- List of what analysis needs to be performed by departments for each month from January through June should be developed including but not limited to: Medical Loss Ratio projections and membership projections.

Additionally, WM recommends the current analysis of variances be formulated into a procedure.

## Appendix A – Best Practice Accounting Manual Components

| Accounting Manual Components |
|---|
| Accounting Manual Objective |
| Accounting Manual Scope |
| Accounting Responsibility, Authority, and Communication |
| Accounting Responsibility and Authority |
| Accounting Management Representative |
| Accounting Internal and External Communication |
| Referenced Accounting Standards |
| Accounting Division Organization |
| Organization Chart |
| Unit Responsibilities |
| Chart of Accounts |
| Management Reports |
| Period-End Review and Closing |
| Taxes and Insurance |
| Cash Receipts and Deposits |
| Wire Transfers |
| Bank Account Reconciliations |
| Inventory |
| Fixed Asset Control |
| Capitalization & Depreciation |
| Accounts Receivable |
| Accounts Payable |
| Purchasing |
| Payroll |
| Grants Management |

Santa Clara
Family Health Plan
*The Spirit of Care*

DRAFT

# SCFHP Medi-Cal Provider Incentive Program

August 25, 2016

# Program Goals

- Improve HEDIS preventive care outcomes affecting auto assignment to the plan
- Improve compliance with DHCS requirements in areas with performance gaps
- Improve overall access and quality of care

# Program Methodology

- Measured on a fiscal year cycle (7/1 – 6/30)
- Using claims and encounter data
  - LOB Medi-Cal, Non-Dual membership
- Five measures total
- 12 point scale for each measure
  - Two tiers per measure
- All claims should be submitted no later than 45 days after the end of the reporting period to be counted towards reporting
- Awards = points earned/points possible
- Program Eligibility
  - Non-Globally Capitated Networks with ≥ 10,000 members
  - Independent physicians/groups with ≥ 100 members by 6/2017

# Medi-Cal Program Measures

1. All Cause Readmission
2. Cervical Cancer Screening
3. Initial Health Assessments
4. Access to Primary Care Practitioners
5. Encounter Data Timeliness

# 1. All Cause Readmission

- Intent: Reduce readmissions within 30 days of previous hospital discharge for any reason
- DHCS Statewide Rate at the end of the Quality Improvement Project (QIP) 2015: 14%
- CY2015 Delegated Network Performance Range: 9% to 17%
- Program Goal
  - Tier 1: Less than or equal to 12% = 12 points
  - Tier 2: Greater than 12% and Less than 14% = 6 points

# 2. Cervical Cancer Screening

- Intent: Increase cervical cancer screenings in women 21-64
- HEDIS measure
  - Plan auto assignment measure
- HEDIS 2015 75th Percentile = 60% (adjusted for admin only)
- HEDIS 2015 90th Percentile = 67% (adjusted for admin only)
- CY2015 Delegated Network Performance Range: 32% to 86%
- Program Goal
  - Tier 1: Greater than or equal to 67% = 12 points
  - Tier 2: Greater than 60% and Less than 67% = 6 points

# 3. Initial Health Assessment within 120 days

- Intent: All new members must receive an Initial Health Assessment within 120 days of enrollment into the plan
- DHCS compliance measure
- DHCS compliance goal: 100%
- CY2015 Delegated Network Performance Range: 32% to 76%
- Program Goal
  - Tier 1: Greater than or equal to 90% = 12 points
  - Tier 2: Greater than 75% and Less than 90% = 6 points

# 4. Children Access to Primary Care

- Intent: Children 12-24 months visit their PCP annually and 12-19 years visit their PCP every two years
- HEDIS measure
- Age 12-19 years
  - HEDIS 2015 75th Percentile = 92%
  - HEDIS 2015 90th Percentile = 95%
  - CY2015 Delegated Network Performance Range: 75% to 93%
- Age 12-24 months
  - HEDIS 2015 75th Percentile = 97%
  - HEDIS 2015 90th Percentile = 98%
  - CY2015 Delegated Network Performance Range: 83% to 98%
- Program Goal
  - Age 12-19 years
    - Tier 1: Greater than or equal to 95% = 6 points
    - Tier 2: Greater than 92% and Less than 95% = 3 points
  - Age 12-24 months
    - Tier 1: Greater than or equal to 98% = 6 points
    - Tier 2: Greater than 97% and Less than 98% = 3 points

# 5. Encounter Data Timeliness

- Intent: Submit encounter data to the plan within 60 days of service
- DHCS compliance measure
- DHCS compliance goal: 100%
- CY2015 Delegated Network Performance Range: 27% to 92%
- Program goal
  - Tier 1: Greater than or equal to 95%= 12 points
  - Tier 2: Greater than 85% and Less than 95% = 6 points

Questions?

Santa Clara
Family Health Plan
*The Spirit of Care*

Meeting Minutes

# SCCHA Quality Improvement Committee

Wednesday, August 10, 2016

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

| Non-Voting Staff Members | Title | Present Y or N |
|---|---|---|
| Andres Aguirre | Quality Improvement Manager | Y |
| Lily Boris, MD | Medical Director | Y |
| Jennifer Clements | Director of Provider Operations | N |
| Caroline Alexander | Administrative Assistant | Y |
| Johanna Liu, PharmD | Director of Quality and Pharmacy | Y |
| Dan Johns | Appeals and Grievances Manager | Y |
| Divya Shah | Quality Improvement Coordinator | Y |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| Introductions | Chairman Ria Paul, MD called the meeting to order at 6:05 p.m. Quorum was established. | | | |
| Review and Approval of May 11, 2016 minutes | The minutes of the May 11, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written. | Minutes of the May 11, 2016 meeting were approved as presented. | | |
| Motion to Approve Revised Agenda | Motion made by Dr. Boris to accept revision of agenda to reflect committee will not adjourn to closed session. It was moved, seconded to approve revision to agenda. | Change to agenda was approved | | |
| Public Comment | No attendees from public. | | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| | | | | |
| CEO Update | Christine Tomcala reported membership is currently at 280, 382. Healthy Kids membership is currently at 4,224. Many are eligible for Medi-Cal transition and anticipate Healthy Kids membership will be at 1,000 after transition.<br><br>RFP for Complex Case Management/Disease Management Program for the Cal MediConnect product line has been completed and Optum was the vendor selected. Currently in the middle of the implementation period. Go Live is targeted for November 1st. Optum will provide both Case Management and Disease Management for Santa Clara Family Health Plan CMC line of business.<br><br>Plan completed the joint Department of Managed Care and Department of Health Care Services (DMHC/DHCS) audit April 18th through 29th. No feedback has been received from DMHC yet. DHCS shared the preliminary results. There were 36 preliminary findings. Ms. Tomcala compared SCFHP to other plans with recent audits, and most plans are in the 36 finding ranges. The plan is working on rebuttal to some findings, possibly decreasing the original number of findings.<br>Final results will be shared with the QIC committee. | | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| Action Items | | | | |
| A. Annual Review and Approval of Case Management Policies | Eight policies were presented to the committee:<br>CM01 Comprehensive Case Management<br>CM02 Disease Management<br>CM03 Transitions of Care<br>CM04 MLTSS Care Coordination<br>CM05 BH Care Coordination<br>CM06 Sensitive Services, Confidentiality, Right of Adults and Minors<br>CM07 Care Coordination Staff Training<br>CM08 Information Sharing with SARC<br>After discussion, it was moved, seconded to approve all eight policies as written. | All policies were approved as presented. | | |
| B. Annual Review and Approval of Health Education Policies | Three policies were presented to the committee:<br>QI09 Health Education Program and Delivery System<br>QI10 IHA and HEBA Assessment Policy<br>QI11 Member and Non-monetary Incentives<br>After discussion it was moved, seconded to approve all three policies as written. | All policies were approved as presented. | | |
| C. Review and Approval of Case Management Program Description | Johanna Liu presented a summary of the Case Management Program Description.<br>After discussion, it was moved, seconded to approve the Case Management Program Description. | Case Management Program Description was approved as presented. | | |
| D. Review and Approval of Health Education Program Description | Angela Sheu-Ma presented the Health Education Program Description. Committee recommends adding information about delegation arrangement for member Health Education.<br>After discussion, it was moved, seconded to approve Health Education Program Description. | Health Education Program Description was approved as presented.<br><br>Bring information on delegation of Health Education | Angela Sheu-Ma | Next Quality Improvement Committee meeting 11/9/2016 |
| E. Review and Approval of Health Education Work Plan | Angela Sheu-Ma presented the Health Education Work Plan.<br>After discussion, it was moved, seconded to approve Health Education Work Plan. | Health Education Work Plan was approved as presented. | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| Discussion Items<br>A. Access and Availability | Andres Aguirre presented Access and Availability report. Plan is mandated by the State to do an annual access survey. Presented 1st Quarter 2016 HEDIS data in the following areas:<br>• Adults Access to Preventive/Ambulatory Health Services<br>• Children and Adolescents' Access to Primary Care Practitioners<br>• Prenatal and Postpartum Care<br>• Ambulatory Care Measures for Outpatient Visits and ED visits | | | |
| B. Appeals and Grievances | Dan Johns presented a summary of Second Quarter 2016 Appeals and Grievances. 214 Medi-Cal/Healthy Kids cases received and 208 Cal MediConnect cases received. Highest type of Medi-Cal grievance was Quality of Service (47 received). Highest type of Cal MediConnect grievance was Billing (124 received). | | | |
| C. CAHPS-Reporting Year 2016 | Andres Aguirre presented the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Report for reporting year 2016. CAHPS is survey driven. Frequency for Medi-Cal is every two years and for Cal MediConnect annually. Final Sample Size was 1,373 for Medi-Cal and 800 for Cal-MediConnect. Members showed similar experience with the health plan across both lines of business. Cal Medi-Connect members showed a better experience with both provider access and provider interaction than Medi-Cal members. Cal Medi-Connect members were more satisfied with the personal doctor than Medi-Cal members.<br>Committee recommended adding to the report how Santa Clara Family Health Plan's results compare nationally. | Add comparison with national results to next report | Andres Aguirre | Next Quality Improvement Committee meeting 11/9/2016 |
| D. HEDIS Reporting Year 2015 | Andres Aguirre presented the HEDIS results for the 2015 Reporting Year. New challenges with this reporting period. HEDIS medical record collection started 2 months late, resulting in three Medi-Cal measures below the MPL and one Cal MediConnect receiving a No Report. Next steps for Medi-Cal are a mailing campaign and incentives for Cervical Cancer Screening, a performance improvement project for Controlling | | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| | High Blood Pressure, and Diabetes Blood Pressure Control. For Cal Medi-Connect, next step is to continue doing interim Verisk builds to correct problems from HEDIS 2016. Committee recommended possibly sending a list to providers of members that are missing documentation elements (BMI, for example). Also, grant providers access to log into a portal to access member records securely and update missing information. | | | |
| Committee Reports<br>A. Credentialing Committee | Dr. Lin presented the June 1, 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 1st Quarter 2016 Pharmacy and Therapeutics Committee minutes. Nine policies were presented and approved. Strattera to be kept on formulary with no prior authorization for those under 18 years old and requires prior authorization for those above 18 years old. | 1st Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented. | | |
| C. Utilization Management Committee | Dr. Lin presented the 2nd Quarter 2016 and June 2nd Ad Hoc Utilization Management Committee minutes. A total of twelve Utilization Management policies were presented and approved. Utilization Management Program Description, Utilization Management Committee Charter, Utilization Management Work Plan for 2016, as well as Clinical Practice, Behavioral Health and Preventive Care Guidelines were presented and approved. | 2nd Quarter 2016 and June 2nd Ad Hoc Utilization Management Committee minutes were approved as presented. | | |
| D. Dashboard | Andres Aguirre presented the 2nd Quarter 2016 Dashboard report. Report includes Facility Site Review, Potential Quality Issues, and Case Management Metrics. 19 sites were reviewed and 2 sites were medical record review only. 32 Potential Quality Issues were referred to Quality. 29.81% of HRA's were | | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| | completed within 90 days of enrollment. | | | |
| Potential Quality Issue Review: Follow up | One Potential Quality Issue was presented at the May 11th Quality Improvement Committee meeting which required follow up. Dr. Boris presented a summary of the follow up actions taken. These were recommended by the QIC to the provider and all recommendations were followed by the provider. Committee recommended an area on Provider Portal where level of severity of Potential Quality Issues can be reported, without naming providers. | Closed | | |
| Adjournment | Meeting adjourned by Dr. Ria Paul at 7:43 p.m. | | | |
| Next Meeting | Wednesday, November 09, 2016- 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, August 10, 2016**
**6:00 PM - 7:30 PM**
**210 E. Hacienda Avenue**
**Campbell, CA 95008**

# AGENDA

| | | | | |
|---|---|---|---|---|
| **1.** | **Introduction** | Dr. Paul | 6:00 | 5 min. |
| **2.** | **Meeting Minutes** | Dr. Paul | 6:05 | 5 min. |

Review minutes of the May 11, 2016 Quality Improvement Committee meeting.
**Possible Action:** Approve 05/11/2016 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** | | 6:25 | 20 min. |

**a.** Review of Case Management Policies — Ms. Liu
- i. CM.01 Comprehensive Case Management
- ii. CM.02 Disease Management
- iii. CM.03 Transitions of Care
- iv. CM.04 MLTSS Care Coordination
- v. CM.05 BH Care Coordination
- vi. CM.06 Sensitive Services, Confidentiality, Right of Adults and Minors
- vii. CM.07 Care Coordination Staff Training
- viii. CM.08 Information Sharing with SARC

**b.** Review of Health Education Policies — Ms. Sheu-Ma
- i. QI.09 Health Education Program and Delivery System
- ii. QI.10 IHA and HEBA Assessment Policy
- iii. QI.11 Member and Non-monetary Incentives

**Possible Action**: Approve Case Management and Health Education policies

| | | | | |
|---|---|---|---|---|
| **c.** | Review of Case Management Program Description<br>**Possible Action**: Approve Case Management Program Description | Ms. Liu | | |
| **d.** | Review of Health Education Program Description<br>**Possible Action**: Approve Health Education Program Description | Ms. Sheu-Ma | | |
| **e.** | Review of Health Education Work Plan<br>**Possible Action**: Approve Health Education Work Plan | Ms. Sheu-Ma | | |
| **6.** | **Discussion Items** | | 6:45 | 20 min. |
| **a.** | Access and Availability | Mr. Aguirre | | |
| **b.** | Appeals and Grievances | Mr. Johns | | |
| **c.** | CAHPS- Reporting Year 2016 | Mr. Aguirre | | |
| **d.** | HEDIS Reporting Year 2015 | Mr. Aguirre | | |
| **7.** | **Committee Reports** | | | |
| **a.** | **Credentialing Committee**<br>Review June 01, 2016 report of the Credentialing Committee.<br>**Possible Action:** Accept June 01, 2016 Credentialing Committee Report as presented | Dr. Lin | 7:05 | 5 min. |
| **b.** | **Pharmacy and Therapeutics Committee**<br>Review minutes of the March 24, 2016 Committee Meeting.<br>**Possible Action:** Accept March 24, 2016 Pharmacy and Therapeutics Committee minutes as presented | Dr. Lin | 7:10 | 5 min. |
| **c.** | **Utilization Management Committee**<br>Review minutes of the April 20 and June 02, 2016 Committee Meetings.<br>**Possible Action:** Accept April 20 and June 02, 2016 Utilization Management Committee minutes as presented | Dr. Lin | 7:15 | 5 min. |
| **d.** | **Dashboard** | Ms. Liu | 7:20 | |
| **8.** | **Adjourn to Closed Session** | Dr. Paul | 7:25 | |
| **a.** | Quality Review | | | |
| | i. Potential Quality Issue Follow Up | Dr. Boris | | |

**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, May 11, 2016

| Voting Committee Members | Specialty | Present Y or N |
|---|---|---|
| Thad Padua, MD | Pediatrics | Y |
| Nayyara Dawood, MD | Pediatrics | Y |
| Jennifer Foreman, MD | Pediatrics | Y |
| Jimmy Lin, MD | Internist | Y |
| Ria Paul, MD | Geriatric Medicine | Y |
| Jeff Robertson, MD, CMO | Managed Care Medicine | Y |
| Christine Tomcala, CEO | N/A | Y |
| Sara Copeland, MD | Pediatrics | Y |
| Ali Alkoraishi, MD | Psychiatry | Y |

| Non-Voting Staff Members | Title | Present Y or N |
|---|---|---|
| Andres Aguirre | Quality Improvement Manager | Y |
| Lily Boris, MD | Medical Director | Y |
| Jennifer Clements | Director of Provider Operations | Y |
| Caroline Alexander | Administrative Assistant | Y |
| Johanna Liu, PharmD | Director of Quality and Pharmacy | Y |
| Dan Johns | Appeals and Grievances Manager | Y |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| INTRODUCTIONS | Chairman Thad Padua, MD called the meeting to order at 6:10 p.m. Quorum was established. | | | |
| Public Comment | No attendees from public. | | | |
| CEO Update | Christine Tomcala reported Quality Improvement Committee is now a committee of the Board. As a committee of the Board, it is appropriate to have a Board Representative on the Quality Improvement Committee. Darrell Evora, member of the Board, has agreed to sit on the Quality Improvement Committee. (Recently appointed by the Board). RFP for Complex Case Management/Disease Management Program is in process. 4 Vendors submitted responses. HEDIS cycle for the year is complete. Data has been submitted for validation. Plan participated in a joint Department of Managed Health Care and | Present HEDIS data feedback at next meeting | Andres Aguirre | Next Quality Improvement Committee Meeting August 10, 2016 |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| | Department of Health Care Services (DMHC/DHCS) audit April 18th through 29th. Membership is currently at 271, 928. Plan will focus on more outreach to encourage enrollment in Cal Mediconnect. | | | |
| Follow Up Items | Dr. Robertson and Dr. Padua presented an update on the new committee organization structure. Quality Improvement Committee will now report up to the Board and is now subject to the Brown Act. Committee meetings will now be open to public attendees. Agenda will now be required to be published and posted within 72 hours prior to the committee meeting date. | | | |
| Consent Agenda | Motion made by Committee Chairman Dr. Padua to change Consent Agenda items to individual action items. It was moved, seconded to change consent agenda items to individual action items. | It was approved to change consent agenda items to individual action items. | | |
| Action Items | | | | |
| A. Review and Approval of February 10, 2016 minutes | The minutes of the February 10, 2016 Quality Improvement Committee Meeting were reviewed.<br>It was moved, seconded to approve minutes as written. | Minutes of the February 10, 2016 meeting were approved as presented. | | |
| B. Annual Review and Approval of Quality Improvement Policies | Six policies were presented and reviewed by the committee:<br>QI01 Conflict of Interest<br>QI02 Clinical Practice Guidelines<br>QI03 Distribution of Quality Improvement Information<br>QI04 Peer Review Process<br>QI05 Potential Quality of Care Issues<br>QI06 Quality Improvement Study Design/Performance Improvement Program Reporting<br>After discussion, it was moved, seconded to approve all six policies as written. | All policies were approved as presented. | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| C. Review and Approval of Quality Improvement Program 2016 Summary of Changes | Dr. Boris presented a summary of changes made to the 2016 Quality Improvement Program Description. After discussion, it was moved, seconded to approve changes to 2016 Quality Improvement Program | Changes to 2016 Quality Improvement Program were approved as presented. Submit copy to DHCS. | Beth Paige/Anna Vuong | |
| D. Review and Approval of 2015 Quality Improvement Program Evaluation | Andres Aguirre presented the 2015 Quality Improvement Program Evaluation for review. Committee recommends adding a comparison grid of each network's performance. After discussion, it was moved, seconded to approve 2015 Quality Improvement Program and Evaluation | 2015 Quality Improvement Program Evaluation was approved as presented. Submit copy to DHCS. | Beth Paige/Anna Vuong | |
| Discussion Items | | | | |
| A. Appointment of new Quality Improvement Committee Chair | Ria Paul, MD, Clinical Associate Professor at Stanford Senior Care Center was appointed as the new Quality Improvement Committee Chairman effective next committee meeting. | | | |
| B. Review of Quality Improvement Committee Charter | The updated Quality Improvement Committee Charter was presented to the committee for review. | Informational only; already approved by the Board | | |
| C. Access and Availability | Jennifer Clements shared the results of the 2015 Timely Access Surveys with the committee. Reported a decrease in the number of providers that responded to the survey. Will continue to educate providers of Timely Access Standards. | Present Quarterly reports to the Quality Improvement Committee | | |
| D. Appeals and Grievances | Dan Johns presented a summary of First Quarter 2016 Appeals and Grievances. Increased training with coordinators reduced the number of cases reported as Quality of Care. | Present Quarterly reports to the Quality Improvement Committee | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| E. CY 2015 Annual Review of SCFHP Cal MediConnect Population Demographics and Specific Health Conditions | Dr. Boris presented a summary of the Cal MediConnect (CMC) Population Demographics and Specific Health Conditions to the committee. Of the 9,070 CMC members, 3,860 or 43% have three or more chronic conditions and 5,006 or 55% receive eight or more prescriptions. | | | |
| F. Cal MediConnect Dashboard | Andres Aguirre presented the 2015 Cal MediConnect (CMC) Dashboard to the committee. Moving towards a new vendor that will complete HRA process from start to finish (Careplan, Data Entry, Data Analytics) effective November 2016. | | | |
| Report of Subcommittees and Approval of Minutes | | | | |
| A. Credentialing Committee | Dr. Robertson presented the April 6, 2016 Credentialing Committee Report. New report format presents a summary of the detailed work of the credentialing committee. 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 4th Quarter 2015 Pharmacy and Therapeutics Committee minutes. Med Impact minutes will be reviewed in advance by Johanna Liu, PharmD, and presented as a summary at future committee meetings. It was moved, seconded to approve 4th Quarter 2015 Pharmacy and Therapeutics Committee minutes as presented. | 4th Quarter 2015 Pharmaceutical and Therapeutics Committee minutes were approved as presented. | | |
| C. Utilization Management Committee | Dr. Lin presented the 4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes. New report on Behavioral Health has been added. Tracking Underutilization as well as Overutilization in Utilization Management reports. It was moved, seconded to approve 4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes as presented. | 4th Quarter 2015 and 1st Quarter 2016 Utilization Management Committee minutes were approved as presented. | | |
| | | | | |
| Adjourn to Closed Session: PQI | Meeting adjourned to closed session at 7:40 p.m. The | Dr. Robertson to | | |

| AGENDA ITEM | DISCUSSION/ACTION | ACTION | RESPONSIBLE PARTIES | DUE DATE |
|---|---|---|---|---|
| Discussion: Protected Information | committee discussed one PQI. | follow up on agreed upon items | | |
| Next Meeting | Wednesday, August 10, 2016- 6:00 PM | Calendar and attend. | All | |

**Reviewed and approved by:**

_____ Date _____

Thad Padua, MD
Quality Improvement Committee Chairperson

# POLICY

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Comprehensive Case Management** | **Policy No.:** | CM01 |
| **Replaces Policy Title (if applicable):** | Case Management | **Replaces Policy No. (if applicable):** | CM030_05 |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☒ Healthy Kids | ☒ CMC |

## I. Purpose

To promote access to appropriate, coordinated services with the intent that members with case management needs may achieve optimal health and functionality.

## II. Policy

A. The comprehensive case management program is established to provide case management processes and procedures that enable SCFHP to improve the health and health care of its membership.
B. To define the fundamental components of SCFHP case management services which include: member identification and screening; member assessment; individual care plan development, interdisciplinary team meetings including primary care, implementation and management; evaluation of the member care plan; and closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.
C. SCFHP defines the process of how the Plan coordinates services for members with complex conditions and helps them access needed resources.

## III. Responsibilities

Health Services collaborates with other SCFHP departments (IT, claims, benefits, provider services) as well as providers and community services to identify, coordinate services, coordinate benefits and provide members with complex case management.

## IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.
Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA.
NCQA Guidelines. 2016.
87890 2016 SCFHP Model of Care
DPL 15-005

# POLICY

**V. Approval/Revision History**

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Disease Management** | **Policy No.:** | CM02 |
| **Replaces Policy Title (if applicable):** | None | **Replaces Policy No. (if applicable):** | None |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☐ Medi-Cal | ☐ Healthy Kids | ☒ CMC |

## I. Purpose

To support processes so the Plan may actively work to improve the health status for members with chronic health conditions.

## II. Policy

A. The Disease Management Program is designed to support the mission of SCFHP by improving the quality of care and disease outcomes for the Santa Clara Family Health Plan CalMediConnect members. The plan takes an active role in helping providers assist members in managing chronic conditions. An evaluation of the Plan's population is conducted annually to identify medical and behavioral health conditions to be included in the Disease Management Program

B. To define how each Disease Management program will be established on evidence based Clinical Practice Guidelines adopted by the Quality Improvement (QI) Committee. These guidelines are evidence based and widely accepted clinical practices, based on literature or other practice guidelines.

## III. Responsibilities

Health Services works with IT, Member Services, Provider Services, Providers, Quality Improvement, Behavioral Health Services, Pharmacy Management, and community based services to support members with Disease Management services.

## IV. References

NCQA Guidelines. 2016
87890 2016 SCFHP Model of Care

## V. Approval/Revision History

| First Level Approval | Second Level Approval |
|---|---|
| Signature | Signature |

| | |
|---|---|
| Name | Name |
| Title | Title |
| Date | Date |

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Transitions of Care** | **Policy No.:** | CM.03 |
| **Replaces Policy Title (if applicable):** | None | **Replaces Policy No. (if applicable):** | None |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☒ Healthy Kids | ☒ CMC |

## I. Purpose

To define the process the Plan adopts to monitor and take action to improve continuity and coordination of care across the health care network, including medical care settings, medical with behavioral health care settings, and for transitioning members between levels of care.

## II. Policy

A. The Plan supports and promotes appropriate transitions between care settings which is critical to improving member quality of care and health outcomes. The Plan's Care Transitions Program goal is to improve transitions between settings to the most appropriate and safe level of care for that member. Objectives include:
- Curtail medical errors
- Identify issues for early intervention
- Minimize unnecessary hospitalizations and readmissions
- Support member preferences and choices
- Reduce duplication of processes and efforts to more effectively utilize resources
- Promote the exchange of information
- Support appropriate use of medications
- Meet special needs of members with behavioral disorders commonly seen in primary care

B. The Plan implements processes that arrange for/ authorize and coordinate services and care needed for members after inpatient discharge, nursing facility residents or at other levels of care into the community or to the least restrictive setting possible. This includes ensuring access to necessary medical/behavioral health care, medications, durable medical equipment, supplies, transportation, and integration of Long Term Support Services (LTSS) benefits and community based resources.

C. The Plan uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system
    a. Between medical care settings
    b. Between medical and behavioral health care settings

Process is detailed in the associated Procedure document Transitions of Care.

## III. Responsibilities

Health Services works with internal departments, providers and community resources for referrals and to transition members to appropriate levels of care.

## IV. References

WIC section 14182.17(d)(4)(H).
NCQA, 2016
87890 2016 SCFHP Model of Care
DHCS/Plan Renewed Contract 2013
DHCS/CMS/Plan 3-Way Contract

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| **v1** | **Original** | | | |

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Managed Long Term Services and Supports (MLTSS) Care Coordination** | **Policy No.:** | CM.04 |
| **Replaces Policy Title (if applicable):** | | **Replaces Policy No. (if applicable):** | |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☐ Healthy Kids | ☒ CMC |

## I. Purpose

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

## II. Policy

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

B. The Plan defines MLTSS procedures to include:

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

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

## III. Responsibilities

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

## IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA.

NCQA Guidelines. 2016.

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1.0 | **Original** | | | |

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Behavioral Health Care Coordination** | **Policy No.:** | CM05 |
| **Replaces Policy Title (if applicable):** | **Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure** | **Replaces Policy No. (if applicable):** | **CM106_1** |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☐ Healthy Kids | ☒ CMC |

## I. Purpose

The plan promotes and coordinates seamless access and availability to appropriate behavioral health providers, community services and support for members identified with behavioral/mental health and substance use needs so that member may achieve optimal health and functionality.

## II. Policy

A. To complement the Comprehensive Case Management policy, the Plan optimizes access to services for members by coordinating care and facilitating referrals to Behavioral Health (Mental Health and Substance Use Disorders) services for Medi-Cal and Cal MediConnect (CMC) members. This includes emergent, non-emergent, in-patient or outpatient referrals. Referrals may encompass community services, a community triage service, a community crisis line, contracted plan providers.

B. The Plan promotes continuity and coordination of care between behavioral healthcare providers and medical providers. Information is gathered regarding exchange of information, appropriate diagnoses, treatment, referrals, medications and follow-up. Successful collaboration is monitored and improvement plans implemented as appropriate.

C. The Plan defines processes for the provision of Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence based behavioral intervention services that develop or restore. The plan provides BHT for members with Autism Spectrum Disorder (ASD). The Plan requires Primary Care Physicians (PCP) to administer the Department of Health Services approved assessment tool as detailed in the procedure.

D. To define how the Plan provides guidelines to PCPs regarding management and treatment for members with Behavioral Health conditions as outlined in the procedure Mental Health Services Provided by PCPs.

## III. Responsibilities

Behavioral Health Services collaborates with other Health Services areas to coordinate care, and with QI to monitor coordination of care, for under/over utilization.

## IV. References


3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

NCQA Guidelines 2016

WIC Sections 14182.17(d)(4) and 14186(b)

28 CCR 1300.74.72(g)(3) through (5)

H7890 2016 SCFHP Model of Care


## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | Sensitive Services, Confidentiality, Rights of Adults and Minors | **Policy No.:** | CM06 |
| **Replaces Policy Title (if applicable):** | Sensitive Services, Confidentiality, Rights of Adults and Minors | **Replaces Policy No. (if applicable):** | CM036_04 |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☒ Healthy Kids | ☒ CMC |

## I. Purpose

To promote timely access to sensitive, confidential medical services for adult and minor children when needed and/or requested.

## II. Policy

A. Santa Clara Family Health Plan (SCFHP) allows minor children and adult members to have access to sensitive, confidential medical services without the need for prior authorization.

I. The following services are considered confidential and sensitive services for adult and minor children aged 12 and older without parental consent:

1. Sexually transmitted diseases
2. Family planning
3. Sexual assault
4. Pregnancy testing
5. HIV testing and counseling
6. Abortion
7. Drug and alcohol abuse
8. Outpatient mental health care

B. Requirements for consent, confidentiality and rights for these sensitive services are defined in the associated procedure CM.06.01.

## III. Responsibilities

Health Services works with IT, benefits, Provider and Customer Services, providers and community services to provide sensitive and confidential services to members without requiring prior authorization.

## IV. References

Fed. Law 1987 OBRA, Sec. 4113 (c)(1)(B), 1905 (a)(4)(c); BBA , DHS Contract A-12, Exhibit A, Attachments 5, et. seq, 9, Items 1, 3, 8, 2. C,; MMCD Pol. Letter #s: 94-13, 96-09, 97-08, 98-11; T22, CCR, 50063.5, 51009, 50063.5; Family Code §6925 et. seq., W & I Code §14132. et seq., 14451 et. seq. ; T28, CCR, Knox-Keene Act; H & S Code §1340. et. seq., 120980, 120990, 121010, 121015, Civ. Code §56. et. seq; Insurance Code §791, et. seq.

**V. Approval/Revision History**

| 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:** | Care Coordination Staff Training | **Policy No.:** | CM07 |
| **Replaces Policy Title (if applicable):** | Long Term Support Services and Social Services Training | **Replaces Policy No. (if applicable):** | 112_01 |
| **Issuing Department:** | Health Services | **Policy Review Frequency:** | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal | ☒ Healthy Kids | ☒ CMC |

## I. Purpose

To provide staff the skills to meet member needs related to care coordination principals.

## II. Policy

A. Care Coordination Staff training includes but is not limited to the following:

1. Overview of regulatory / contractual requirements including ICP and ICT training
2. Accessibility and accommodations; independent living;
3. Wellness principles
4. Criteria for safe transitions, transition planning, care plans after transitioning
5. Along with other required training as specified by DHCS—both initially and on an annual basis
6. Dementia care management for specially designated care coordination
7. LTSS operations including:
    a. LTSS benefits
    b. Eligibility and Service Authorization process
    c. Program limitations
    d. Referrals
    e. Interface with Case Management
    f. Overview of characteristics and needs of LTSS target population
8. Self-direction
9. Behavioral Health coordination
10. Community Services
11. Model of Care
12. Cultural and Linguistic Services
13. Care Plan Options
14. Person centered planning process
15. Home and Community Based Services

B. Training content is reviewed and updated as needed in regards to state and federal regulations as well as other best practices. Staff training is completed upon hire, reviewed annually and additional reviewed as needed.

## III. Responsibilities

Health Services management works with internal departments, external partners and providers to provider staff training.

## IV. References

3 Way Contract. (2014). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

Cal MediConnect Prime Contract (§2.9.10.10.)
H7890 2016 SCFHP Model of Care

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | | | | |

# POLICY

Santa Clara
Family Health Plan

| | | | |
|---|---|---|---|
| **Policy Title:** | **Information Sharing with San Andreas Regional Center (SARC)** | Policy No.: | CM08 |
| **Replaces Policy Title (if applicable):** | None | Replaces Policy No. (if applicable): | None |
| **Issuing Department:** | Health Services | Policy Review Frequency: | Annually |
| **Lines of Business (check all that apply):** | ☒ Medi-Cal ☒ Healthy Kids | | ☐ CMC |

## I. Purpose:

This policy supports the agreement between San Andreas Regional Center (SARC) and the Santa Clara Family Health Plan (SCFHP) to perform care coordination and information exchange activities when Medi-Cal beneficiaries are accessing medically necessary Behavioral Health Treatment Services (BHT). The agreement addresses both new referrals for BHT and clients/beneficiaries receiving BHT when funding for this service is transitioning from SARC to SCFHP.

## II. Policy

SCFHP is responsible for the provision of BHT as a managed care health benefit, including the coordination of the client's care with SARC and the BHT provider(s). SARC will support SCFHP's care coordination by providing necessary client information to SCFHP and vendors in accordance with any and all privacy laws and regulations.

**Santa Clara Family Health Plan**

- SCFHP is responsible for coordination of services including primary care, California Children's Services, Specialty Mental Health Services.
- SCFHP shall arrange for and pay for diagnostic evaluations and BHT services according to criteria outlined in DHCS APL 15-025.
- SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.

**San Andreas Regional Center**

- SARC shall provide client information, including comprehensive diagnostic evaluation(s), treatment plan(s), utilization data and assessment information to SCFHP upon receipt of appropriate release of information (ROI)
- SARC shall refer clients under age 21 who are diagnosed with Autism Spectrum Disorder (ASD) for evaluation for medically necessary BHT services.
- SARC shall provide case management & care coordination services related to SARC's Early Start Program clients.
- SARC shall provide case management and care coordination to eligible clients and assist those clients in maintaining an ongoing relationship with the SCFHP's assigned primary care provider when medical needs arise.
- SARC will identify a staff person to be the primary liaison to SCFHP. The liaison will meet not less than quarterly to ensure continuous communication and resolve any operational, administrative and policy complications.

## POLICY

- SARC will share information on community resources.
- SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families
- SARC agrees to provide periodic training to SCFHP's staff.
- SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.

## III. Responsibilities

Health Services works collaboratively with plan benefits, compliance, QA , IT, plan and community providers to coordinate members' Behavioral Health Treatment services and members' Behavioral Health managed care.

## IV. References

Center for Medicare & Medicaid Services approved California State Plan Amendment (SPA) 14-026
Section 1915 C waiver, CA.336 HCBS Waiver for Californians with Developmental Disabilities
Department of Health Services (DHCS) All Plan Letter (APL) 15-025

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| 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<br>Angela Sheu-Ma | Signature |
| Name<br>Health Educator | Name |
| Title | Title |
| Date | Date |

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

# 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

# POLICY

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

# 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.

# POLICY

## V. Approval/Revision History

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

| Version Number | Change (Original/ Reviewed/ Revised) | Reviewing Committee (if applicable) | Committee Action/Date (Recommend or Approve) | Board Action/Date (Approve or Ratify) |
|---|---|---|---|---|
| v1 | **Original** | | | |

Santa Clara Family Health Plan Health Services

# Comprehensive Case Management
# Program Description
# 2016

| | |
|---|---|
| _____ | _____ |
| Date | Jeff Robertson, MD<br>Chief Medical Officer |
| _____ | _____ |
| Date | Bob Brownstein<br>Chairperson, Board of Directors |

# Table of Contents

## Contents

## I. SCFHP Background

Santa Clara Family Health Plan (SCFHP) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Santa Clara County. Established in January 1996, SCFHP was created by the Santa Clara County Board of Supervisors for residents and reflects the cultural and linguistic diversity of the community. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with providers, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, behavioral health, dental and vision coverage through our health insurance programs: Medi-Cal, Cal MediConnect and Healthy Kids. Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program.

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families. We currently serve over 250,000 residents of Santa Clara County. For the Cal MediConnect Line of Business we are serve approximately 9,000 members.

SCFHP offers an array of care management services to support a collaborative patient and provider treatment process and to improve the health of the member population. Comprehensive case management is one such SCFHP service that assists members and providers in aligning effective healthcare services and appropriate community resources.

The activities of the comprehensive case management program support SCFHP members and providers to attain the highest level of functioning available to the member in relation to their overall health conditions. SCFHP oversees and maintains the following three case management service types in the comprehensive case management program: (1) Basic Case Management Services, (2) Moderate Case Management Services and (3) Complex Case Management.

The comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and individual program descriptions for each of the three case management services that comprise the comprehensive case management program.

## II. Purpose and Scope

The purpose of the Santa Clara Family Health Plan (SCFHP or the "Plan") Comprehensive Case Management Program Description is to define the goals and objectives of the program, the methods and processes of identifying and assessing members, managing member care, and measuring the impact of Case Management (CM) interventions. . Case management is defined by the Case Management Society of America (CMSA) as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes." The Plan also abides by the principles of case management practice, as described in CMSA's Standards of Practice for Case Management, providing both episodic and complex case management, based on member needs and the intensity of service required.

The Case Management Program has three components: Basic Case Management, Moderate Case Management and Complex Case Management. All Case Management activities maintain the member's privacy, confidentiality and safety. The Case Manager advocates for the member and adheres to ethical, legal and accreditation/regulatory standards while reinforcing the member's Rights and Responsibilities as noted in the Member Handbook.

Case management activities are performed telephonically or in-person depending upon the member's needs. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, various payer sources and the community at large.

SCFHP promotes case management services through multidisciplinary teams that address member specific medical conditions, behavioral, functional, psychosocial issues in a single health care setting or during the member's transitions of care across the continuum of care.

The comprehensive case management program is established to provide case management processes and procedures that enable SCFHP to improve the health and health care of its membership. The fundamental components of SCFHP case management services encompass: member identification and screening; member assessment; individual care plan development, interdisciplinary team meetings including primary care, implementation and management; evaluation of the member care plan; and closure of the case. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The SCFHP Care Delivery Model for comprehensive case management provides coordinated care across the full continuum of care including medical, Behavioral Health (BH) and Long Term Services and Supports (LTSS). This model reflects a person-centered, outcome-based, community-centered approach. The focus is on providing care in the most appropriate, safe, and least restrictive setting for members including monitoring of nursing facility utilization and facilitating successful care transitions between facilities and community. SCFHP comprehensive case management services span medical and LTSS systems, emphasizing coordination with county agencies, direct contractors for Behavioral Health and appropriate community resources. The CM Program focuses on the integration of the array of services and proactively facilitates the communication and collaboration between them.

The case management team, in conjunction with the member, and using the health risk assessment (HRA) will create and monitor a dynamic interdisciplinary care plan (ICP). Simultaneously, the interdisciplinary care team (ICT) which includes anyone the member deems important to their care and the PCP, will meet as needed to create, activate and monitor the individual care plan.

## III. Goals and Objectives

### A. Goals

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the SCFHP membership and to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long term services and supports; and further the goals of the Olmstead Decision1. In doing so, more specific goals for the program include:

- Identification of the most vulnerable members
- Provide support, education and advocacy to members in collaborative communications and interactions
- Interact with members as a "whole person," not as a condition or event
- Work collaboratively with the member, family and caregivers to develop goals and assist member is achieving these goals.
- Enhance member health self-management skills and knowledge regarding their disease and condition
- Engage the providers and community as collaborative partners in the delivery of effective healthcare
- Support the foundational role of the primary care physician and care team to achieve high-quality, accessible, efficient health care
- Integrate seamlessly into the primary care office workflow to ease use of program by physicians and staff
- Coordinate with community services to promote and provide member access to available resources in the Santa Clara County service area
- Promote early and timely interventions that prevent avoidable emergency room visits and hospitalizations.
- Provide financial stewardship and diligence, while ensuring the provision of high quality, evidence-based health care services
- Promote utilization of participating providers
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards
- Help members regain optimum health or regain functional capability
- Identify barriers that may impede member's functionality
- Treatment of the member in the least restrictive setting appropriate

### B. Objectives

The objectives of the comprehensive case management program is to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the SCFHP membership. The Chief Medical Officer and the Manager of Case Management develop measurable goals and objectives and monitor them. The Quality Improvement Committee (QIC) reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Prevent and reduce hospital and facility readmissions as measured by admission and readmission rates
- Prevent and reduce emergency room visits as measured by emergency room visit rates
- Achieve and maintain member's high levels of satisfaction with case management services as measured by member satisfaction rates
- Improve functional health status and sense of wellbeing of comprehensive case management members as measured by member self-reports of health condition

The comprehensive case management program is a supportive and dynamic resource that SCFHP uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

## IV. Program Oversight and Staff Responsibility

### A. Quality Improvement Committee (QIC)

The QIC supports the objective and systematic monitoring and evaluation of the overall processes and procedures of the comprehensive case management program. The QIC is a standing committee of the SCFHP Board of Governors and meets a minimum of four times per year, and as often as needed to follow-up on findings and required actions. All meetings are open to the public, except when matters deal with peer review activities, contracting issues and other proprietary matters of business. Signed and dated minutes are maintained that summarize committee activities and decisions. The elected Chair of the QIC and members are appointed for two-year terms and include the following representatives:

- SCFHP Chief Medical Officer
- SCFHP Chief Executive Officer (ex officio)
- SCFHP Contracted physicians (3)
- Behavioral Health Practitioner / Specialist

The QIC holds oversight and monitoring responsibility for clinical activities, services and programs provided by the SCFHP health plans. These responsibilities include:

- Oversight of the utilization, case and disease management, and quality management programs.
- Review and approval of annual QI (Quality Improvement), CM (Case Management), DM (Disease Management) and UM (Utilization Management) program descriptions, work plans, and evaluations.
- Annual Population Assessment for Case Management and Disease Management programs
- Review results and effectiveness of quality improvement, case and disease management and utilization management activities and measures, and provide recommendations for priorities and corrective action interventions.
- Review and approval of medical necessity criteria and clinical practice guidelines.
- Oversight of all delegation arrangements to include review of summary reports and evaluations.
- Monitor and review regulatory and accreditation compliance activities.
- Monitor and review member grievance and appeals information.
- Review reports from the Pharmacy and Therapeutics Committee.
- Provide summary reports of clinical activities, services and programs to the Board of Governors.

Specific to the comprehensive case management program, the QIC maintains the following responsibilities and functions:

- Oversight of development, implementation, administration, and management of program.
- Integration of program activities with other SCFHP functions, including utilization management, disease management, Behavioral Health and Long Term Services and Supports, quality and performance improvement, member services, and provider network services.
- Recommendations for coordination and promotion of program to provider, community and consumer stakeholders.
- Review of annual program evaluation that includes analysis of performance measures, review of policies, procedures and program description, analysis of member population characteristics, and evaluation of the resources to meet the case management needs of membership.
- Recommendations for program improvement and approaches to address barriers to care.
- Assure overall effectiveness, efficiency, quality and satisfaction with the program.

## B. Staff Resources

### 1. Chief Medical Officer

The Chief Medical Officer (CMO) has ultimate responsibility for and provides support to the Plan's Case Management Programs. The Plan's CMO, Medical Director, Director of Health Services along with the Plan President and CEO are the senior executives responsible for implementing the Case Management Programs including cost containment, quality improvement monitoring, medical review activities, outcomes tracking, recommendation of guidelines, oversight of annual membership analysis with monthly stratification, and reporting relevant to case management. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. The CMO provides guidance for all clinical aspects of the program. The CMO makes periodic reports to the QIC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with SCFHP network physicians to continuously improve the services that the comprehensive management program provides members and providers.
The CMO's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees

### 2. Medical Director

The Medical Director, a licensed physician, provides clinical leadership and stewardship to the Health Services programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of members enrolled in the disease management programs, utilization management, transitions of care, and care coordination. The Medical Director works collaboratively with the SCFHP network physicians to continuously improve the services that the disease management program provides members and providers. The Medical Director's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides clinical support to the case management staff in the performance of their case management responsibilities
- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed

- Educates practitioners regarding case management issues, activities, reports, requirements, etc.

**3. Pharmacists**

Pharmacists are an integral part of the Model of Care and the Interdisciplinary Care Team. SCFHP has an internal pharmacy director, clinical pharmacists and pharmacy technicians. The core functions of pharmacists are to ensure member access to appropriate medications, ensure safety, increase adherence, maximize medication outcomes, provide education and optimize medication therapy.
SCFHP Pharmacists target those members most in need of pharmacy management, including:

- Recently hospitalized members
- Members on multiple medications or with multiple prescribers
- Members on anticoagulants and other high risk drugs
- Members referred by CMs, PCPs or other team members for medication reviews
- Perform Medication Reconciliation at points of transition of levels of care

**4. Manager, Case Management**

The Manager of Case Management oversees the comprehensive case management program. Under the supervision of the Director of Health Services and the Medical Director, the scope of responsibilities of the Manager of Case Management includes management of daily operations, training of case management staff, tracking of program metrics, oversight of vendors and continuous quality and compliance reviews. The CM Manager is also involved in development of the operational plan; allocation and management of program resources, and accountability for quality of care and services.

**5.Director of MLTSS Operations**

The Director of Managed Long Term Services and Supports(MLTSS) serves as the point of contact within the Plan for Long Term Support Services (LTSS) and oversees planning, implementation and management of plan operations for LTSS programs and the provider network including In Home Supportive Services (IHSS), Multi Senior Services Program (MSSPC), BAS, Care Plan Options (CPO), Long Term Care and Home and Community Based Services (HCBS) waiver programs and other non-covered LTSS community-based providers.

**6. Behavioral Services Manager**

Reporting to the CMO, this positon is responsible for oversight of all Behavioral Health care coordination for SCFHP including BH Utilization management, compliance reporting and BH staff supervision. The BH Manager will review all complex cases and provide consultation to the rest of the Health Services staff as needed. This position is responsible for all utilization management under the contract with the County Behavioral Health Department. Any denials of Behavioral Health Service is reviewed first by the SCFHP CMO and then by the SCFHP consulting psychiatrist.

### 7. Case Manager

SCFHP uses licensed California registered nurses, licensed vocational nurses, social workers, Behavioral Health and LTSS professionals in the role of the Case Managers. The Case Manager provides case management services for members with highly complex medical conditions where advocacy and coordination are necessary to help the member reach the optimum functional level and autonomy within the constraints of the member's disease conditions. Working within a multi-functional team, the Case Manager coordinates with the member, member caregiver(s), Behavioral Health and LTSS and/or community resources, and health plan partners to assess member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. SCFHP uses staffing guidelines to assign caseloads to each Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of members, primary care provider, health plan product; and relevant case management responsibilities.

### 8. Personal Care Coordinator (PCC)

Personal Care Coordinators are unlicensed staff that support the Case Manager and member by performing a variety of operational functions that include assisting clinical staff in identifying and providing outreach, orientation, and educational materials. The PCC also assists Case Managers with facilitating access to services and supports for care transitions, providing information on community resources and tracking member referrals for LTSS and other services. They also arrange appointments and ensure that the member has transportation. The PCC may act as a bridge for the member between the health plan, health care providers, community resources and the member. The PCC may act as a patient navigator, patient educator and coordinator for the various care plans from community providers. The PCC may be directed to organize the interdisciplinary team meetings and provide information to each of the members of the team, including the care plan documents.

## V. Eligibility Criteria & Risk Stratification

### A. Criteria

Population Assessment includes annual review of the member population and program processes. In order to identify members who may benefit from Case Management services, the Plan annually assesses and maintains a defined set of case management population criteria for use with all members and including at a minimum:

- Children, adolescents, adults and seniors
- Children with special needs
- Individuals with disabilities, including the Developmentally disabled (DD)
- Individuals with serious and persistent mental illness (SPMI)
- Seniors and persons with disabilities (SPD)
- CalMediConnect (CMC)

At least annually, the population assessment will be reviewed and recorded by the Utilization Management and Quality Improvement Committees, which will include both the population assessment but also include:

- Review of the complex case management processes with updates as necessary to meet member needs
- Review of the complex case management resources with updates as necessary to meet member needs

SCFHP routinely assesses the characteristics and needs of the member population, including relevant subpopulations. SCFHP analyzes claims and pharmacy data, as well as enrollment and census data to obtain the population characteristics of its total membership. Population characteristics for member participation in the comprehensive case management program include:

- Product lines and eligibility categories
- Language and subpopulations
- Literacy
- Psycho-social needs
- Disabilities
- Social support
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Chronic and co-morbid medical conditions
- Utilization

In order to effectively address member needs, subsequent to the collection of member population data, the Manager of Case Management and Disease Management and the Medical Director(s) analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program.

The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- Department staffing – by analyzing the data SCFHP revises staffing ratios and roles, for example adding nurse case managers versus social workers when the level of higher risk members increases in the program.
- Evidence-based guidelines – as the mix of condition types increase the Medical Director assists in identifying clinical guidelines to be used in creating care plans for members.
- Member materials – SCFHP uses data, case manager feedback and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

## B. Risk Stratification

The Plan or vendor uses internally established criteria to identify and stratify members for case management levels. No sooner than 60 calendar days prior to new member enrollment, DHCS and/or CMS electronically transmits historical Medicare and Medi-Cal FFS utilization and other applicable data to the MMP for its use in the risk stratification process. This data may include, but is not limited to:

Medicare Parts A, B, and D; Medi-Cal FFS; Medi-Cal In Home Supportive Services (IHSS); Multipurpose Senior Services Program (MSSP); Skilled Nursing Facility (SNF); Behavioral Health pharmaceutical utilization; outpatient; inpatient; emergency department; pharmacy; and ancillary services for the most recent 12 months. SCFHP has an established risk stratification mechanism designed for the purpose of identifying new members who are considered to be higher or lower risk. Higher risk for risk stratification purposes means a member who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive his or her initial contact by SCFHP within 45 calendar days of enrollment.

After analyzing the historical data, SCFHP identifies a member as **higher risk** if he or she, at a minimum, meets any one of the following criteria:

- Has been on oxygen within the past 90 calendar days;
- Has been hospitalized within the last 90 calendar days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases);
- Has In Home Supportive Services (IHSS) greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
- Is enrolled in MSSP
- Is receiving Community Based Adult Services (CBAS);
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
- Has cancer and is currently being treated;
- Has been prescribed anti-psychotic medication within the past 90 calendar days;
- Has been prescribed 15 or more medications in the past 90 calendar days; or
- Has other conditions as determined by SCFHP, based on local resources.

Diagnostic categories typically associated with high intensity of services and high cost of care may be in Basic, Moderate or Complex Case Management, depending of the member's individual needs, capabilities and resources. Typical conditions include:

- Newly diagnosed cancer
- Sickle Cell Anemia
- Tuberculosis
- Hepatitis C
- HIV / AIDS
- Children with special needs
- Life changing conditions

Specific to Behavioral Health needs, conditions may include:

- Anxiety disorders and phobias
- Bipolar Disorder
- Major / Chronic Depression
- Mood Disorder – other
- Substance Abuse / Substance Use
- Child Psychiatric Disorders
- Autism Spectrum Disorders
- Other Mental Health

SCFHP has a health risk assessment survey (HRA) tool that is used to assess a member's current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

## VI. Case Management Clinical Systems

### A. Clinical Information Systems

Delivery and documentation of case management services either directly provided by SCFHP staff or through a vendor is accomplished through a clinical information system. SCFHP uses a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic evidence based clinical guidelines or algorithms to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program.

Care plans are generated within the system and are individualized for each member and include short and long term goals, interventions and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; records actions or interactions with members, care givers and providers; and automatic date, time and user stamps. This feature automatically identifies the staff member, date and time of actions / interaction with member, practitioner or provider. To facilitate care planning and management, the clinical information system includes features to send automated prompts and reminders for next steps or follow-up contact as defined in the member's care plan.

### B. Clinical Decision Support Tools

Evidence-based clinical guidelines are embedded into the clinical information system to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the SCFHP involves board certified specialists in the development of the appropriate guidelines. Assessment questions are based on evidence-based guidelines from The

National Guideline Clearinghouse (www.guideline.gov), medical and behavioral healthcare specialty societies and/or SCFHP guidelines of care. The clinical guidelines that are used by the SCFHP case manager and disease management program team are reviewed and approved by the QIC.

### C. Integration of Case Management Services

Case Management services are integrated with the services of others involved in the member's care through a number of processes including, but not limited to

- Communication of Integrated Care Team with the PCP
- Case Management rounds
- Medication reconciliation activities
- Collaboration with the Disease Management program
- Integration with the SCFHP's wellness programs including member self-management tools
- Health Information line
- Behavioral Health services
- Hospice and palliative care programs

## VII. Case Management Functions

**A. The Comprehensive Case Management Program supports processes and efforts of the organizational mission, strategic goals and objectives through the following functions**:

1. Early identification of members who have potential or actual CM needs
2. Assessment of member's risk factors
3. Development of an individualized plan of care in concert with the member and/or member's family and the Primary Care Provider (PCP)
4. Identification of barriers to meeting goals included in the plan of care
5. Referrals and assistance to support timely access to necessary providers
6. Active coordination of care linking members to providers, medical services, residential, social and other support services where needed
7. Ongoing monitoring and revision of the plan of care as required by the member's changing condition
8. Continuity of care and coordination of services
9. Ongoing monitoring, follow up, and documentation of all care coordination and case management activities
10. Addressing the right of the member to decline participation in the case management program or dis-enroll at any time
11. Accommodating member specific cultural, linguistic, literacy and disability needs
12. Conducting all case management procedures in compliance with HIPAA regulations and state laws

## VIII. Levels of Case Management

### A. Basic Case Management

1. Characteristics
    a. Typically has adequate family/caregiver support
    b. Moderate/Minimal case management needs
    c. Clinical needs for minor medical or behavioral health issues
    d. Basic CM by PCP in collaboration with the case manager
        i. Initial Health Assessment (IHA)
        ii. Initial Health Behavioral Assessment (IHEBA)
        iii. Identification of appropriate providers and facilities (such as medical, rehabilitation and support services)
            1. as needed to meet member needs
        iv. Direct communication between provider, member and family
        v. Member and family education
            1. Including healthy lifestyle changes as warranted
        vi. Coordination of carved out/linked services
        vii. Referral to appropriate community resources/agencies
2. Examples of Basic Case Management Services and Coordination of Care services are provided for members who may need support or interventions on a minimal basis, frequently once or twice a year. These members may have specific conditions requiring support but are generally self-managed with a strong understanding of their condition with sufficient support. These members may include but not be limited to the following:
    a. Dental services that are the responsibility of SCFHP
    b. Public Health Tuberculosis Services, including Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
    c. Women's, Infants, and Children (WIC) Supplemental Nutrition Program
    d. Stable diabetics
    e. Controlled hypertension
    f. Post-operative procedures
    g. Smoking cessation
    h. Mild weight management conditions
    i. Controlled asthma
    j. Hospice cases
    k. ER Diversion
3. Basic Case Management also supports member self-case management through on-line resources including interactive self-management tools developed through evidence-based resources to help members stay healthy and reduce risk. On-line interactive resources include tolls derived from available evidence that provide members with information on at least the following wellness and health promotion areas
    a. Health weight (BMI) maintenance
    b. Smoking and tobacco use cessation
    c. Encouraging physical activity
    d. Healthy eating
    e. Managing stress
    f. Avoiding at-risk drinking

**B. Moderate Case Management**

1. Characteristics
    a. Chronic disease well managed and meeting goals
    b. Chronic disease not well managed but have not developed complications
    c. Moderate use of healthcare resources
    d. Frequent Emergency Department use
    e. Goal of treatment with avoidance of serious complications
    f. Behavioral Health diagnosis that requires day treatment
    g. Psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services.
2. Examples of Services and Coordination of Care include
    a. Basic case management
    b. Record of Medication History
    c. Assessment and Health History
    d. Development of Care Plan (ICP)
        1. Specific to member needs
        2. Member and PCP input
        3. Updated at least annually

    e. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
    f. Direct communication between provider, member/family or caregiver and case manager/care coordinator
    g. Member/family or caregiver education, including healthy lifestyle changes as appropriate
    h. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

**C. Complex Case Management**

1. Characteristics
    a. Identified through stratification activities
        1. HRA
        2. UM/Clinical
    b. Highest acuity requiring intensive CM
        1. Behavioral Health (BH) diagnosis with over 3 hospitalizations in a 12 month period
        2. BH conditions resulting in over 4 ED visits in a 12 month period
        3. Complex condition(s) or multiple co-morbidities generally well managed
        4. Members eligible for Home and Community Based Services (HCBS) waiver program or the Nursing Facility program
        5. Specialty CM members requiring
            i. Adaptive equipment

ii. Adult day health services
iii. Behavioral Services
iv. Day Habilitation
v. Emergency Home Response
vi. Environmental Accessibility Adaptations

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

2. Examples of Complex Case Management Services and Coordination of Care services are provided for members who may need more intense support to navigate the health care system, stabilize their condition or manage long term or terminal conditions. These members may include but not be limited to the following:
    a. 3 or more hospital admissions within 6 months for the same or related diagnosis
    b. Major or multiple system failure
    c. Multiple Trauma
    d. Med/Surg inpatient cases with extenuating complications
    e. Head or spine injuries with potential residual deficits (includes CVA)
    f. Severe burns over 20% of the body surface
    g. Complicated coordination of care or discharge planning (any disease/condition)
    h. Cancer with critical event or treatment requiring the extensive use of resources
    i. Chronic diseases with co-morbidities or complications leading to high dollar claims or high utilization
    j. High risk pregnancy
    k. Transplant – solid organ or bone marrow (excludes corneal)
    l. compliance with treatment plan or medications
    m. Extensive use of health care and/or community resources
    n. Newborn/Pediatric with critical event or diagnoses requiring the extensive use of resources
    o. NICU babies with a length of stay greater than 10 days

An annual evaluation of the effectiveness of the program and member and provider satisfaction will be implemented. Based on findings the program will be adjusted to reflect the needs of the members and providers population-wide

## IX. Care Coordination and Case Management Services

### A. Discharge Planning and Care Coordination

#### 1. Discharge Planning

SCFHP utilization management and case management staff ensure discharge planning when a member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning activities ensure that necessary care, including Long Term Services and Supports (LTSS) and Behavioral Health (BH) Services are in place for the member once the member is discharged from a hospital or institution. This includes scheduling an outpatient appointment, conducting follow-up with the member and/or caregiver, facilitating access to and coordination with other LTSS or community resources. Minimum elements for discharge planning include:

a. Documentation of pre-admission status, including living arrangements, physical and mental functioning, social support, durable medical equipment (DME), and other services received
b. Documentation of pre-discharge factors, including an understanding of the medical condition by the member or a representative of the member as applicable, physical and mental functioning, financial resources, and social supports and community case managers
c. Services needed after discharge, type of placement preferred by the member and/or caregiver and hospital/institution, type of placement agreed to by the member and/or caregiver, specific agency/home agreed to by the member and/or caregiver, and pre-discharge counseling recommended
d. Coordination, as appropriate with County agencies for In Home Supportive Services (IHSS) and Behavioral Health services, LTSS providers including, Multipurpose Senior Services Program (MSSP) provider, Community Based Adult Services (CBAS) Centers, nursing facilities, specialized providers and others community organizations as deemed appropriate. For IHSS, the coordination process must be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning
e. Summary of the nature and outcome of member and/or caregiver of the member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action considered by the hospital or institution

#### 2. Coordination of Care for Short Term Medical Needs

SCFHP Case Management staff maintains procedures to assist members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations of the complexity of the community-based services. Members are assigned to a Case Manager to assist with short term assistance with care coordination. Members, during the course of program enrollment, will also be assessed for longer term Complex Case Management and Disease Management.

**3. Patient Safety**

The SCFHP complex case management process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The complex case management program includes the following activities to ensure and enhance member safety

a. Completion of a comprehensive general and initial health risk assessment that supports proactive prevention or correction of patient safety risk factors.
b. Active management of transitions of care to ensure that the member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
c. Care plan development that ensures individualized access to quality, safe, effective and timely care.
d. Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care.
e. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety.
f. Appropriate setting assessments
g. Patient advocacy to ensure the care plan is followed by all providers.
h. Annual evaluation of satisfaction with the complex case management program.

**4. Coordination of Care with Community Resources**

SCFHP maintains procedures to identify and facilitate coordinated service delivery for members receiving comprehensive case management services. Case Managers provide appropriate referrals to carve out services, SCFHP Intensive Case Management to support access to community-based services and resources. SCFHP assists eligible members in obtaining access to the following services or programs:

a. Out-of-Plan Case Management and Coordination of Care
b. Specialty Mental Health
c. Alcohol and Substance Abuse Treatment Services
d. Dental services
e. Excluded Services Requiring Member Disenrollment
f. Home and Community Based Services Waiver Programs
g. Care Plan Options

## B. Comprehensive Case Management

SCFHP oversees and maintains three case management services in the comprehensive case management program. These include Basic Case Management, Moderate Case Management and Complex Case Management. All three of these programs have the following case management elements:

a. Completion of a Health Risk Assessment (HRA)

b. Creation of an Individual Care Plan (ICP)
c. Formation of Interdisciplinary Care Team (ICT)
d. Care Plan implementation and care coordination

**1. Basic Case Management Services**

Basic Case Management services are made available to SCFHP members when appropriate and medically indicated. Basic Case Management services are provided by the primary care provider and or the SCFHP staff, in collaboration with SCFHP, and include the following elements:

- Review of clinical information from the provider
- Completion of the Health Risk Assessment
- Creation of the Interdisciplinary Care Plan (ICP)
- Initial Health Assessment (IHA)
- Initial Health Education Behavioral Assessment (IHEBA)
- Identification and referral to appropriate providers and facilities (such as medical rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services and for covered and non-covered services) to meet member needs
- Direct communication between the provider and member, family and/or caregiver.
- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of services outside of the CalMediConnect Plan such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services

**2. Moderate Case Management Services**

SCFHP facilitates and coordinates care for eligible members through Moderate Case Management services. SCFHP staff follows preset criteria and collaborates with community partners when necessary to determine eligibility for Moderate Case Management services. SCFHP members may self-refer, or be referred to receive services through community partners, case managers, delegates and vendors.

SCFHP members eligible for Moderate CM services meet one or more of the following criteria:

- Member is already served with case management by community partners
- High utilizers of high cost services including multiple hospitalizations in the last three months, severely mentally ill, 10+ multiple medications
- Already receiving case management services from a community provider (County Behavioral Health, New Directions, MSSP, etc.)
- Care plan requires intensive coordination with a focus on local resources
- Member in transition from acute or long term care to lower level of care or member wishes to transition to lower levels of care
- Member is unable to be contacted

Once a member is identified and referred for Moderate case management, they are assigned to a lead Case Manager to take responsibility for screening, referrals, care planning, interdisciplinary care team management and communication and all other care coordination activities. Members are matched to a Case Manager that is specialized based on the prominence of medical, LTSS, or behavioral health needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed in order to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those members who are multiple diagnosed with medical, functional, cognitive, and psychosocial conditions.

For Members who are already connected to services through a community social service, LTSS, or behavioral health provider, the responsibilities of lead Case Manager will fall to that agency. Generally, ICM services performed by the external agency that demonstrates expertise in the area of the referred member's most pressing needs. For example, members who require primary support for housing assistance are referred to community partners for the provision of ICM services.

Lead case manager, whether SCFHP -based or community-based, is responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment that includes behavioral health
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

**3. Complex Case Management Services**

Complex Case Management services are made available to SCFHP members with chronic and complex medical conditions, across medical, LTSS and Behavioral Health domains. Complex case management services are offered through SCFHP Complex Case Management program. Complex Case Management includes but is not limited to the following elements:

- Basic Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure member regains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline and avoids institutionalization when appropriate and possible.

- Interdisciplinary Care Teams creation prior to the ICP, training and communication with member and input from Interdisciplinary Care Team
- Development of Individual Care Plans (ICPs) specific to member needs and updated at least annually.
- Referral to Disease Management Program
- Referral to Intensive Case Management

**4. Behavioral Health and MLTSS Services**

Behavioral Health and MLTSS Case Management may fall into different levels of Comprehensive Case Management. Although they follow the same program requirements unique requirements and procedures exist as described below.

a. Behavioral Health Services

1. Assesses the characteristics and needs of its member population and relevant subpopulations
2. Assesses the needs of children and adolescents
3. Assesses the needs of individuals with disabilities
4. Assesses the needs of individuals with serious and persistent mental illness
5. Reviews its complex case management processes and updates them, if necessary to address member needs
6. Reviews its case management resources and updates them, if necessary to address member needs
7. The Plan selects collaborative data to analyze for improving coordination of care and determine areas to carry over, specific to meet the behavioral health needs of the Plan's membership.

b. Coordination of Care Management and Long Term Services and Supports

SCFHP has processes and models in place to coordinate with external organizations for provision of covered services including LTSS benefits, as appropriate for the member. This includes referral mechanisms, coordinated assessment, eligibility determination and intake activities, coordination of benefits, delineation of roles and responsibilities for care management and participation on the interdisciplinary care team with:

1. Multipurpose Senior Services Program (MSSP), a program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides complex care management as an alternative to nursing facility placement.
2. Community Based Adult Services (CBAS), an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services and transportation to eligible members.
3. In-Home Supportive Services (IHSS), a program for aged, blind and disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help.

4. Nursing Facilities - to coordinate care for residents including care transition plans and programs to move members back into the community to the extent possible.
5. Care Plan Options – for the purchase of services and supports that are not covered benefits for Cal MediConnect members that meet the criteria.
6. Examples of Complex Case Management Services and Coordination of Care services are provided for members specific to the Cal MediConnect (CMC) member population for behavioral health and Long Term Services and Supports (LTSS). These members may include but not be limited to the following:
    a. Dementia
    b. Community Based Adult Services (CBAS) or Adult day care health services
    c. Coordination of Medical, Behavioral Health and LTSS
    d. Major mental health (severe, persistent mental illness) or substance abuse disorder or critical event: may be characterized by suicidal or homicidal ideation or behaviors, inability to carry out activities of daily living independently, or persistent issues with
    e. Member treatment is referred to community resources

7. Specially designated case management staff in dementia care are trained in:
    a. Understanding dementia
        i. Symptoms and progression
        ii. Understanding and managing behaviors
        iii. Communication problems
        iv. Caregiver stress and management

## X. Basic Case Management Program Description

### A. Identifying Members for Basic Case Management

SCFHP implements Basic Case Management when utilization or case management staff identifies that a member's condition or diagnosis indicates the appropriateness and necessity for services. This identification may take place through admission review, concurrent review processes, provider referral, or at the request of the member.

### B. Basic Case Management Process

SCFHP maintains policies and procedures for Basic Case Management services. Basic Case Management procedures and processes include:

#### 1. Intake

a. When a member is identified or a referral is received for basic case management, the case management staff enters the referral into the care management system and coordinates case management services with the member's PCP.

#### 2. Health Risk Assessment, Initial Health Assessment and Behavioral Risk Assessment.

a. The HRA will be completed either by SCFHP vendor or provider. PCP schedules with the member and performs an Initial Health Assessment (IHA) and an Individual Health

Education Behavioral Assessment (IHEBA). The IHA includes a history and physical evaluation sufficient to assess the acute, chronic and preventive health needs of the member. The IHEBA includes a series of age specific questions to evaluate risk factors for developing preventable illness, injury, disability, and major diseases.

3. **Identification of care needs**
    a. The PCP in collaboration with SCFHP Health Services, case management staff identifies appropriate providers and facilities to meet the specific health condition needs of the member to ensure optimal care delivery to the member.

4. **Creation of Individual Care Plan with member and ICT**
    a. Development of an individualized case management plan is accomplished through input by the Interdisciplinary Care Team (ICT), including the following:

5. Prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan. Identification of barriers to a member meeting goals or complying with the plan.
6. Development of a schedule for follow-up and communication with members.
7. Development and communication of member self-management plans.
8. A process to assess members' progress against case management plans for members.

9. **Communication with membe**r
    a. The PCP communicates directly with the member to meet member specific health care needs, and includes family, caregivers and other appropriate providers, per the member's choosing facilitated through an Interdisciplinary Care Team (ICT). The ICT facilitates the participation of the member, and any family, friends, and professionals of their choosing to participate in any discussion or decisions regarding treatments, services, support and education. The PCP in collaboration with SCFHP Health Services case management staff ensures that the member receives all necessary information regarding treatment and services so that the member makes informed choices regarding case management, prioritized goals, and interventions.

10. **Creation of Individual Care Plan (ICP)**
    a. An ICP will be developed for each member that include member's goals, preferences, measurable goals and timetable that meets their medical, behavioral health and long term services and support needs. It will also include timeframes for reassessment and is developed with the ICT. ICPs will be developed within 30 days of the HRA completion for high risk members and 45 days for low risk members.

11. **Coordination of services**

a. The PCP in collaboration with SCFHP Health Services, Behavioral Health and LTSS case managers facilitate linkages between members and community organizations to enhance access to community resources and ensure members are able to utilize these resources. Health Services staff coordinates access to community services, monitors service delivery, advocates for member needs, and evaluates service outcomes.

**12. Monitoring of PCP services**

a. SCFHP Health Services monitors the member's condition, responses to case management interventions, and access to appropriate care. SCFHP ensures the PCP performs the necessary activities of Basic Case Management services such as the IHA and the IHEBA and identification of appropriate healthcare, behavioral health and LTSS services.

**13. Identification of barriers to care**

a. SCFHP Health Services case managers monitor barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues, housing and transportation problems. Case Managers identify intervention actions to reduce or resolve member specific healthcare barriers.

**14. Case Closure**

a. The PCP in collaboration with SCFHP case management staff terminate Basic Case Management services for members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require BCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

## XI. Moderate Case Management Program Description

### A. Identifying Members for Moderate Case Management

In accordance with SCFHP Model of Care, SCFHP provides Moderate Case Management services directly to members that meet the following criteria:

1. Already receiving case management services from a community provider
2. Care plan requires intensive coordination with a focus on community resources
3. Member in transition from acute or long term care to lower level of care
4. Members that are currently placed in nursing facilities
5. Members that are appropriate for and desire lower level of care
6. Members that are possibly at risk for institutional placement
7. Members identified with behavioral/mental health and substance use needs

SCFHP identifies members that may be eligible for case management services through admission review, concurrent review processes, provider referral, or at the request of the member.

### B. Moderate Case Management Process

SCFHP maintains policies and procedures for intensive case management services. MCM procedures and processes include:

#### 1. Referral

When a member is identified, self-refers or a referral is received for moderate case management, the staff enters the referral into the care management system (Altruista) and coordinates case management services with the provider or community partner, as appropriate.

#### 2. Documented Assessment

The case manager conducts an Assessment of the member's health and psychosocial status to identify the specific needs of the member. If applicable, other member assessments that have been conducted on their behalf by providers will be obtained and reviewed. This may include LTSS providers such as IHSS, CBAS, MSSP, nursing facilities and community mental health providers.

#### 3. Development of comprehensive service plan – Individual Care Plan (ICP).

The case manager develops an individualized, comprehensive care plan to include information from the member assessment as well as member input regarding preferences and choices in treatments, services, and abilities. If applicable, other member care plans that have been conducted on their behalf by providers will be obtained and reviewed. This may include LTSS providers such as IHSS, CBAS, MSSP, nursing facilities and community mental health providers.

#### 4. Coordination of services and Interdisciplinary Care Team (ICT)

The intensive case management staff facilitates access to benefits and other community resources through established protocols with providers. This includes triage of multiple services and supports, monitoring service delivery, advocating for member needs, and evaluating service outcomes. An Interdisciplinary Care Team (ICT) is developed that includes anyone the member deems important to their care and the PCP. The ICT meets as needed to create, activate and

monitor the individual care plan. The Case Manager oversees communication among ICT members and SCFHP provider training, as needed for ICT.

**5. Crisis Assistance**

Case management staff coordinate and arrange crisis services or treatment for the member when immediate intervention is necessary or in situations that appear emergent in nature.

**6. Identification of barriers to care**

Case management staff identifies and monitors barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues, transportation or housing problems. The case management staff identifies intervention actions to reduce or resolve member specific healthcare barriers.

**7. Case Closure**

The PCP in collaboration with SCFHP utilization management, and case management staff terminate targeted case management services for members based on established case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines Case Management
- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

## XII. Complex Case Management Program Description

SCFHP delegates to an NCQA-accredited entity to provide the majority of Complex Case Management services to CalMediConnect members. Delegated activities will be outlined in the Delegation Agreement and may include but not be limited to the following:

- Risk Stratification
- Individual Care Plan development telephonic Health Risk Assessment (HRA)
- Member communication & ICT development

- Individual Care Plan development with member
- Referrals to DM, and SCFHP for Moderate Case Management, Behavioral Health and LTSS benefits and services

Defined Case Management Functions, Services, and Processes

**1. Identifying Members for Complex Case Management**

**A. Criteria**

Highest acuity members requiring intensive case management are referred for Complex Case Management. Criteria for identifying members for complex case management are developed under the guidance of the Medical Director. Routinely, but no less than annually, SCFHP evaluates the criteria and its staff resources to determine if there are sufficient vendor staff resources to provide complex case management to those members who are at high risk and are potential participants in the complex case management program.

**B. Data Sources**

SCFHP uses the following data sources to continuously identify appropriate members for participation in complex case management:

- Claims data
- Hospital Discharge data
- Data supplied by purchasers as applicable
- Data supplied by members or caregivers
- Data supplied by practitioners (Referrals and Medical Records)
- Data supplied by community services
- Pharmacy Data (including Behavioral Health medications)
- Utilization management / authorization activity
- Re-admission data
- State data / CMS claims history
- Health Risk Assessments

**C. Referrals to Complex Case Management**

There are multiple referral avenues for members to be considered for complex case management services. Services are available to all SCFHP members who meet the general criteria for case management, regardless of specific line of business. Referral sources include:

**1. Health Information line referral**

SCFHP will have mechanisms in place to gather information from the phone-based health information line to identify members who are eligible for complex case management.

2. **Disease Management program referral**
The Disease Management vendor and staff have criteria to assist them in identifying high-risk members for case management.

3. **Hospital discharge planner referrals**
SCFHP has relationships with discharge planners and the case managers at the hospitals in the provider network and they will refer to case management members they believe are at high risk.

4. **Utilization Management referral**
The Utilization Management program identifies members in need of case management at admission, discharge, concurrent review and Transition of care.

5. **Member, caregiver and practitioner referrals**
The Member Services Department receives calls from members, caregivers and practitioners and refers them to case management based on either a request by the caller or if the nature of the call indicates that the member would benefit from the service. The members and providers are informed about their ability to make referrals in the Provider and Member newsletters at least annually.

6. **LTSS and Community-based referrals**
Health Services may receive referrals for case management from LTSS providers (IHSS, CBAS, MSSP) and community organizations/partners including other community-based case management programs.

7. **Behavioral health referrals**
Health Services may also receive referrals for case management services from the County Behavioral Health or community-based behavioral health providers or institutions.

8. **Date of Eligibility for Complex Case Management**
Members identified or referred for complex case management are reviewed for health plan enrollment and eligibility prior to beginning a health risk assessment and general assessment.

9. **Complex Case Management Process**

SCFHP complex case management program uses a systematic approach to patient care delivery and management. Primary steps of SCFHP complex case management process include: member identification and screening; member assessment; ICT and care plan development, implementation and management; evaluation of the member care plan; and closure of the case.

SCFHP maintains policies and procedures for the complex case management process. Complex case management procedures and processes include:

**D. Referral & Screening.**

When a member is identified, or a referral is received for case management, the CM staff or vendor enters the referral into the care management system and verifies member health plan enrollment and eligibility. After health plan eligibility is confirmed the staff submits the referral. The case manager then screens and determines program eligibility in complex case management or other appropriate programs by performing the initial health risk assessment. If the member does not meet criteria for complex case management, the member may be referred to the other SCFHP program for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner.

**E. Basic Case Manage Services: As detailed above**

**F. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team**

**G. Intense coordination of resources to ensure member regains optimal health or improved functionality**

**H. With member and primary care provider input, development of care plan specific to the individual needs, and updating these plans at least annually**

**I. Assessment of health status**

The Care Coordinator initially conducts a Health Risk Assessment (HRA) which is a comprehensive assessment of the member's health specific to identified health conditions and comorbidities, for behavioral, functional and psychosocial status including living arrangements and LTSS. The HRA process is completed within 30 calendar days for high risk members and 90 days for low risk members in CalMediConnect. This also serves as a risk stratification tool. HRAs are conducted telephonically, by mail or in-person if the member chooses that option.

At the time of the health risk assessment, the case manager obtains consent from the member to participate in the complex case management program, obtains information about the member's primary care practitioner and identifies members of the interdisciplinary care team. If the member declines complex case management services, the member may be referred to the community services or assistance in identifying a primary care practitioner. The member is provided information about the case management program so that they may, at a later time, choose to participate in the program. The Case Manager informs the member that they will be calling them within six months to check in. The HRA is supported by a separate and detailed policy and procedure. Elements are assessed initially through the HRA and, if the member consents to case management, the member will continue to be assessed on an ongoing basis in the Health Assessment.

The Case Manager collects information and uses it to determine barriers to care and to identify issues to include in the member care plan. The Initial Assessment includes at a minimum the following:

**1.** Member health status, including condition-specific issues

**2.** Documentation of clinical history, including medications

a. Clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications including schedules and dosages. All clinical documentation is collected and stored in a secure clinical

information system and is organized in structured templates to facilitate efficient access and use of information.

3. Activities of daily living (ADL)
    a. The Case Manager evaluates member functional status related to activities of daily living such as eating, bathing and mobility.
4. Assessment of behavioral health status, including cognitive functions
    **a.** During the initial assessment and ongoing evaluations as appropriate, the Case Manager evaluates member mental health status, including cognitive functions, and depression. The Case Manager also completes an alcohol and drug use screen as part of the Health Assessment. Referrals are made to behavioral health clinicians for case management members that meet specified criteria.
5. Assessment of psychosocial issues
    a. The Case Manager evaluates the member's psychosocial status including an understanding of, beliefs or concerns about their condition or treatment about the likelihood that it will improve their health. Perceived barriers are identified that may hinder the member from participating in care such as financial, transportation, housing status or capacity
6. Assessment of life-planning activities
    a. Member preferences about healthcare and treatment decisions may impact the care plan. The HRA and Health Assessment and case management process includes an assessment of member life planning activities such as wills, living wills or advanced care directives, and health care powers of attorney. The Case Manager documents situations when life-planning activities are not appropriate, and mails appropriate information (e.g., advanced care directives) to member when needed
7. Evaluation of cultural and linguistic needs, preferences or limitations
    a. Communication issues can compromise effective healthcare for the member. In order to identify communication methods best suited for the member, cultural and linguistic needs, care preferences or limitations are assessed.
8. Evaluation of visual and hearing needs, preferences or limitations
    a. In order to ensure an appropriate care plan and healthcare needs are effectively met, member visual and hearing needs, preferences or limitations are assessed.
9. Evaluation of caregiver resources and involvement.
    a. The Case Manager evaluates caregiver resources such as family involvement and decision making about the member's individualized care plan. The Case Manager follows the member's direction about the level of involvement of his or her caregivers
10. Evaluation of health plan benefits, including Behavioral Health (Mental Health and Substance Use Disorder services) LTSS and community resources.

a. When indicated for the member, the Case Manager refers the member to SCFHP LTSS Team to access local, county, and state public agencies, and other community-based organizations to provide services such as housing assistance, home delivered meals, transportation or home modifications. When indicated for the member, the Case Manager refers to community Behavioral Health Services and/or to the BH department for consultation.

**J. Development and Documentation Person-Centered Individualized Care Plan (ICP)**

The ICP includes a person-centered planning and treatment approach that is collaborative and responsive to meet member specific health care needs. The ICP will be completed with the member and Interdisciplinary Care Team (ICT) input regarding preferences and choices in treatments, services, and abilities. Working with the member, the case manager establishes and documents a set of prioritized goals.

These goals are incorporated into the care plan which also includes:

1. Timeframe for re-evaluation
2. Resources to be used in meeting the goals and addressing the member's needs
3. Plans for addressing continuity of care needs, transitions and barriers
4. Involvement of the family and/or caregiver in the plan
5. Educational needs of the member
6. Plans for supporting self-management goals

The Case Manager facilitates the participation of the member, and any family, friends, behavioral health and LTSS providers and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support and education. The Case Manager ensures that the member receives all necessary information regarding treatment and services so that the member makes informed choices regarding care management, prioritized goals, and interventions. The Case Manager includes the member with appropriate and regular updates to the care management plan that occur at a minimum on an annual basis. Behavioral Health - Specialty Mental Health providers will be provided with a copy of the ICP and will be requested to sign and return the ICP.

**K. Identification of barriers to goals or compliance with plan of care**

The complex case management procedures address barriers to care such as member lack of understanding of condition, motivation, financial or insurance issues and transportation problems. The care management plan identifies barriers to care and intervention actions to reduce or resolve member specific healthcare barriers.

**L. Facilitation of member referrals to resources and follow-up process**

The case management plan includes follow-up to reduce or eliminate barriers for obtaining needed health care services. The case management process facilitates linkages between members and community organizations to enhance access to community resources and ensure members are able to utilize these resources. Case management staff coordinates closely with

SCFHP LTSS and Behavioral Health staff to facilitate access to community services, monitor service delivery, advocate for member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers as they work with members, caregivers, and providers. Case Management and Disease Management department staff regularly compile and document resources available in Santa Clara County and update the directory when necessary.

**M. Development of schedule for follow-up and communication**

The member care plan includes a schedule for follow-up that includes, but is not limited to, counseling, referral to disease management, intensive case management providers, primary and specialty care, education or self-management support. Complex case management work flows and processes specify when and how the Case Manager follows up with a member.

**N. Development and communication of member self-management plan**

The Case Manager provides the member or member caregiver(s) instructions and/or materials to assist the member with self-management of his or her complex medical condition. The development and communication of a self-management plan includes member monitoring of key symptoms, activities, behaviors, and vital statistics as appropriate (i.e., weight, blood pressure and glucose levels). The Case Manager documents oral or written communication of self-management activities provided to the member or caregiver(s).

**O. Crisis Assistance**

Case management staff coordinate and arrange crisis services or treatment for the member when immediate intervention is necessary or in situations that appear emergent in nature.

**P. Process to assess progress** of the member care plan

The Case Manager continuously monitors and reassesses the member's condition, responses to case management interventions, and access to appropriate care. The case management plan includes an assessment of the member progress toward overcoming barriers to care and meeting treatment goals. The complex case management process includes reassessing and adjusting the care plan and its goals, as needed.

**Q. Case Closure**

The Case Manager terminates case management services for members based on established case closure guidelines. The criteria for case closure of complex case management (CCM) include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require CCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM

- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

## XIII. Program Evaluation and Assessment of Effectiveness

The Chief Medical Officer/Medical Director and the Director of Case Management collaboratively conduct an annual evaluation of SCFHP complex case management program. The evaluation includes the following.

**A. Measures/Process**- The evaluation includes analysis of population characteristics and of the resources to meet the needs of the population. SCFHP selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. SCFHP annually measures the effectiveness of its complex case management program based on the following guidelines.

1. Measurement of effectiveness of Complex Case Management annually
    a. Minimum of three measures (annually defined). For each measure.
        1. Identify a relevant process/outcome
        2. Valid methods for quantitative results

            i. Numerator and denominator
            ii. Sampling methodology
            iii. Sample size calculation
            iv. Measurement periods and seasonality effects
        3. Setting a performance goal

            i. Explicit, quantifiable performance goal
        4. Using clearly identified measures

            i. Data source
            ii. Eligible population
            iii. Coding and other means
            iv. Adaptation of HEDIS if used
        5. Collecting data and analyzing results

            i. Quantitative and qualitative analysis with comparison against goals
                a. includes causal analysis as appropriate
        6. Identify opportunities for improvement as applicable

            i. Report to and follow through with QIC

**B. Member Satisfaction/member experience**

**1. Achieve and maintain high levels of satisfaction with CM services**

a. Member Satisfaction Rates

1. Feedback from members

SCFHP measures member satisfaction and experience with the complex case management program. A satisfaction survey is mailed after case closure. The member is asked to rate experiences and various aspects of the program's services, including interactions with the Case Manager. The survey also collects information involving member complaints and inquiries about the program. Data is collected and reported within a secure clinical information system.
The Health Services staff systematically analyzes the feedback from member surveys at least annually.

2. Analyze member complaints
   a. This includes complaints about
      i. Access to Case Manager
      ii. Dissatisfaction with Case Manager
      iii. Timeliness of Case Management services
   b. SCFHP tracks and trends complaints and grievances quarterly
      i. Summarizes annually
      ii. Compares with previous year
3. Satisfaction surveys
   a. SCFHP focuses at minimum on
      i. Complex Case Management
      ii. Usefulness of information
      iii. Member ability to adhere to recommendations

**C. Performance measures**

**1. Purpose**

SCFHP maintains performance measures for the case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. Likewise, a needs assessment is conducted to identify gaps in care and community resources. These findings are brought to the QIC, when appropriate and other community forums. An annual report of the effectiveness of this program will be provided to the QIC and the Board of Directors. The following are measured.

**a. Improve member outcomes**

i. **All-Cause Admission Rate**

SCFHP measures admission rates for all causes for members in the complex case management program who had an admission within six months of being enrolled in the complex case

management program. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services staff.

ii. **Emergency Room Visit Rate**

SCFHP measures emergency room visit rates of members enrolled in the complex case management program. The Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

**b. Achieve optimal member functioning**

i. **Health Status Rate**

SCFHP measures the percentage of members who received complex case management services and responded that their health status improved as a result of complex case management services. A satisfaction survey that includes questions to assess health status is administered after case closure. SCFHP collects data and reports within a secure clinical information system. The Health Services Staff systematically analyses the feedback from member surveys at least annually.

**c. Use of Appropriate Health Care Services**

i. **Use of Services**

SCFHP measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within SCFHP network. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

**2. Procedure**

For each of the performance measures, SCFHP completes the following procedures to produce annual performance measurement reports:

a. **Identify a relevant process or outcome**

The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

b. **Use valid methods that provide quantitative results**

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period.

c. **Set a performance goal**

The Manager of Case Management in collaboration with the Chief Medical Officer/Medical Director, establish a quantifiable performance goal for each measure that reflects the desired level of achievement or progress.

d. **Clearly identify measure specifications**

The Manager of Case Management in collaboration with analysts from the Healthcare Analytics department identifies measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources.

e. **Analyze results**

The Manager of Case and Management with data analytic support from the Healthcare Analytics Department complete an annual comparison of results against performance goals and an analysis of the causes of any deficiencies.

f. **Identify opportunities for improvement, if applicable**

The Director of Case and Disease Management in collaboration with the Chief Medical Officer/Medical Director and feedback from the HCQC use qualitative and quantitative analysis to prioritize opportunities to improve performance on the measure.

g. **Develops a plan for intervention and re-measurement**

The Manager of Case Management in collaboration with the Chief Medical Officer/Medical Director and feedback from the HCQC develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention. The Manager of Case Management coordinates with the Healthcare analytics department to report the results of the performance improvement intervention.

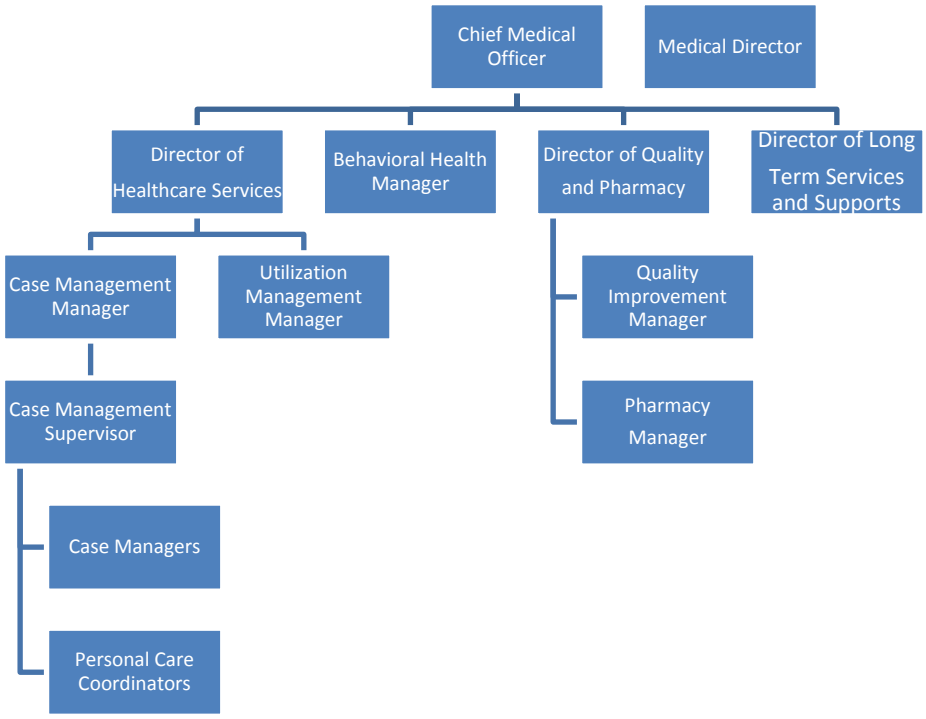
**D. Evaluation Review/Follow-up**

The results of the annual program evaluation are reported to the QIC for review and feedback. The QIC makes recommendations for corrective action interventions to improve program performance, as appropriate. The Manager of Case Management is responsible for implementing the interventions under the oversight of the Chief Medical Officer/Medical Director.

## XIV. END NOTE

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

APPENDIX A: Case Management and Disease Management Organizational Chart




# Health Education Program

2016

**Angela Sheu-Ma, CHES, MPH, RDH**

Santa Clara
Family Health Plan

# SANTA CLARA FAMILY HEALTH PLAN

# 2016 HEALTH EDUCATION PROGRAM

## ***Executive Summary***

As a community based health plan, Santa Clara County Health Authority, a public agency operating business as Santa Clara Family Health Plan (SCFHP), strives to provide high quality health care to those who cannot access affordable health care. A component to achieving this goal is **SCFHP's Health Education Program** which assists and engages the community to reach their wellness goals.

The Health Education Program is under the direction of a full-time health educator with a Master's degree in public health with specialization in health education. The program identifies the health education needs of its members and utilizes findings for continuous development and improvement of health education programs and services. As part of the Quality Improvement Department, Health Education Program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

Implementation of the Health Education Program includes: 1) Providing programs, classes and/or materials free of charge to members, 2) Point of service education for members as part of their preventive and primary health care visits, 3) Practitioner education and training, 4) program evaluation, monitoring, and quality improvement, 5) Group needs assessment, and 6) The formation of a Community Advisory Committee (CAC).

Santa Clara
Family Health Plan

# SANTA CLARA FAMILY HEALTH PLAN

# 2016 HEALTH EDUCATION PROGRAM

## TABLE OF CONTENTS

## I. INTRODUCTION

Santa Clara County Health Authority is a public agency which operates business as Santa Clara Family Health Plan (SCFHP) in order to provide medical coverage for persons with Medi-Cal Managed Care. Santa Clara Family Health Plan is licensed under the Knox Keene Act of 1975 and is subject to the regulations set forth by the State of California's Department of Managed Health Care (DMHC).

SCFHP is contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program.

SCFHP then entered into a series of contracts which extended care to a broader range of the population. From 2007 to 2009 SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) to serve as a Special Needs Plan in Santa Clara County. In 2014, SCFHP contracted with CMS and the State of California for the Managed Long Term Services and Supports (MLTSS) programs. And most recently in 2015, SCFHP contracted with CMS for the Cal MediConnect (CMC) Dual Demonstration Project.

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

## II. MISSION

As a community based health plan, we strive to provide consistently high quality health care to those who cannot access affordable health care.

With a richly diverse population residing in the area, it is crucial for information to be presented in a manner that takes into account the culture and linguistic capability of those we serve. Because of this we strive to develop procedures to ensure the materials are appropriately structured for maximum clarity and effectiveness. SCFHP is committed to delivering culturally and linguistically appropriate health care services.

## III. Statement of Purpose

The goal of SCFHP's Health Education program is to assist and engage the community to reach their wellness goals and structure informational and educational materials in a manner all plan members can easily read and understand. In order to accomplish this, the following components are included in the program:

- Health Education
- Community Advisory Committee (CAC)

## IV. SCOPE OF PROGRAM

The scope of the Health Education program is to identify the health education needs of its members and to utilize the findings for continuous development and improvement of health education programs and services. In order to accomplish this, multiple reliable data sources, methodologies, techniques, and tools will be used to identify these needs.

## V. PROGRAM GOALS AND OBJECTIVES

Community Advisory Committee (CAC)

- A community advisory committee will be in place.

Health Education

- Health Education system provides organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education.
- Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and complimentary and alternative care.
- Risk reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.
- Self-care and management of health conditions – pregnancy, asthma; diabetes; and hypertension
- Members receive point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracting medical providers in the delivery of health education services for Members.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for Members to have an IHA within 120 days of being eligible with the health plan.
- Ensure all written Member information is provided at a sixth grade reading level

## VI. PROGRAM STRUCTURE AND ORGANIZATION

The Health education program is under the direction of a full-time health educator with a Master's degree in public health with specialization in health education.
The Health Education program is part of the Quality Improvement Department. Health education program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

## V. PROGRAM IMPLEMENTATION

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

1. Nutrition and physical activity
2. Healthy Weight(BMI) Management
3. Healthy eating
4. Healthy weight maintenance
5. Encouraging physical activity
6. Managing stress
7. Parenting
8. Smoking and Tobacco use cessation
9. Alcohol and drug use
10. Injury prevention
11. Prevention of sexually transmitted diseases, HIV and unintended pregnancy
12. Management of chronic diseases or health conditions, including asthma, diabetes, and hypertension
13. Pregnancy care
14. Identifying depressive symptoms

### Point of Service Education

Individual members will receive health education services as part of their preventive and primary health care visits. Health risk behaviors, health practices and health education needs related to health conditions are identified. Educational intervention, including counseling and referral for health education services will be conducted and documented in the member's medical record.

Medical providers will use an Individual Health Education Behavioral Assessment tool and other relevant clinical evidence to identify member's health education needs and conduct educational intervention. SCFHP will provide resource information, educational material and other program resources to assist contracting medical providers to provide effective health education services for members.(DHS PL 02-004)

### Practitioner Education and Training

SCFHP will provide education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members. Practitioner training will cover: a)Group needs assessment findings, b) The individual health education behavioral assessment; c) Techniques to enhance effectiveness of provider/patient interaction, d)Educational tools, modules, materials and staff resources, e) Plan specific resource and referral information, and f)Health Education requirements, standards, guidelines, and monitoring.

SCFHP will ensure providers are trained and administering the IHAs (initial health assessment) with the health education behavioral risk assessment for all members within 120 days of enrollment.

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

Program Standards, Evaluation, Monitoring, and Quality Improvement

The Health Education System will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving health education program goals and objectives. Policies and procedures will be in place for ensuring providers receive training on a continuing basis regarding DHCS developed cultural awareness and sensitivity instruction for Senior and Persons with Disability (SPD) beneficiaries.
SCFHP will monitor the performance of providers contracted to deliver health education programs and services to members. Strategies will be implemented to improve provider performance and effectiveness. (DHCS PL 13-001)

Group Needs Assessment

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

Community Advisory Committee

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

## VII. CONFIDENTIALITY AND CONFLICT OF INTEREST

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

## X. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

The Health Education Program will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of training, evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving health education program goals and objectives.

SCFHP will monitor the performance of providers contracted to deliver health education programs and services to members. Strategies will be implemented to improve provider performance and effectiveness (SCFHP/Medi-Cal contract Exhibit A, Attachment 10 Scope of Services).

Training

Initial Health Assessment

The Provider Services Department educates new PCPs about the IHA and IHEBA within the first 10 days of their effective date, during the new provider orientation and annually thereafter (Provider services policy PS019_03)

1) A log will be kept of Initial Health Assessment (IHA) training which is included in the new Provider handbook given to new providers.
2) The provider services department administers training for new providers which include IHA requirements.
3) Providers who are found to be noncompliant with IHA requirements during periodic Facility Site Reviews (FSR's) will receive retraining.

Monitoring

Facility Site Reviews

The QI Department monitors PCP's IHA and IHEBA process during periodic site reviews.

Facility Site Reviews (FSR's) will include medical chart reviews to monitor if providers are compliant with IHA requirements. IHA requirements will be included in providers' corrective action plans (CAP) for providers not passing any section of their FSR's.

| Health Education Workplan 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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, Attchmnt 10 Scope of Services<br><br>Exhibit A Attchmnt 11 Case Management and Coordination of Care<br><br>Exhibit A, Attchmnt 18 Implementation Plan and Deliverables | -Ensure IHA for adult members is performed within 120 calendar days of enrollment<br><br>-Ensure performance of initial complete history and physical exam for adults to include health education behavioral risk assessment and member and family education. | -Chart audits and provider training<br><br>-FSR (every 3 yrs) | -P&P for administration of a disease management program<br><br>-P&P for case management coordination of care of LEA (local education agencies)services | Baseline< | QI and Health Educator | | Continous | |
| Scope of Services | Scope of Services | Pregnant Women | pg. 73 Exhibit A, Attchmnt 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, provider services | | Continous | |
| 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, Attchmnt 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<br><br>- Contact community organizations for ptoential health ed partherships | 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 | |
| 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 behavioural change. | -Use findings from GNA to select educational strategies and methods<br><br>-Measure pre and post educational intervention behavior | Health Education Program | Organized delivery of health ed program | Health Educator | | Continuous | |

| Health Education Workplan 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Scope | Area | Objective | Contract Reference | Project Objectives | Activity | Final Deliverable(s) | Goals or Baseline | Responsible Position | Reporting Frequency | Target Completion | Completed |
| 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,<br>-Field test material at CAC meetings | -Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use) | | | | Continuous | |
| | Health Ed | | | -Contracter 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 | | MI incentives<br><br>Health Ed courses/activities | Baseline | Health Educator | | Continuous | |
| Member Services | Health Ed | Member Services | pg. 101 Exhibit A, Attchmnt 13 Member Services | -Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make infromed health decisions<br><br>-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<br><br>-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 | |
| 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 | | Jun-16 |

| Health Education Workplan 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Scope | Area | Objective | Contract Reference | Project Objectives | Activity | Final Deliverable(s) | Goals or Baseline | Responsible Position | Reporting Frequency | Target Completion | Completed |
| 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 | All providers trained | Health Educator, Provider operations, 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 evaulation 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 submitted to MMCD | All continuous MI incentives with justificaton | Health Educator | Update must be submitted on annual basis; the first update is due within one year of the original approval date. | Continuous | |
| 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, Attchmnt 13 Member Services | -Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make infromed health decisions<br><br>-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 | |

| Health Education Workplan 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | |
| Quality of Services | QIS | Ensure medical records reflect all aspects of patient care. | pg. 27 Exhibit A, Attchmnt 4 Quality Improvement System, pg. 140 Exhibit A, Attchmnt 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.<br><br>-Provide list and schedule of health ed classes and/or programs to providers<br><br>-Submit P&P for application and use of Health Information Form (HIF) data submitted thru the Member Evaluation Tool (MET) | | QI (FSR) & Health Educator | | Jun-16 | |
| Quality of Services | Access and Availability | Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanentely prevent or delay pregnancy. | pg. 57 Exhibit A, Attchment 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 | | | Jun-16 |

| Health Education Workplan 2016 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | Conduct group needs assessment to identify health education and cultural and linguistic needs | pg. 61 Exhibit A, Attchment 9 Access and Availability,DHS APL Policy Letter 10-012 | | Conduct GNA | GNA Summary Report submitted to DHCS within 6 mos of completion of each GNA<br><br>-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.<br><br>-Electronically submit an Executive Summary of GNA Report every yrs | Every 5 yrs perform GNA Update<br><br>Annual update GNA summary report | QI manager and Health Educator | Every 5 yrs & Annual update | October 15th, 2016 | |
| Community Advisory Committee | Access and Availability | Community Advisory Committee | pg. 64 Exhibit A, Attchmnt 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<br>-Record of plan members on CAC | | QI and Health Educator, Marketing | | Continuous | |

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: June 1, 2016

**Areas of Review or Committee Activity**

Credentialing of new applicants and recredentialing of existing network practitioners

**Findings and Analysis**

| | | |
|---|---|---|
| Total number of practitioners in network (includes delegated providers) as of 03/31/16 | 3525 | Threshold |
| **Initial Credentialing (excludes delegated practitioners)** | | |
| Number initial practitioners credentialed | 10 | |
| 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 | |

| | Stanford | LPCH | NT 20 | NT 40 | NT 50 | NT 60 |
|---|---|---|---|---|---|---|
| **Total # of Initial Creds** | 0 | 8 | 14 | 4 | 5 | 2 |
| **Total # of Recreds** | 148 | 44 | 32 | 80 | 28 | 6 |
| **(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 |

**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

# Santa Clara Family Health Plan
# Pharmaceutical and Therapeutics Committee
# March 24, 2016
# CONFIDENTIAL

| Voting Committee Members | Specialty | Present Y or N |
|---|---|---|
| Jimmy Lin, MD | Internist | Y |
| Hao Bui, BS, PharmD | Walgreens | Y |
| Minh Thai, MD | Family Practice | Y |
| Amara Balakrishnan, MD | Pediatrics | Y |
| Ria Paul, MD | Geriatric Medicine | Y |
| Peter Nguyen, MD | Family Practice | Y |
| Jesse Parashar-Rokicki, MD | Family Practice | Y |
| Narinder Singh, Pharm D | SCVMC Pharmacy Director | N |
| Ali Alkoraishi, MD | Psychiatry | Y |
| Johanna Liu, PharmD | SCFHP Pharmacy Director | N |
| Jeff Robertson, MD | SCFHP Chief Medical Officer | Y |

| 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 | Clinical Pharmacist | Y |
| Joseph Cherian, PharmD | MedImpact | N |
| Angelique Tran | Pharmacy Coordinator | Y |

| Item | Discussion | Follow-Up Action |
|---|---|---|
| | The meeting convened at 6:10 PM. | |
| I. | **REVIEW, REVISE, AND APPROVE MEETING MINUTES of December 10, 2015.**<br>The minutes were reviewed by Committee as submitted. | Upon motion duly made and seconded, the P&T Committee minutes of **December 10, 2015** were approved as submitted and will be forwarded to the QI Committee and Board of Directors. |
| | | |

| | | |
|---|---|---|
| II. | **SCFHP UPDATES – Jeff Robertson, MD, CMO** Dr. Robertson reported that membership is currently at 272, 916 members. Received notification from Department of Managed Health Care and Department of Health Care Services of joint audit to take place during the last two weeks of April (April 18-22; and April 25-29). Surveyors will also audit provider offices (Primary Care Physicians only, not Specialists). Will be looking for key elements in medical records: Name, Date of Birth, allergies list, required screenings, and immunizations. Current focus for SCFHP is fostering a culture of compliance and preparing for NCQA accreditation. Recently worked with WeiserMazars consultants to review and revise policies to be consistent with state guidelines. | |
| | | |
| III. | **OLD BUSINESS/DISCUSSION ITEMS**<br>No old business to discuss since interim from last meeting. | |

**Santa Clara Family Health Plan**
**Pharmaceutical and Therapeutics Committee**
**March 24, 2016**
**CONFIDENTIAL**

| Item | Discussion | Follow-Up Action |
|---|---|---|
| IV. | **NEW BUSINESS/ACTION ITEMS** | |
| | a. Formulary Modifications | |
| | i. Prior Authorization Guideline Review Project/Archive List<br>Presented 2015 and 2016 Formulary Modifications.<br>Presented proposals to archive PA guidelines for drugs that are currently on formulary without restriction and for drugs that are no longer on formulary. | Upon motion duly made and seconded, Formulary Modifications and proposed changes to Prior Authorization Guidelines were approved as submitted |
| | b. MedImpact P&T Minutes | |
| | i. Presented 4Q15 MedImpact minutes for approval | Upon motion duly made and seconded, the MedImpact minutes were approved as submitted. |
| | c. Pharmacy Policy Review | Motion approved to accept policies as written |
| | Presented 9 policies for review:<br><br>PH01 Pharmacy and Therapeutics Committee<br>PH02 Formulary Development and Guideline Management<br>PH03 Prior Authorization<br>PH04 Pharmacy Clinical Programs and Quality Monitoring<br>PH05 Continuity of Care for Pharmacy Services<br>PH06 Pharmacy Communications<br>PH07 Drug Recalls<br>PH08 Pain Management Drugs for Terminally Ill<br>PH09 Medications for Members with Behavioral Health Conditions | |
| | d. New Drugs | |
| | i. Zepatier-Presented as informational only<br>AASLD Guidelines updated end of February.<br>Updated SCFHP Hepatitis C Treatment Guidelines. | |
| | ii. Uptravi<br>Presented as a new Pulmonary Hypertension medication.<br>Recommendation: Leave as non-formulary Add Generic Revatio (sildenafil 20mg) with prior authorization. | Motion approved |

| Item | Discussion | Follow-Up Action |
|---|---|---|
| | e. Class Reviews<br>i. Long Acting Insulins<br>3 new medications: Basaglar, Ryzodeg, and Tresiba<br>Recommendation: Remove Levemir Flextouch from formulary (to match Levemir vial non-formulary status). | Motion approved |
| | ii. Multiple Myeloma<br>3 new agents: Ninlaro, Darzalex, Empliciti<br>Recommendation: Leave as non-formulary. | |
| | iii. ADHD Non-Stimulant<br>Request for recommendation on what to do with Strattera.<br>3 options:<br>1) Keep on formulary with no prior authorization<br>2) Keep on formulary and add prior authorization<br>3) Make non-formulary and grandfather in those currently taking Strattera | |
| | Motion made to keep on formulary with no prior authorization for those under 18 years old and require prior authorization for those above 18 years old. | Motion approved |
| | f. 1Q2016 Drug Trend and Utilization Review | Informational only |
| | g. Medi-Cal Formulary Drug Updates<br>Recommend add Bexsero and Menveo to formulary<br>Recommend add Gardasil to formulary<br>Recommend add Cytoxan to formulary | <br>Motion approved<br>Motion approved<br>Motion approved |
| | h. Generic Pipeline-Presented as informational only | |
| | | |
| V. | **REPORTS**<br>a. Membership Report – presented by Jeff Robertson, MD<br>b. Prior Authorization Report – presented by Jeff Robertson, MD | |

| | | |
|---|---|---|
| VI. | **ADJOURNMENT**<br>The meeting was adjourned at 7:45 PM. | |

**Submitted by:**

Date: 6/16/16
**Caroline Alexander**
**Administrative Assistant**

**Internal Approved By:**

Date: 6/16/16
**Johanna Liu, PharmD**
**Pharmacy Director, SCFHP**

**External Approved by:**

Date: 6/16/16
**Jimmy Lin, MD**
**Pharmacy & Therapeutics Chair**

Santa Clara
Family Health Plan

*The Spirit of Care*

# MINUTES
# UTILIZATION MANAGEMENT COMMITTEE
## April 20, 2016

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

| Non-Voting Staff Members | Title | Present Y or N |
|---|---|---|
| Christine Tomcala | CEO | Y |
| Lily Boris, MD | Medical Director | N |
| Lori Andersen | LTSS Operations Director | Y |
| Gregg Bernhard | Interim Health Services Director | N |
| Andres Aguirre | Quality Improvement Manager | 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 6:10 p.m.<br>Introduced Lori Anderson, LTSS Operations Director to the group.<br>The minutes of the February 24, 2016 meeting were approved as presented. | |
| **II. CEO Update** | Ms. Tomcala presented the update for Santa Clara Family Health Plan. DMHC/DHCS audit is currently taking place and will continue through next week. Updated policies and procedures as part of preparation for audit UM Committee will now report to the Quality Improvement Committee which is now a committee of the Board. | |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| **III. Old Business** | No old business to present. | |
| **IV. Action Items** | a. Review of Policies and Procedures<br>Dr. Robertson reported reduced number of policies from 51 to a total of 9 policies and revised to be consistent with regulatory requirements. Presented a summary of the revised policies and reviewed with committee.<br><br>b. DM Program Description 2016<br>Dr. Robertson presented the DM Program Description. Currently going through RFP to obtain vendor to do Disease Management and Complex Case Management for Chronic Conditions. Program will be implemented no later than October 2016. (Pending approval)<br><br>c. UM Program Description 2016<br>Dr. Robertson presented the UM Program Description for 2016.<br><br>d. UM Committee Charter<br>Dr. Robertson presented the UM Committee Charter. Recommend add in sentence indicating members are appointed by the CEO, not the Board. No maximum or minimum number of committee members indicated per Charter.<br><br>e. CPO Overview<br>Ms. Andersen presented an overview of Care Plan Options (CPO). Allows Cal MediConnect plans to offer services beyond those covered by Medi-Cal and MediCare. CPO services help to enhance member's care, prevent unnecessary hospitalizations or prolonged care in institutional settings, and allow plans to respond more quickly to changes in an enrollee's health. CPO is added only after assessing for existing LTSS benefits such as IHSS, CBAS, MSSP and LTC. | Approved by committee. Will finalize drafts, obtain approval signatures<br><br>Approved as written.<br><br>Approved with recommendation of adding in phrase regarding CEO appointing members. |
| **V. Reports** | a. Membership<br>Dr. Robertson reported membership is at 270, 934 in April. Cal MediConnect membership is at 8,488 and MediCal is at 257, 469. Plan will continue to increase marketing effort to Providers to encourage members to enroll in Cal MediConnect. | |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| | b. UM Reports 2016<br>Turn Around Time/ Denial Approval<br>Dr. Robertson presented an update on UM Referrals for the 1st Quarter of 2016. A total of 3,074 referrals were received during the 1st Quarter of 2016: 89% approved, 5% denied, 1% Pending, 5% cancelled. MediCal Authorizations Turnaround time is 98% for routine, 97% for urgent, 99% for retroactive. Cal MediConnect turnaround time is 100%.<br><br>c. Pharmacy Authorizations<br>Dr. Robertson presented an update on Pharmacy authorizations. Medi-Cal authorization turnaround time within 24 hours is at 100% over the last six months. Cal MediConnect authorization turnaround time is also at 100% over the last six months.<br><br>d. Mental Health Update<br>Dr. Robertson presented an update on Behavioral Health Treatment for the 1st Quarter 2016. Numbers of members actually receiving services through Santa Clara Family Health Plan (SCFHP) is inclusive of those transitioning from Regional Center to SCFHP. 136 referrals were made for comprehensive diagnostic evaluation. 88 members had a completed diagnostic evaluation. 87 members are receiving behavioral health therapy services. 38 members are transitioning from San Andreas Regional Center (SARC); excluding Kaiser members. 104 Cal MediConnect member with Care Coordination and Specialty Mental Health.<br><br>e. LTSS Ops Report<br>Ms. Andersen presented the LTSS Operations Report Summary from April 2015 to March 2016. As of March 2016: 562 in CBAS; 11, 998 receiving assistance from IHSS (In Home Supportive Services); 269 MSSP (Multi Purpose Senior Services Program); 1,649 LTC (Long Term Care) Number of LTSS referrals has increased. | |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| | | |
| **VI. Adjournment** | Meeting adjourned at 7:35 p.m. | |
| **NEXT MEETING** | The next meeting is scheduled for Wednesday, July 20, 2016, 6:00 PM | All: Calendar this event and plan to attend. |

**Prepared by:**

Caroline Alexander
**Administrative Assistant**

Date 7/20/16

**Reviewed and approved by:**

Jimmy Lin, M.D.
Committee Chairperson

Date 7/20/16

Santa Clara
Family Health Plan

*The Spirit of Care*

# MINUTES
# UTILIZATION MANAGEMENT COMMITTEE AD HOC MEETING
**June 02, 2016**

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

| Non-Voting Staff Members | Title | Present Y or N |
|---|---|---|
| Lily Boris, MD | Medical Director | Y |
| Caroline Alexander | Administrative Assistant | Y |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| **I. Review and Approval of Agenda** | Dr. Boris reviewed the agenda with the committee. It was moved, seconded to approve agenda as written. | Agenda approved |
| **II. Review and Approval of UM Policies** | Three policies were presented and reviewed by the committee:<br>HS10 Financial Incentives<br>HS11 Informed Consent<br>HS12 HS Preventive Guidelines<br>After discussion, it was moved, seconded to approve all three policies as written. | All policies were approved as presented. |
| **III. Review and Approval of 2016 UM Workplan** | Dr. Boris presented a summary of the 2016 UM Workplan to the committee.<br>After discussion, it was moved, seconded to approve 2016 UM Workplan. The UM workplan outlines the years activities and highlighted were the CMC and Medi-Cal reporting, compliance with TAT, Inter Rater Reliability, Quality of Service categories and Quality of Clinical Care. | 2016 UM Workplan was approved as presented. |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| | | |
| **IV. Medi-Cal, Healthy Kids, and CMC Updated Prior Authorization Grids** | Dr. Boris presented a summary of the updates to the Medi-Cal, Healthy Kids, and Cal MediConnect authorization grids. Highlighted is the removal of Chemotherapy from Prior Authorization requirements.<br>The Committee and CMO requested that there be a combined two lists into a common format which is easier to read. After discussion, it was moved, seconded to approve updates to Medi-Cal and Cal MediConnect Authorization Grids.<br>The UM Manager and Supervisor will create a combined grid and present it at the next meeting. | Updates to Medi-Cal, Healthy Kids, and Cal MediConnect Authorization Grids approved |
| **V. Review and Approval of Clinical Practice Guidelines (Medical and Behavioral) and Preventative Guidelines** | Santa Clara Family Health Plan uses clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances. These clinical practice guidelines are also used in related programs such as disease and population management.<br>Practice guidelines are developed from scientific evidence or a consensus of health care professionals in the particular field. Practice guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. Santa Clara Family Health Plan monitors compliance and member outcomes related these clinical guidelines for quality improvement initiatives.<br><br>These clinical practice guidelines are intended to assist providers in clinical decision-making and attempt to define clinical practices that apply to most patients in most circumstances.<br><br>The guidelines are not intended to replace clinical judgment but are provided to assist our practitioners with making decisions about a range of clinical conditions. The treating practitioner should make the ultimate decision in determining the appropriate treatment for each patient.<br><br>a. Clinical Practice Guidelines<br>Dr. Boris presented 5 recommended guidelines for discussion. Recommendation to keep Antithrombotic Guidelines. After discussion, it was moved, seconded to approve Clinical Practice Guidelines as presented.<br><br>b. Behavioral Health Guidelines<br>Dr. Boris presented 3 recommended guidelines for discussion. After discussion, it was moved, seconded to approve Behavioral Health Guidelines as presented. | Clinical Guidelines approved as presented.<br><br>Behavioral Health Guidelines approved as presented.<br><br>Preventative Care Guidelines approved as presented.<br><br>Marketing to post links to guidelines on Provider Website |

| ITEM | DISCUSSION | ACTION REQUIRED |
|---|---|---|
| | c. Preventative Care Guidelines<br>Dr. Boris presented 5 recommended guidelines for discussion. After discussion, it was moved, seconded to approve Preventive Care Guidelines as presented. | |

**Prepared by:** Caroline Alexander Date 7/20/16

Caroline Alexander
Administrative Assistant

**Reviewed and approved by:** Jeff Robertson Date 7-20-16

Jeff Robertson , M.D.
Committee Chairperson
ACTING

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, September 13, 2016**
**6:00 – 7:00 pm**
**210 E. Hacienda Avenue**
**Campbell, CA 95008**

# Minutes - DRAFT

**Committee Members present:**
Waldemar Wenner, M.D.
Blanca Ezquerro
Danette Zuniga
Hung Vinh
Myrna Vega
Rachel Hart
Tran Vu
Lesley Gutierrez (Guest)
Margaret Kinoshita (Guest)

**Staff Present:**
Laura Watkins, Director, Marketing and Communications
Chelsea Byom, Marketing and Communications Manager
Paromita Ghosh, Project Manager
Sherita Gibson, Marketing Coordinator
Johanna Liu, Director of QI and Pharmacy

---

**1. Roll Call**

Dr. Waldemar Wenner, Chairperson, called the meeting to order at 6:05 pm. Roll call was taken and a quorum was established.

**2. Meeting Minutes**

Minutes of the March 8, 2016 meeting were reviewed.
**It was moved and seconded** to approve the March 8, 2016 meeting minutes. The minutes were **approved** as presented.

Minutes of the June 14, 2016 meeting were reviewed.
**It was moved and seconded** to approve the June 14, 2016 meeting minutes. The minutes were **approved** as presented.

**3. Public Comments**

There were no public comments.

**4. Health Plan Update – Laura Watkins**

Ms. Watkins presented enrollment updates as follows: Medi-Cal enrollment is 269,400, Cal MediConnect is 7,909, and Healthy Kids enrollment is down to 2,962. Decrease in Healthy Kids enrollment is due to the transition of members to Medi-Cal under SB 75.

Acupuncture benefits have been reinstated for Medi-Cal and Cal MediConnect. Ms. Zuniga inquired if this was a SCFHP benefit or a Medi-Cal fee-for-service benefit. Ms. Watkins replied it is a SCFHP benefit. Ms. Zuniga asked if providers are available on the website. Ms. Watkins replied that contracting with providers is under way, noting that Customer Service is always a resource to find a specific type of provider.

Ms. Watkins went on to inform the group of the implementation of streamlined enrollment for Cal MediConnect, which will enable SCFHP Medi-Cal members to enroll in Cal MediConnect by simply calling SCFHP. Ms. Ezquerro asked about the status of Covered California kids' enrollment in SCFHP. Ms. Watkins stated she will be covering that later in the meeting.

**5. Quality and Pharmacy Update**

Johanna Liu, Director of Pharmacy and Quality Improvement, informed the Committee that SCFHP has a formulary (list of covered drugs or medications) for each line of business. The formulary includes prescription and over the counter products.

The formulary is decided by a pharmacy and therapeutics committee that meets four times a year. The formulary is posted on the website. Members can always call Customer Service to find out what is covered and what's not.

The formulary has some drugs with restrictions. This is decided in two ways:
1. Clinical: SCFHP wants to make sure drugs on the formulary are safe and effective.
2. Cost: If two drugs work the same but one costs less, SCFHP will select the lower cost drug to include on the formulary.

Restrictions do not mean that the drug is not covered or that a member can't get it. It means that prior authorization may be needed to get it. A prior authorization is paperwork that the doctor needs to fill out to specify why the member needs the drug. Once submitted, the turnaround time for the prior authorization is one business day. When the prior authorization is approved, a notice is sent back to the doctor, and the pharmacy is also informed that the drug has been approved.

Ms. Ezquerro asked if the prior authorization form is available online. Ms. Liu stated yes, and it can be sent securely via fax.

Ms. Liu continued to describe pharmacy access in SCFHP. All the major chains are in our network and can be found in our provider directory. This also includes the Valley pharmacies.

Ms. Zuniga asked what can be done if going on vacation out of state. Ms. Liu replied that it is a national network, but it can be complicated. You may need to plan ahead and call your pharmacy so they can transfer your prescription out of state. They will also have to transfer it back once you return from your trip. Any easier option we offer is to call Customer Service or ask your pharmacy for a one time override to get enough of your prescription to last throughout your entire trip.

Ms. Liu stated that SCFHP has six 24-hour pharmacies in the county available to members within the network.

There is no copay for Medi-Cal. Healthy Kids members may have a copay. If a drug goes through the prior authorization process and is approved, then it follows the same copay rules as if it were on the formulary.

Ms. Zuniga asked if we cover homeopathic drugs. Ms. Liu stated we only cover FDA approved drugs that are proven to be safe and effective.

Ms. Liu also stated that she is available if CAC members have any questions.

**6. Consumer Advisory Committee**

**Charter Update**

Ms. Watkins explained that the Consumer Advisory Committee Charter is written to make sure we are meeting regulatory requirements. These requirements come from our contract with DHCS for Medi-Cal, regulatory requirements that are required by our bylaws, and ordinances from Santa Clara County. These contracts, bylaws and ordinances put importance on getting feedback from the community, because SCFHP is a community organization. The charter has been edited and updated to make sure it incorporates all the requirements.

Dr. Wenner stated that the charter describes why we are here. Dr. Wenner noticed that the charter doesn't say who we're providing feedback to. Ms. Watkins edited the charter to include that our feedback is provided to SCFHP staff and Governing Board.

Ms. Watkins stated that Dr. Wenner reports at every Governing Board meeting about the business of the CAC.

Discussion continued about access to care, provider network adequacy, and future topics for CAC meetings, such as behavioral health.

Dr. Wenner recommended that the Charter be presented to the Governing Board for consideration. The motion was moved, seconded, and approved.

**New Members**

Ms. Watkins stated that new CAC members to be recommended to the Governing Board for appointment, and invited discussion about timing for doing this.

SCFHP will follow up with the two guests in attendance at today's meeting to discuss membership. The Committee agreed that at the December CAC meeting, recommendations for new members will be made and then send to the Governing Board for consideration.

**7. Changes in Children's Coverage**

Ms. Watkins updated the CAC on children's coverage changes. On April 1, 2016 the Covered California data systems were updated to allow for enrollment of eligible C-CHIP children into the Healthy Kids program. On May 17, 2016, SB 75 expanded Medi-Cal coverage to all children under 19 who meet eligibility requirements, regardless of immigration status. This has caused an overall decrease in enrollment in Healthy Kids of 30% as Healthy Kids members transition to Medi-Cal.

The renewal process for Healthy Kids will be changing. All applications will be processed through CalHEERS or MyBenefitsCalWIN.

Ms. Zuniga expressed her concerns about the C-CHIP enrollment process. In her experience, the process was very challenging. Ms. Watkins offered to follow up with Ms. Zuniga separately to troubleshoot the issues she was experiencing. Dr. Wenner also told Ms. Zuniga if she knows anyone else who has been having the same problems to call Customer Service for support.

**8. Videos**

Ms. Byom shared three videos that have been developed with the support and input of the CAC. Ms. Ezquerro commented that the video on Medi-Cal should indicate that it is a health *coverage* program, because ObamaCare says you have to have health *coverage*. Ms. Byom said she will see how to best incorporate that feedback. In response to the "Keeping Your Medi-Cal Coverage" video, Ms. Hart asked if there were other ways to send documents to the County besides mail. Ms. Byom offered to research the issue.

Ms. Kinoshita asked if there was a way to keep the numbers up longer on the screen for the audience. Ms. Byom will figure out a way to do this.

**9. Next Meeting Discussion**

The CAC identified Mental Health/Behavioral Health as a potential topic for a future meeting. Ms. Watkins stated that she will invite the Director of Provider Network Management to a future meeting as well.

The committee confirmed that they would like to be contacted the week before the meeting and also receive a follow-up reminder the day before.

**10. Adjournment**

The meeting was adjourned at 7:16 pm.

_____

Waldemar Wenner, MD
Consumer Affairs Committee Chairperson

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

**Compliance Department Activity**
**July-September 2016**

**Reporting**

- Regulatory Filings/Reports/Other:
  - Routine DMHC Plan Filings
    - Quarterly Claims Assessment
    - Quarterly Survey of Risk Bearing Organizations (RBO) Report
    - Quarterly Pending and Unresolved Grievances Report.
    - Follow-Up Response to 2015 Timely Access Submission
    - Medi-Cal Network Assessment Review 4Q 2015
    - 2017 CMC Member Materials Filing
    - Updated 2014 and 2015 Timely Access Filing
    - Updated BHT Filing

  - Routine DHCS Reports – All filed timely
    - Medi-Cal Reports (includes monthly, quarterly, semi-annual and annual filings)
      - BHT Reports (BHT CDE Provider Survey, BHT Transition File updates and monthly BHT Detailed Report)
      - CBAS Quarterly Report
      - DHCS Quarterly Medical Exemption and Continuity of Care Report
      - CCI Contract Adequacy Quarterly Report
      - DHCS Quarterly Grievance Report
      - DHCS Quarterly Mental Health Report
      - DHCS Quarterly SPD Reporting
      - DHCS Quarterly MLTSS Reporting
      - DHCS Quarterly Targeted Low Income Child Report
      - DHCS Quarterly Dental General Anesthesia Report
      - DHCS Quarterly Call Center Report
      - DHCS Quarterly Geo Access and Plan Subcontractor Report
      - DHCS Quarterly QI Committee Meeting Minutes

      - Annual Medi-Cal Marketing Plan
      - Semi-annual AB 85 Expansion Plan Report
      - Annual QI Program, QI Work Plan, QI Evaluation of the 2015 QI Program
      - Annual CMC FSR/PAR High Volume Provider Attachment C Survey

    - Cal MediConnect Reports (includes monthly and quarterly filings)
      - DHCS Quarterly CMC Complaint and Resolution Report
      - DHCS Quarterly CMC Risk Reporting
      - CA 1.1 High risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely Health Risk Assessment (HRA)
      - CA 1.3 Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely Health Risk Assessment (HRA)
      - CA 1.5 Members with an ICP completed.

- CA 1.11 Members with first follow-up visit within 30 days after hospital discharge.
- CA 2.1 The number of critical incident and abuse reports for members receiving LTSS
- MMP Core 2.1 Members with an assessment completed within 90 days of enrollment
- MMP Core 4.2 Grievances and Appeals.
- MMP Core 5.1 Care coordinator to member ratio.
- MMP Core 9.1 Emergency room behavioral health services utilization

- Ad Hoc Requests
  - Safety Net Provider List for 2017
  - Timely Access Methodology Survey
  - Follow-Up Question to BHT Report for May
  - Follow-Up Question to 1Q MER and COC Report
  - Follow-Up Question to BHT Reconciliation of July 1st Transition
  - Follow-Up Question to BHT CDE Provider Survey
  - Follow-Up Question to 2Q 2016 Detailed Provider Network (SPD) Report
  - Follow-Up Request to CMC FSR/PAR High Volume Provider Attachment C Survey
  - FQHC/RHC/FBC Survey
  - Cal MediConnect HRA Review Template Deliverable Submission and Additional Information Request

**Regulatory Communications**

- General
  - SB 75 - Medi-Cal Expansion for All Children began mid- May and opened up full scope Medi-Cal benefits to all children under 19 who meet the income standards, regardless of immigration status. Due to this change, many Healthy Kids members now qualify for Medi-cal. Healthy Kids enrollment has dropped by about 1300 members.
  - In parallel with the implementation of SB75, Cover California has implemented logic in its enrollment system, (CalHEERS), so that children eligible for the County Children's Health Initiative Program (CCHIP) are now being enrolled in Healthy Kids. The State is obligated to CCHIP until 2019.
  - End of Life Option Act – DHCS established a Medi-Cal Fee-For-Service (FFS) benefit to comply with the End of Life Option Act. It is for terminally ill patients over 18 years of age who have the capacity to make a decision to be prescribed aid in dying medication. Certain conditions must be met. This is carved out of Medi-Cal Managed Care. FFS providers have the option of providing this benefit. DHCS has recommended referring members to the FFS Help Desk.
  - DHCS established a new benefit of providing automatic blood pressure monitors, to patients with hypertension.
  - DMHC is in the process of consolidating all health plan information from its public website into a dashboard that will be displayed on its website. This will include: county(s) served, enrollment, complaints, enforcement actions, premiums, medical surveys and financial exams. These are currently all publicly available on the website.

- Medi-Cal
  - Approval of MC Revised Provider Directory
  - Approval of MC EOC Acupuncture Errata

- Member Complaints via Regulator
  - DMHC
    - Member complaint: Member requesting service on wheelchair. Appropriately denied as Medicare was primary and must be billed first.
    - Member complaint: Member's mother wanted 3 hours/per week for both occupational therapy and speech therapy. SCFHP/VHP had not denied services. New provider only requested 1 ½ hours of each per week for each. Mother disagreed and DMHC sent to IMR as a medical necessity denial. Awaiting IMR outcome.
    - Member complaint: Appealing denial for biofeedback. Biofeedback is not a Medi-Cal covered benefit and also not a recommended treatment for the member's condition.
    - Member complaint: Does not have timely access to BHT services. Mother is requesting after school appointment times and none are available at this time. There are morning and early afternoon times available which the mother had declined. Awaiting DMHC decision.
    - Member complaint: Member dissatisfied that SCFHP would not provide her with transportation to a dental appointment. Dental services are a carve out to Denti-Cal and Denti-Cal offers transportation to services.

- Medicare
  - CMS Inquiry
    - Contract Management Team requested information pertaining to the 2015 Care Coordination data. The inquiry asked the plan about specific improvements SCFHP is making in Care Coordination (e.g. care coordinator to member ratios) and actions being taken to improve scores.
    - NORC contacted the plan about review of its risk assessment data. They felt there was a discrepancy in the numbers and asked SCFHP to confirm its numbers. SCFHP identified factors contributing to the discrepancies that had to do with changes SCFHP made to the risk stratification system and an error in the data extract process that caused a shift in the risk from high-to-low and/or low-to-high. SCFHP resubmitted data for element CA 1.5. This is a repeat issue with reporting of this element, CA1.5.
  - Notice of Non-Compliance
    - On July 6, 2016, SCFHP received a notice of non-compliance for failure to review and process out-of-area cancellations, disenrollments and for failure to mail required out-of-area notice to members. SCFHP self-disclosed the issue on January 13, 2016 and implemented procedures to correct the process. SCFHP now processes out-of-area transactions timely and appropriately.
  - CMS 2016 Data Validation Audit Findings
    - In May, Advent Advisory Group completed our CMS 2016 Data Validation Audit. This audit focuses on validating data SCFHP submits to CMS on an annual basis, including: Grievances, Organization Determinations/Reconsiderations, Coverage Determinations and Redeterminations and the Medication Therapy Management Program. The audit includes a review of data collection methodologies, systems, written policies and

procedures and data accuracy of reports submitted in Q1 2016 for services provided in calendar year 2015. The standard required to pass the audit is a score of 95% or better and SCFHP received an overall score of 81%..

This was SCFHP's first CMS data validation audit, reviewing the first year of operating the CMC program. Even prior to the audit, work had begun to improve known areas of concern. These efforts continue and now include a work plan to address the audit findings in preparation of an anticipated CMS request for a corrective action plan.

**Internal Monitoring/Auditing**

- General
    - Joint DHCS/DMHC Audit
        - SCFHP received its final DHCS Audit Report. Two findings were overturned leaving 34 findings to be corrected. This is the same number of findings as DHCS identified in the 2014 audit. Departments are working on corrective action plans which are due to DHCS in early October.
        - DMHC has not issued its report as yet.
    - Gap Analysis
      A compliance gap task list was developed that consolidates areas identified in the consultant review conducted earlier in the year, DHCS audit, CMS data validation audit and anticipated findings of the DMHC audit. The goal is to have the gaps corrected well in advance of the anticipated April 2017 DHCS audit.
    - HIPAA
        - 5 privacy incidents were reported to DHCS. DHCS reviewed and determined that none required notification.
        - Member Appointment of Representative requests processed:
            - July – 249
            - August – 289
            - September – 89 (as of 9/14/16)

**Oversight**

- Delegation Oversight
    - Year to date, 71% of the scheduled annual delegate/vendor audits have been completed. 3 are scheduled in September.
    - There are three delegates/vendors with corrective actions in process.

**Response and Prevention**

- General
    - Timely Access to Impacted Services at VMC
      SCFHP continues to monitor access to services at VMC.

**Training**

- Governing Board
  Compliance training for the Board continues. The due date for completion is October 15, 2016.

4 Board members have completed the training.

- SCFHP Staff
  Compliance training will be held for SCFHP staff beginning the first of October.

Santa Clara
Family Health Plan

*The Spirit of Care*

# Financial Statements
## For Twelve Months Ended June 2016
(Unaudited)

# Table of Contents

# Santa Clara Family Health Plan
# CFO Finance Report
# For the Month and Year to Date Ended June 30, 2016

## Summary of Financial Results (*Revised Budget*)

For the month of June 2016, SCFHP recorded a net surplus of $18.4 million compared to a budgeted net surplus of $0.7 million resulting in a favorable variance from budget of $17.7 million. For year to date June 2016, SCFHP recorded a net surplus of $30.7 million compared to a budgeted net surplus of $15.5 million resulting in a favorable variance from budget of $15.2 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 – Jun 2016

Favorable/ (Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $177,647,584 | $ 88,335,793 | $ 89,311,791 | 101.1% | Revenue | $ 1,168,835,642 | $ 1,068,753,355 | $100,082,287 | 9.4% |
| 155,560,533 | 83,172,436 | (72,388,097) | -87.0% | Medical Expense | 1,101,654,416 | 1,011,740,079 | (89,914,337) | -8.9% |
| 22,087,051 | 5,163,357 | 16,923,695 | 327.8% | Gross Margin | 67,181,225 | 57,013,276 | 10,167,949 | 17.8% |
| 3,773,175 | 4,314,875 | 541,699 | 12.6% | Administrative Expense | 35,595,647 | 39,993,409 | 4,397,762 | 11.0% |
| 18,313,876 | 848,482 | 17,465,394 | 2058.4% | Net Operating Income | 31,585,578 | 17,019,867 | 14,565,711 | 85.6% |
| 110,929 | (139,752) | 250,680 | 179.4% | Non-Operating Income/Exp | (841,171) | (1,472,252) | 631,081 | 42.9% |
| $ 18,424,805 | $ 708,730 | $ 17,716,075 | 2499.7% | Net Surplus/ (Loss) | $ 30,744,408 | $ 15,547,615 | $ 15,196,792 | 97.7% |

## Member Months

For the month of June 2016, overall member months were higher than budget by 17,408 (+6.8%). For year to date June 2016, overall member months were higher than budget by 53,351 (+1.7%).

For the fiscal year, membership in Medi-Cal increased by 10.8%, membership in the Healthy Kids program decreased by 2.3%, and membership in the Agnews program decreased by 1.8%. Starting in FY17 Agnews membership will be included in Medi-Cal enrollment.

In January 2015, we started enrolling members in Cal MediConnect (CMC). For the month of June 2016, membership in the CMC program was lower than the budget by 956 member months (- 10.4%). For year to date June 2016, membership in the CMC program was lower than the budget by 3,123 member months (- 3.0%). For the fiscal year, membership in CMC program increased by 14.1%.

Member months, and changes from prior year, are summarized on Page 11.

## Revenue

The Health Plan recorded net revenue of $177.6 million for the month of June 2016, compared to budgeted revenue of $88.3 million, resulting in a favorable variance from budget of $89.3 million, or 101.1%. For year to date June 2016, the Plan recorded net revenue of $1,168.8 million, compared to budgeted revenue of $1,068.8 million, resulting in a favorable variance from budget of $100.1 million, or 9.4%. The favorable variance was largely driven by several year end adjustments and reconciliations. IHSS was the largest of these adjustments, with a favorable revenue variance offset by a corresponding increase in medical expense. The CCI Rate Recast, which reflected the more expensive MLTSS mix than originally projected by the State during the rate setting, was another significant favorable year-end adjustment. The Plan also received a $5 million calendar year 2015 risk adjustment payment for the Medicare line of business. These positive variances were partially offset by unfavorable variance in Maternity Kick revenue as well as retroactive payments back to the State. A detailed listing of the significant adjustments is shown in the Appendix.

A statistical and financial summary for all lines of business is included on page 9 of this report.

## Medical Expenses

For the month of June 2016, medical expense was $155.6 million compared to budget of $83.2 million, resulting in an unfavorable budget variance of $72.4 million, or -87.0%. For year to date June 2016, medical expense was $1,101.7 million compared to budget of $1,011.7 million, resulting in an unfavorable budget variance of $89.9 million, or -8.9%. As noted above, a significant year-end adjustment was made to both IHSS revenue and medical expense. In addition, increased year to date medical expenses were attributable to higher than budgeted member months with majority of the variance driven by higher Long Term Care, Inpatient, and Pharmacy expenses. Some of this unfavorability was offset by a year-end reduction in the CCI PDR estimate and net positive reinsurance recoveries.

## Administrative Expenses

Overall administrative costs were under budget by $0.5 million (12.6%) for the month of June 2016, and under budget by $4.4 million (11.0%) for year to date June 2016. Personnel costs (combined salaries and benefits, consulting costs, and temporary costs) were under budget due to the longer than expected ramp up time to hire/engage additional resources approved at the mid-year budget review. Printing and Reproduction and Contracted Services expenses were lower due to the printing/mailing of the materials being deferred to a later month. Some of this favorability is offset by higher than budgeted Information Systems expenses.

Overall administrative expenses were 3.0% of revenues for the year to date June 2016.

## Balance Sheet (Page 6)

Current assets at June 30, 2016 totaled $569.8 million compared to current liabilities of $459.8 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 as of June 30, 2016. Working capital increased by $31.6 million for the twelve months year to date ended June 30, 2016.

Cash as of June 30, 2016, increased by $35.6 million compared to the cash balance as of year-end June 30, 2015. Net receivables increased by $230.9 million during the same twelve month period ended June 30, 2016. The cash position increased largely due to the continued overpayment of Medi-Cal expansion premium revenues by DHCS. Commencing in January, DHCS started to recoup some MCE over payments. However, DHCS has still not implemented the substantially reduced FY16 rate, so this liability amount is likely to continue growing despite partial recoupment. Net receivables increased due to a significant increase in IHSS; however, this increase is largely offset by a corresponding increase in payables. The material increase, therefore, is due to the receivable for the CCI recast rates recorded in June 2016.

Liabilities increased by a net amount of $249.4 million during the twelve months ended June 2016. This was primarily due to an increase in medical cost reserves largely as a result of the rapid growth of long term care claims, and an increase in the aforementioned overpayment of Medi-Cal expansion rate and IHSS receivable amounts. Additionally, the Health Plan recorded the unfunded Pension Liability of $5.0 million as required by GASB 68, as of June 30, 2016. The increase in liabilities was partially offset by a $9.7 million reduction in Premium Deficiency Reserve for the Cal MediConnect contract period ending December 31, 2017 based on updated projections. Additionally, the provider incentive plan liability was reduced due to a lower risk pool accrual than FY15.

Capital Expenses increased by $1.8 million for the twelve months ended June 30, 2016.

# Tangible Net Equity

Tangible Net Equity (TNE) was $103.4 million at June 30, 2016 or 319% of the minimum Required TNE per the Department of Managed Health Care (DMHC) of $32.4 million. A chart showing TNE trends is shown on page 14 of this report.

At the December 2011 Board of Director's meeting, a policy was adopted for targeting the organization's capital reserves to equal two months of Medi-Cal capitation revenue.

As of June 30, 2016, the Plan's reserves are below the current reserve target by about $50.3 million (see calculation below).

Calculation of targeted reserves as of June 30, 2016

| | |
|---|---|
| Estimate of two months' capitation based on June 2016 (rounded) $148,440,000<br>(June 2016 Medi-Cal capitation of $74,219,679 x 2 = $148,439,359) | |
| Less: Unrestricted Net Equity per balance sheet (rounded) | $ 98,128,000 |
| Approximate reserves below target | $ 50,312,000 |

**Santa Clara County Health Authority**
**Balance Sheet**

| | JUN 16 | MAY 16 | APR 16 | JUN 15 |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Cash and Marketable Securities | $ 146,082,070 | $ 226,333,649 | $ 143,160,175 | $ 110,520,927 |
| Premiums Receivable | 408,392,699 | 240,947,195 | 317,887,525 | 177,531,031 |
| Due from Santa Clara Family Health Foundation - net | | | | 3,612 |
| Prepaid Expenses and Other Current Assets | 15,310,308 | 2,445,165 | 2,796,167 | 1,917,101 |
| Total Current Assets | 569,785,077 | 469,726,008 | 463,843,868 | 289,972,670 |
| **Long Term Assets** | | | | |
| Equipment | 13,717,799 | 13,249,656 | 13,165,506 | 11,879,173 |
| Less: Accumulated Depreciation | (8,775,886) | (8,632,945) | (8,491,534) | (7,363,871) |
| Total Long Term Assets | 4,941,913 | 4,616,711 | 4,673,972 | 4,515,302 |
| **Total Assets** | $ 574,726,990 | $ 474,342,719 | $ 468,517,839 | $ 294,487,972 |
| **Deferred Outflow of Resources** | $ 1,293,524 | $ 1,367,331 | 1,367,331 | 1,367,331 |
| **Total Deferred Outflows and Assets** | 576,020,514 | 475,710,050 | 469,885,170 | 295,855,303 |
| **Liabilities and Net Position** | | | | |
| **Current Liabilities** | | | | |
| Trade Payables | $ 4,824,017 | $ 3,138,974 | $ 2,212,842 | $ 3,547,100 |
| Deferred Rent | 142,408 | 144,469 | 146,529 | 167,134 |
| Employee Benefits | 1,013,759 | 1,046,300 | 1,026,662 | 973,066 |
| Retirement Obligation per GASB 45 | | 556,515 | 505,923 | |
| Advance Premium - Healthy Kids | 65,758 | 65,866 | 69,101 | 65,828 |
| Deferred Revenue - Medicare | | | 8,006,172 | |
| Liability for ACA 1202 | 5,503,985 | 503,985 | 516,561 | 5,069,225 |
| Payable to Hospitals (SB90) | 55,140 | 55,140 | 55,140 | 55,140 |
| Payable to Hospitals (SB208) | (35,535) | (35,535) | (35,535) | (35,535) |
| Payable to Hospitals (AB 85) | 1,717,483 | 1,691,053 | 1,733,119 | 4,615,251 |
| Due to Santa Clara County Valley Health Plan and Kaiser | 6,604,472 | 3,594,104 | 3,333,266 | 12,550,402 |
| MCO Tax Payable - State Board of Equalization | 10,769,953 | 11,304,960 | 11,082,866 | 8,909,559 |
| Due to DHCS | 107,213,315 | 89,784,938 | 81,374,937 | 22,173,221 |
| Liability for In Home Support Services (IHSS) | 238,387,141 | 181,522,714 | 170,791,594 | 69,537,810 |
| Premium Deficiency Reserve (PDR) | 2,374,525 | 13,088,054 | 13,088,054 | 13,088,054 |
| Medical Cost Reserves | 81,126,598 | 71,784,407 | 78,738,257 | 70,819,543 |
| Total Current Liabilities | 459,763,019 | 378,245,943 | 372,645,488 | 211,535,798 |
| **Non-Current Liabilities** | | | | |
| Noncurrent Premium Deficiency Reserve | 5,919,500 | 4,911,946 | 4,911,946 | 4,911,946 |
| Net Pension Liability GASB 68 | 5,020,514 | 5,708,971 | 5,633,971 | 4,883,971 |
| Total Liabilities | 470,703,033 | 388,866,860 | 383,191,405 | 221,331,715 |
| **Deferred Inflow of Resources** | 1,942,120 | 1,892,634 | 1,892,634 | 1,892,634 |
| **Net Position / Reserves** | | | | |
| Invested in Capital Assets | 4,941,913 | 4,616,711 | 4,673,972 | 4,515,302 |
| Restricted under Knox-Keene agreement | 305,350 | 305,350 | 305,350 | 305,350 |
| Unrestricted Net Equity | 67,383,691 | 67,708,893 | 67,651,632 | 30,416,972 |
| Current YTD Income (Loss) | 30,744,408 | 12,319,603 | 12,170,177 | 37,393,330 |
| Net Position / Reserves | 103,375,361 | 84,950,557 | 84,801,131 | 72,630,954 |
| **Total Liabilities, Deferred Inflows, and Net Assets** | $ 576,020,514 | $ 475,710,050 | $ 469,885,170 | $ 295,855,303 |
| **Solvency Ratios:** | | | | |
| Working Capital | $ 110,022,058 | $ 91,480,066 | $ 91,198,379 | $ 78,436,872 |
| Working Capital Ratio | 1.2 | 1.2 | 1.3 | 1.4 |
| Average Days Cash on Hand | 47 | 78 | 49 | 55 |

**Santa Clara County Health Authority**
**Income Statement for the Twelve Months Ending June 30, 2016**

| | For the Month of Jun 2016 | | | | | For Twelve Months Ending Jun 30, 2016 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | % of Revenue | Budget | % of Revenue | Variance | Actual | % of Revenue | Budget | % of Revenue | Variance |
| **REVENUES** | | | | | | | | | | |
| MEDI-CAL | $ 160,420,138 | 90.3% | $ 78,239,744 | 88.6% | $ 82,180,393 | $ 1,050,759,591 | 89.9% | $ 952,485,845 | 89.1% | $ 98,273,747 |
| HEALTHY KIDS | $ 400,892 | 0.2% | $ 346,342 | 0.4% | $ 54,550 | $ 4,545,795 | 0.4% | $ 4,425,319 | 0.4% | $ 120,475 |
| MEDICARE | $ 16,826,554 | 9.5% | $ 9,749,706 | 11.0% | $ 7,076,848 | $ 113,530,256 | 9.7% | $ 111,842,191 | 10.5% | $ 1,688,065 |
| **TOTAL REVENUE** | $ 177,647,584 | 100.0% | $ 88,335,793 | 100.0% | $ 89,311,791 | $ 1,168,835,642 | 100.0% | $ 1,068,753,355 | 100.0% | $ 100,082,287 |
| **MEDICAL EXPENSES** | | | | | | | | | | |
| MEDI-CAL | $ 152,215,857 | 85.7% | $ 74,597,259 | 84.4% | $ (77,618,598) | $ 1,006,129,679 | 86.1% | $ 907,876,092 | 84.9% | $ (98,253,587) |
| HEALTHY KIDS | $ 359,165 | 0.2% | $ 358,818 | 0.4% | $ (347) | $ 4,389,044 | 0.4% | $ 4,460,823 | 0.4% | $ 71,779 |
| MEDICARE | $ 2,952,911 | 1.7% | $ 8,178,799 | 9.3% | $ 5,225,888 | $ 90,693,967 | 7.8% | $ 98,949,958 | 9.3% | $ 8,255,991 |
| AGNEWS | $ 32,600 | 0.0% | $ 37,561 | 0.0% | $ 4,960 | $ 441,726 | 0.0% | $ 453,205 | 0.0% | $ 11,479 |
| **TOTAL MEDICAL EXPENSES** | $ 155,560,533 | 87.6% | $ 83,172,436 | 94.2% | $ (72,388,097) | $ 1,101,654,416 | 94.3% | $ 1,011,740,079 | 94.7% | $ (89,914,337) |
| **MEDICAL OPERATING MARGIN** | $ 22,087,051 | 12.4% | $ 5,163,357 | 5.8% | $ 16,923,695 | $ 67,181,225 | 5.7% | $ 57,013,276 | 5.3% | $ 10,167,949 |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | | | |
| SALARIES AND BENEFITS | $ 2,043,225 | 1.2% | $ 2,562,319 | 2.9% | $ 519,094 | $ 18,813,750 | 1.6% | $ 21,463,857 | 2.0% | $ 2,650,107 |
| RENTS AND UTILITIES | $ 106,646 | 0.1% | $ 110,064 | 0.1% | $ 3,417 | $ 1,282,708 | 0.1% | $ 1,313,551 | 0.1% | $ 30,842 |
| PRINTING AND ADVERTISING | $ 96,873 | 0.1% | $ 50,473 | 0.1% | $ (46,400) | $ 497,925 | 0.0% | $ 1,360,337 | 0.1% | $ 862,411 |
| INFORMATION SYSTEMS | $ 229,871 | 0.1% | $ 89,944 | 0.1% | $ (139,927) | $ 2,113,636 | 0.2% | $ 1,555,623 | 0.1% | $ (558,013) |
| PROF FEES / CONSULTING / TEMP STAFFING | $ 951,754 | 0.5% | $ 968,762 | 1.1% | $ 17,008 | $ 9,451,766 | 0.8% | $ 10,738,982 | 1.0% | $ 1,287,216 |
| DEPRECIATION / INSURANCE / EQUIPMENT | $ 183,467 | 0.1% | $ 176,027 | 0.2% | $ (7,439) | $ 1,814,450 | 0.2% | $ 1,735,924 | 0.2% | $ (78,526) |
| OFFICE SUPPLIES / POSTAGE / TELEPHONE | $ 77,678 | 0.0% | $ 266,684 | 0.3% | $ 189,006 | $ 749,142 | 0.1% | $ 978,643 | 0.1% | $ 229,501 |
| MEETINGS / TRAVEL / DUES | $ 70,684 | 0.0% | $ 80,365 | 0.1% | $ 9,681 | $ 790,265 | 0.1% | $ 770,294 | 0.1% | $ (19,971) |
| OTHER | $ 12,977 | 0.0% | $ 10,236 | 0.0% | $ (2,741) | $ 82,004 | 0.0% | $ 76,198 | 0.0% | $ (5,806) |
| **TOTAL ADMINISTRATIVE EXPENSES** | $ 3,773,175 | 2.1% | $ 4,314,875 | 4.9% | $ 541,699 | $ 35,595,647 | 3.0% | $ 39,993,409 | 3.7% | $ 4,397,762 |
| **OPERATING SURPLUS (LOSS)** | $ 18,313,876 | 10.3% | $ 848,482 | 1.0% | $ 17,465,394 | $ 31,585,578 | 2.7% | $ 17,019,867 | 1.6% | $ 14,565,711 |
| **GASB 45-POST EMPLOYMENT BENEFITS EXPENSE** | $ 102,064 | 0.1% | $ (80,007) | -0.1% | $ 182,071 | $ (454,451) | 0.0% | $ (783,597) | -0.1% | $ 329,146 |
| **GASB 68 - UNFUNDED PENSION LIABILITY** | $ (75,000) | 0.0% | $ (75,000) | -0.1% | $ - | $ (900,000) | -0.1% | $ (900,000) | -0.1% | $ - |
| **INTEREST & OTHER INCOME** | $ 83,865 | 0.0% | $ 15,255 | 0.0% | $ 68,609 | $ 513,280 | 0.0% | $ 211,345 | 0.0% | $ 301,935 |
| **NET SURPLUS (LOSS) FINAL** | $ 18,424,805 | 10.4% | $ 708,730 | 0.8% | $ 17,716,075 | $ 30,744,408 | 2.6% | $ 15,547,615 | 1.5% | $ 15,196,792 |

**Administrative Expense**
**Actual vs. Budget**
**For the Current Month & Fiscal Year to Date - Jun 2016**
Favorable/(Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 2,043,225 | $ 2,562,319 | $ 519,094 | 20.3% | Personnel | $ 18,813,750 | $ 21,463,857 | $ 2,650,107 | 12.3% |
| 1,729,950 | 1,752,555 | 22,605 | 1.3% | Non-Personnel | 16,781,897 | 18,529,552 | $ 1,747,654 | 9.4% |
| 3,773,175 | 4,314,875 | 541,699 | 12.6% | Total Administrative Expense | 35,595,647 | 39,993,409 | 4,397,762 | 11.0% |

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

**Twelve Months Ended Jun 30, 2016**

| | Medi-Cal (incl. Agnews) | CMC | Healthy Kids | **Grand Total** |
|---|---|---|---|---|
| **P&L (ALLOCATED BASIS)** | | | | |
| REVENUE | 1,019,217,048 | 145,072,799 | $4,545,795 | **$1,168,835,642** |
| MEDICAL EXPENSES | 972,380,661 | 124,884,711 | 4,389,044 | **$1,101,654,416** |
| (MLR) | 95.4% | 86.1% | 96.6% | **94.3%** |
| GROSS MARGIN | 46,836,386 | 20,188,089 | 156,750 | **67,181,225** |
| ADMINISTRATIVE EXPENSES | 30,652,903 | 4,418,038 | 524,706 | **35,595,647** |
| *(% MM allocation except CMC)* | | | | |
| OPERATING INCOME/(LOSS) | 16,183,483 | 15,770,051 | (367,956) | **31,585,578** |
| OTHER INCOME/(EXPENSE) | (733,495) | (104,404) | (3,271) | **(841,171)** |
| *(% of Revenue Allocation)* | | | | |
| NET INCOME/ (LOSS) | $15,449,988 | $15,665,647 | ($371,227) | **$30,744,408** |
| **PMPM (ALLOCATED BASIS)** | | | | |
| REVENUE | $335.35 | $1,423.08 | $87.38 | **$366.04** |
| MEDICAL EXPENSES | 319.94 | 1,225.04 | 84.36 | **345.00** |
| GROSS MARGIN | 15.41 | 198.03 | 3.01 | **21.04** |
| ADMINISTRATIVE EXPENSES | 10.09 | 43.34 | 10.09 | **11.15** |
| OPERATING INCOME/(LOSS) | 5.32 | 154.69 | (7.07) | **9.89** |
| OTHER INCOME / (EXPENSE) | (0.24) | (1.02) | (0.06) | **(0.26)** |
| NET INCOME / (LOSS) | $5.08 | $153.67 | ($7.14) | **$9.63** |
| **ALLOCATION BASIS:** | | | | |
| *MEMBER MONTHS - YTD* | *3,039,258* | *101,943* | *52,025* | ***3,193,226*** |
| *Member MONTHS by LOB* | *95.2%* | *3.2%* | *1.7%* | ***100%*** |
| *Revenue by LOB* | *87.2%* | *12.4%* | *0.4%* | ***100%*** |

**Santa Clara Family Health Plan**
**Statement of Cash Flows**
**For Twelve Months Ended Jun 30, 2016**

| | | |
|---|---|---|
| Cash flows from operating activities | | |
| Premiums received | $ | 1,024,878,073 |
| Medical expenses paid | $ | (936,829,839) |
| Administrative expenses paid | $ | (51,161,746) |
| Net cash from operating activities | $ | 36,886,488 |
| | | |
| Cash flows from capital and related financing activities | | |
| Purchases of capital assets | $ | (1,838,626) |
| | | |
| Cash flows from investing activities | | |
| Interest income and other income, net | $ | 513,280 |
| | | |
| Net (Decrease) increase in cash and cash equivalents | $ | 35,561,143 |
| | | |
| Cash and cash equivalents, beginning of year | $ | 110,520,927 |
| | | |
| Cash and cash equivalents at Jun 30, 2016 | $ | 146,082,070 |
| | | |
| Reconciliation of operating income to net cash from operating activities | | |
| Operating income (loss) | $ | 30,231,127 |
| Adjustments to reconcile operating income to net cash from operating activities | | |
| Depreciation | $ | 1,412,014 |
| Changes in operating assets and liabilities | | |
| Premiums receivable | $ | (230,861,669) |
| Due from Santa Clara Family Health Foundation | $ | 3,612 |
| Prepaids and other assets | $ | (13,393,207) |
| Deferred outflow of resources | $ | 73,807 |
| Accounts payable and accrued liabilities | $ | (2,490,291) |
| State payable | $ | 86,900,488 |
| Santa Clara Valley Health Plan payable | $ | (4,625,834) |
| Net Pension Liability | $ | 136,543 |
| Medical cost reserves and PDR | $ | 601,080 |
| Deferred inflow of resources | $ | 49,486 |
| Total adjustments | $ | 6,655,361 |
| Net cash from operating activities | $ | 36,886,488 |

## Santa Clara Family Health Plan Enrollment Summary

| | For the Month of Jun 2016 | | | Twelve Months Ending Jun 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Prior Year Actual** | **Change FY16 vs. FY15** |
| Medi-Cal | 259,919 | 241,992 | 7.4% | 3,037,938 | 2,982,434 | 1.9% | 2,584,745 | 17.5% |
| Healthy Kids | 4,435 | 3,994 | 11.0% | 52,025 | 51,029 | 2.0% | 57,356 | ( 9.3%) |
| Medicare | 8,203 | 9,159 | ( 10.4%) | 101,943 | 105,066 | ( 3.0%) | 39,516 | 158.0% |
| Agnews | 110 | 114 | ( 3.5%) | 1,320 | 1,346 | ( 1.9%) | 1,359 | ( 2.9%) |
| Total | 272,667 | 255,259 | 6.8% | 3,193,226 | 3,139,875 | 1.7% | 2,682,976 | 19.0% |

**Santa Clara County Health Authority**
**Jun 2016**

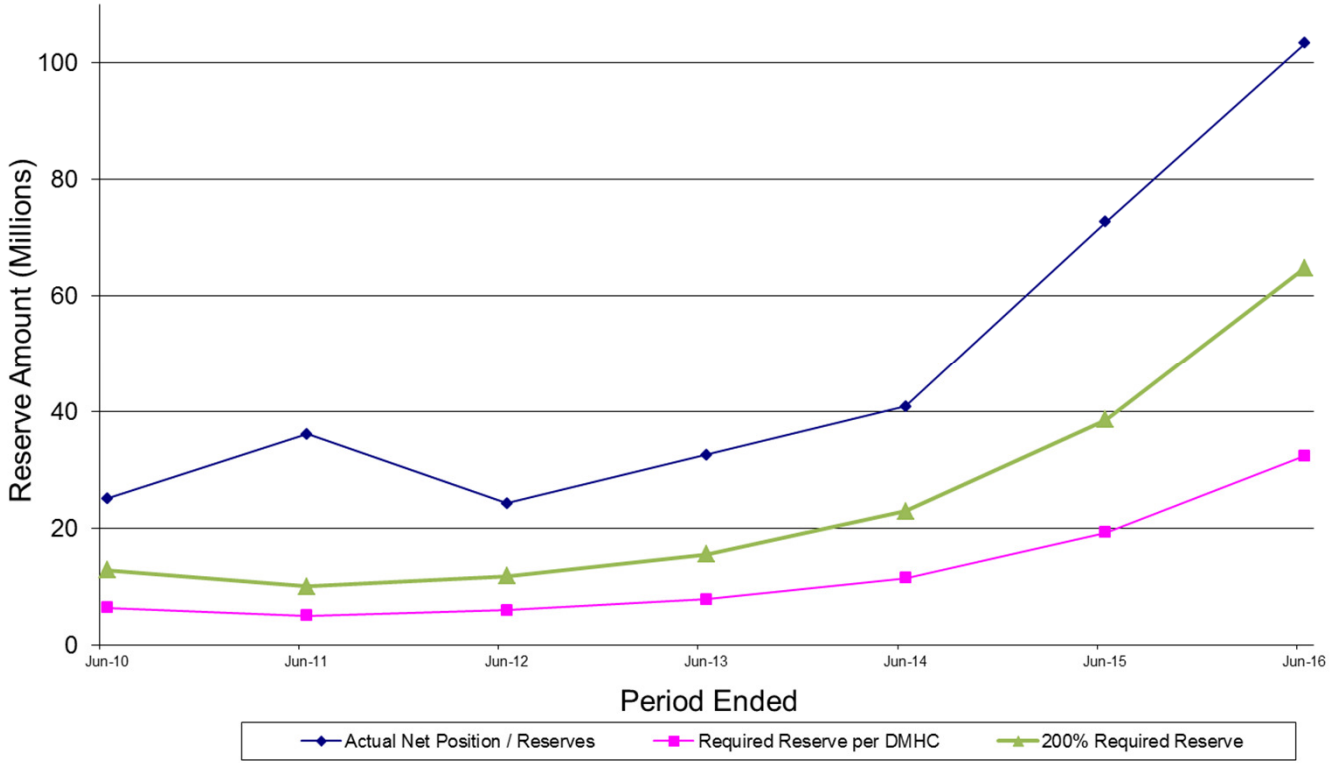
| | Medi-Cal | | Healthy Kids | | CMC | | AG | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contract Physicians | 23,203 | 9% | 253 | 6% | 8,203 | 100% | 110 | 100% | 31,769 | 12% |
| SCVHHS, Safety Net Clinics, FQHC Clinics | 139,020 | 53% | 2,941 | 66% | 0 | 0% | 0 | 0% | 141,961 | 52% |
| Palo Alto Medical Foundation | 7,471 | 3% | 35 | 1% | 0 | 0% | 0 | 0% | 7,506 | 3% |
| Physicians Medical Group | 46,951 | 18% | 1,050 | 24% | 0 | 0% | 0 | 0% | 48,001 | 18% |
| Premier Care | 16,017 | 6% | 156 | 4% | 0 | 0% | 0 | 0% | 16,173 | 6% |
| Kaiser | 27,257 | 10% | 0 | 0% | 0 | 0% | 0 | 0% | 27,257 | 10% |
| Total | 259,919 | 100% | 4,435 | 100% | 8,203 | 100% | 110 | 100% | 272,667 | 100% |
| Enrollment @ 6-30-15 | 234,497 | | 4,541 | | 7,187 | | 112 | | 246,337 | |
| Net % Change from Beginning of FY | 10.8% | | -2.3% | | 14.1% | | -1.8% | | 10.7% | |

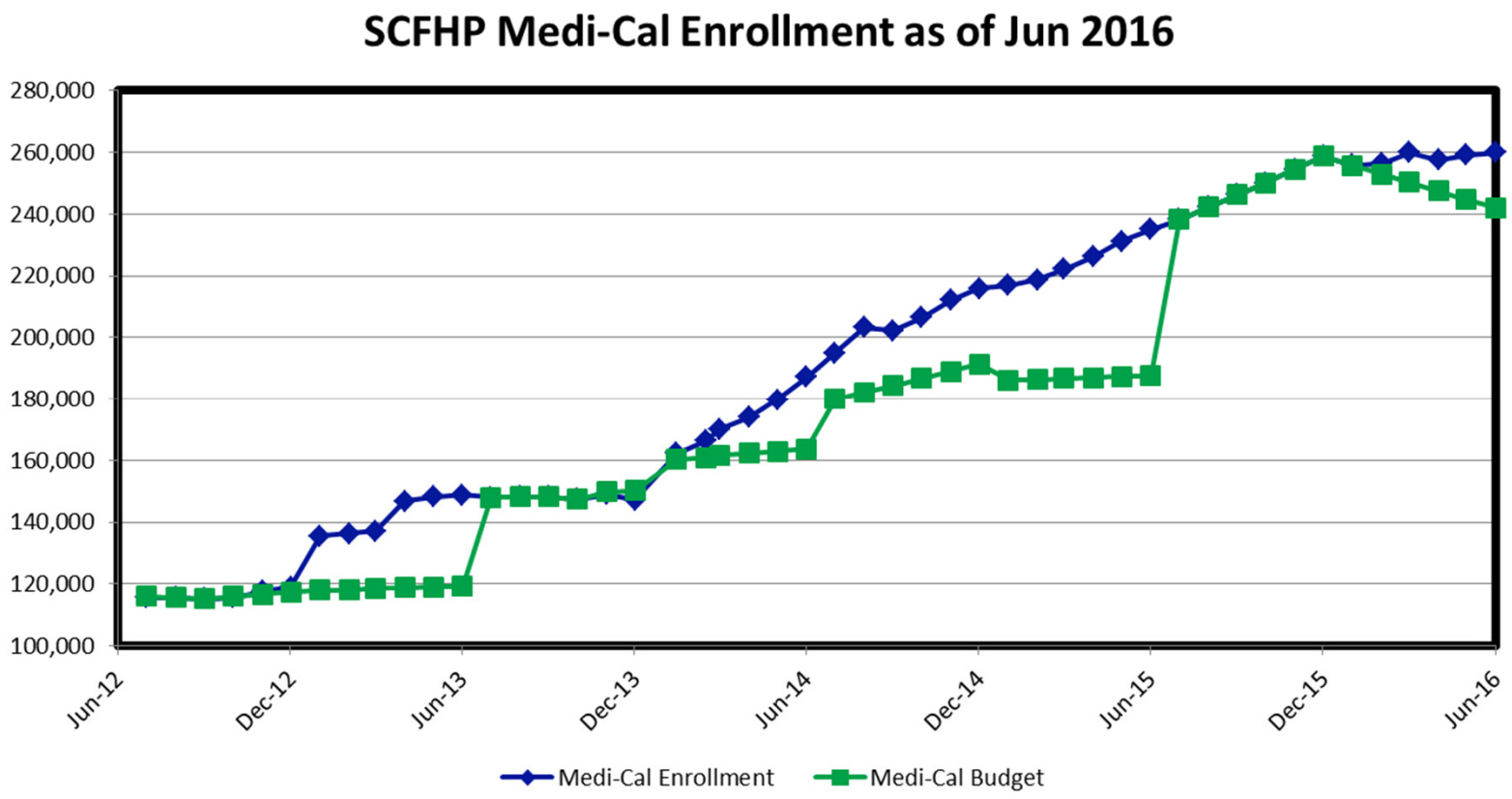
# Santa Clara Family Health Plan
# Enrollment by Aid-Category

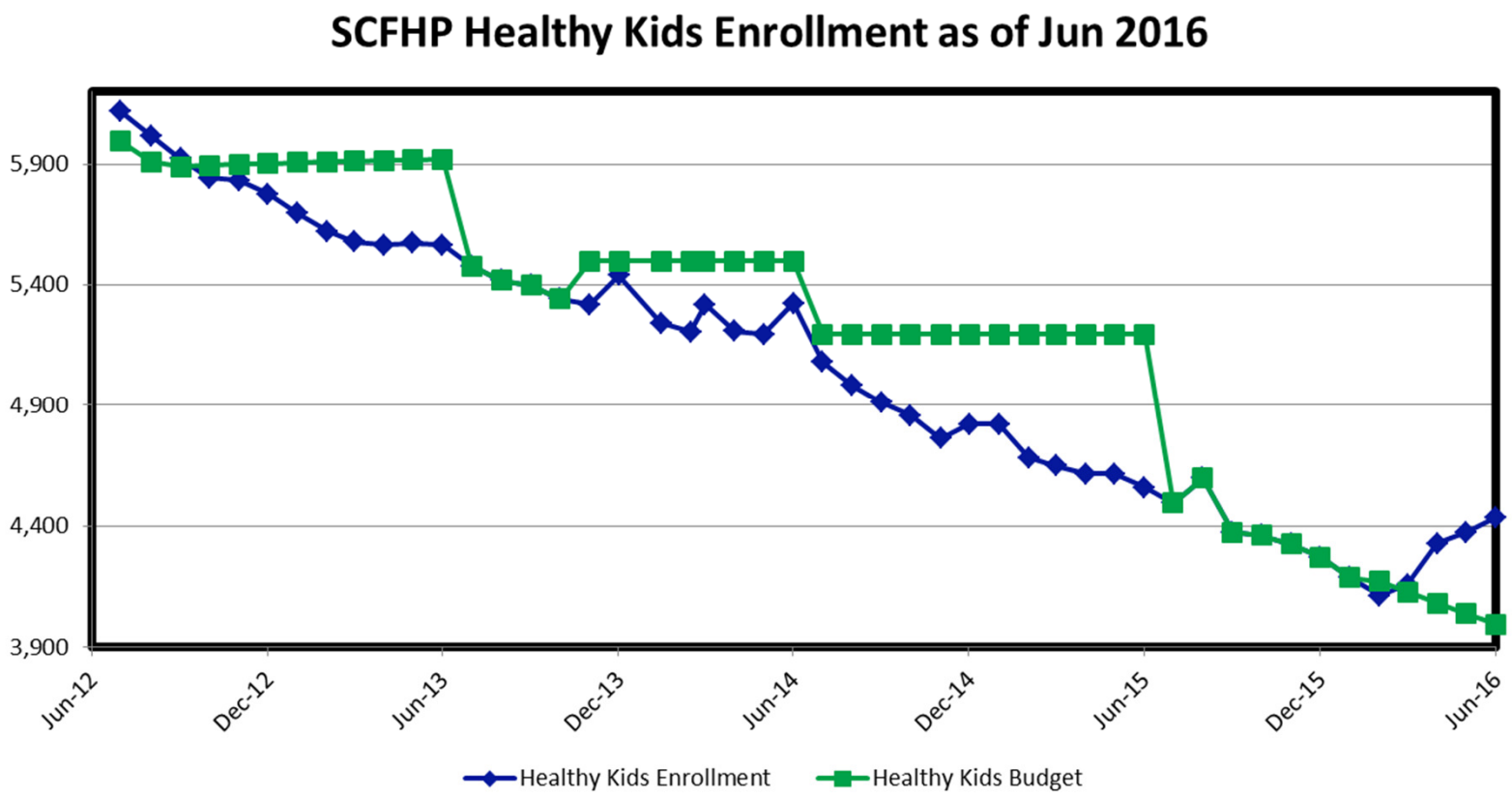
| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 2015-07 | 2015-08 | 2015-09 | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 | 2016-06 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 27,844 | 27,331 | 27,080 | 27,148 | 27,229 | 27,493 | 27,509 | 27,485 | 27,857 | 27,436 | 27,431 | 27,482 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 | 105,341 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 8,642 | 8,730 | 8,858 | 8,909 | 9,103 | 9,235 | 9,241 | 9,158 | 9,150 | 9,145 | 9,144 | 9,101 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 | 10,840 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 9,541 | 7,791 | 6,032 | 4,575 | 3,837 | 3,461 | 3,211 | 2,863 | 2,556 | 2,301 | 2,045 | 1,828 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 | 81,785 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 | 38 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 | 269 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 | 236,684 |
| | | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 | 14,502 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 4,727 | 4,932 | 5,235 | 5,544 | 5,852 | 6,042 | 6,049 | 6,070 | 6,058 | 6,050 | 6,018 | 6,037 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 1,238 | 1,303 | 1,370 | 1,458 | 1,483 | 1,638 | 1,638 | 1,654 | 1,701 | 1,711 | 1,787 | 1,814 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 | 992 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 16,612 | 17,635 | 19,002 | 20,332 | 21,698 | 22,779 | 22,819 | 23,008 | 23,106 | 23,068 | 23,223 | 23,345 |
| | | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 | 260,029 |
| | | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 4,496 | 4,598 | 4,375 | 4,362 | 4,325 | 4,273 | 4,186 | 4,114 | 4,158 | 4,328 | 4,375 | 4,435 |
| | | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 | 7,874 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 | 329 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 7,543 | 7,698 | 7,912 | 8,354 | 8,906 | 9,699 | 9,159 | 8,886 | 8,728 | 8,488 | 8,367 | 8,203 |
| | | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** | **272,667** |

**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 |
|---|---|---|---|---|---|---|---|
| **Actual Net Position / Reserves** | 25,103,011 | 36,093,769 | 24,208,576 | 32,551,161 | 40,872,580 | 72,630,954 | 103,375,361 |
| **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 |
| **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 |




SCFHP Medi-Cal Enrollment as of Jun 2016
280,000
260,000
240,000
220,000
200,000
180,000
160,000
140,000
120,000
100,000
Jun-12
Dec-12
Jun-13
Dec-13
Jun-14
Dec-14
Jun-15
Dec-15
Jun-16
Medi-Cal Enrollment
Medi-Cal Budget


SCFHP Healthy Kids Enrollment as of Jun 2016
5,900
5,400
4,900
4,400
3,900
Jun-12
Dec-12
Jun-13
Dec-13
Jun-14
Dec-14
Jun-15
Dec-15
Jun-16
Healthy Kids Enrollment
Healthy Kids Budget

# APPENDIX – LIST OF SIGNIFICANT YEAR-END ADJUSTMENTS

| Adjustment/Reconciliation | Description/Objective/Purpose | $ Fav/(Unfav) |
|---|---|---|
| CCI Rate Recast | Revised estimate | $15,300,000 |
| CMC PDR Calculation | Revised estimate | $9,700,000 |
| RAF Mid-Year Sweep Adjustments | Accrued receivable | $5,200,000 |
| Part D Reconciliation | Accrued receivable | $3,300,000 |
| RX Rebates | Accrued receivable | $2,800,000 |
| Reinsurance Receivable | Accrued receivable | $2,300,000 |
| Maternity | Revised estimate | $1,188,000 |
| BHT Accrual | Accrued receivable and playable | $756,000 |
| CalPERS-Related Liabilities | Post annual adjustments | $140,000 |
| Bonus Accrual | Accrue payable | ($600,000) |
| Risk Pool Accruals | Revised estimate | ($1,000,000) |
| Agnews | Accrue payable to DHCS | ($3,500,000) |
| IHSS Reconciliation CY14/CY15 | Adjust receivable/payable | ($4,600,000) |
| ACA1202 for CY15 | Increase accrual | ($5,000,000) |

# June 2016
# Financial Summary

SCCHA Governing Board Meeting

September 22, 2016

# Fiscal Year 2015-16 Highlights (*Revised Budget*)

- **Net Surplus –** June $18.4m surplus and YTD $30.7m surplus ($15.2m) favorable to budget
  - The variance is primarily related to CCI rate recast and the CMC Premium Deficiency Reserve (PDR )reduction.
- **Enrollment**
  - June 2016 membership: 272,667 (6.8% favorable to budget)
  - June YTD: 3,193,226 member months (1.7% favorable to budget and 19% higher than June YTD last year)
  - Continued growth in Medi-Cal Expansion membership. CMC membership has been trending downward since January.
- **Revenue –** over budget by $100.1 m (+9.4%)
  - Increase is due to higher Medi-Cal membership, higher In Home Support Services (IHSS) revenue, CCI rate recast, and risk adjustment revenue for the Medicare line of business.
- **Medical Expenses –** over budget by $89.9m (-8.9%)
  - Increase is due to higher Medi-Cal membership with majority of variance in LTC, Pharmacy, and IHSS expenses. Some of this increase was offset by a reduction in the CCI PDR estimate and net positive reinsurance recoveries.
- **Administrative Expenses –** under budget by $4.4m (11.0%)
  - Slower hiring personnel (FTE and Consultants) ramp up than budgeted. Printing/Reproduction/Contracted costs deferred to a later date. Some favorability offset by higher Information Service expenses.
- **Other Expenses –** under budget by $0.6m; due to higher interest earned and lower post-employment benefits expense.
- **Balance Sheet**
  - Net receivables due from DHCS have increased $231m primarily because of IHSS and CCI rate recast. IHSS receivable have a corresponding increase in payables.
  - Medi-Cal Expansion rate overpayment: State recouped most of the FY15 overpayments; however, FY16 overpayments continued to grow. This improved the cash position as well.
  - TNE of $103.4M or 319% of Required TNE of $32.4m per DMHC.

# Consolidated Performance
# June 2016 and Year to Date

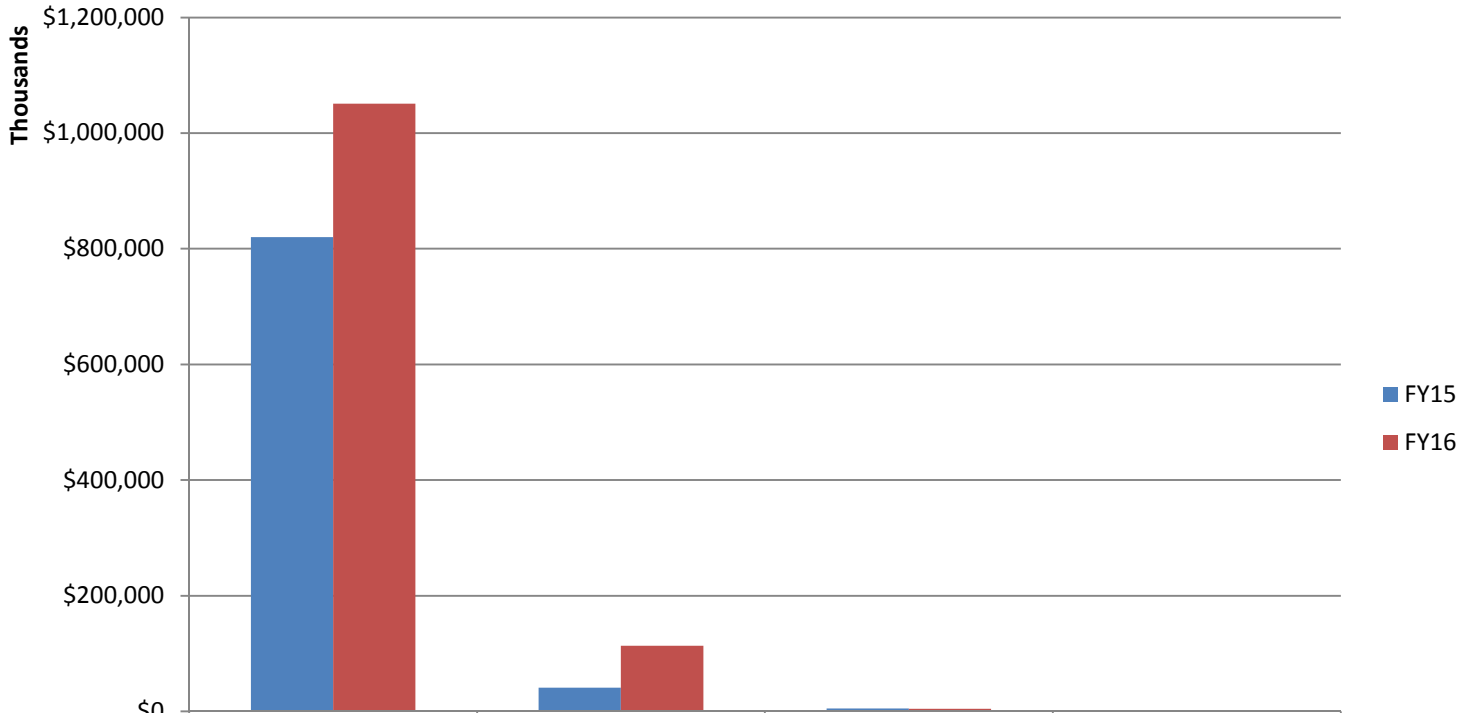
| | Month of Jun | FYTD through Jun |
|---|---|---|
| **Revenue** | $177.6 million | $1168.8 million |
| **Medical Costs** | $155.6 million | $1101.7 million |
| **Medical Loss Ratio** | 87.6% | 94.3% |
| **Administrative Costs** | $3.8 million (2.1%) | $35.6 million (3%) |
| **Other Income/ Expense** | $110,929 | ($841,171) |
| **Net Surplus (Loss)** | $18,424,805 | $30,744,408 |
| | | |
| Cash on Hand | | $146.1 million |
| Net Cash Available to SCFHP | | $14.3 million |
| Receivables | | $408.4 million |
| Current Liabilities | | $459.8 million |
| Tangible Net Equity | | $103.4 million |
| Pct. Of Min. Requirement | | **319%** |

# Consolidated Performance

**Summary Operating Results - Actual vs. Budget**
**For the Current Month & Fiscal Year to Date - Jun 2016**
Favorable/(Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $177,647,584 | $ 88,335,793 | $ 89,311,791 | 101.1% | Revenue | $ 1,168,835,642 | $ 1,068,753,355 | $100,082,287 | 9.4% |
| 155,560,533 | 83,172,436 | (72,388,097) | -87.0% | Medical Expense | 1,101,654,416 | 1,011,740,079 | (89,914,337) | -8.9% |
| 22,087,051 | 5,163,357 | 16,923,695 | 327.8% | Gross Margin | 67,181,225 | 57,013,276 | 10,167,949 | 17.8% |
| 3,773,175 | 4,314,875 | 541,699 | 12.6% | Administrative Expense | 35,595,647 | 39,993,409 | 4,397,762 | 11.0% |
| 18,313,876 | 848,482 | 17,465,394 | 2058.4% | Net Operating Income | 31,585,578 | 17,019,867 | 14,565,711 | 85.6% |
| 110,929 | (139,752) | 250,680 | 179.4% | Non-Operating Income/Exp | (841,171) | (1,472,252) | 631,081 | 42.9% |
| $ 18,424,805 | $ 708,730 | $ 17,716,075 | 2499.7% | Net Surplus/ (Loss) | $ 30,744,408 | $ 15,547,615 | $ 15,196,792 | 97.7% |

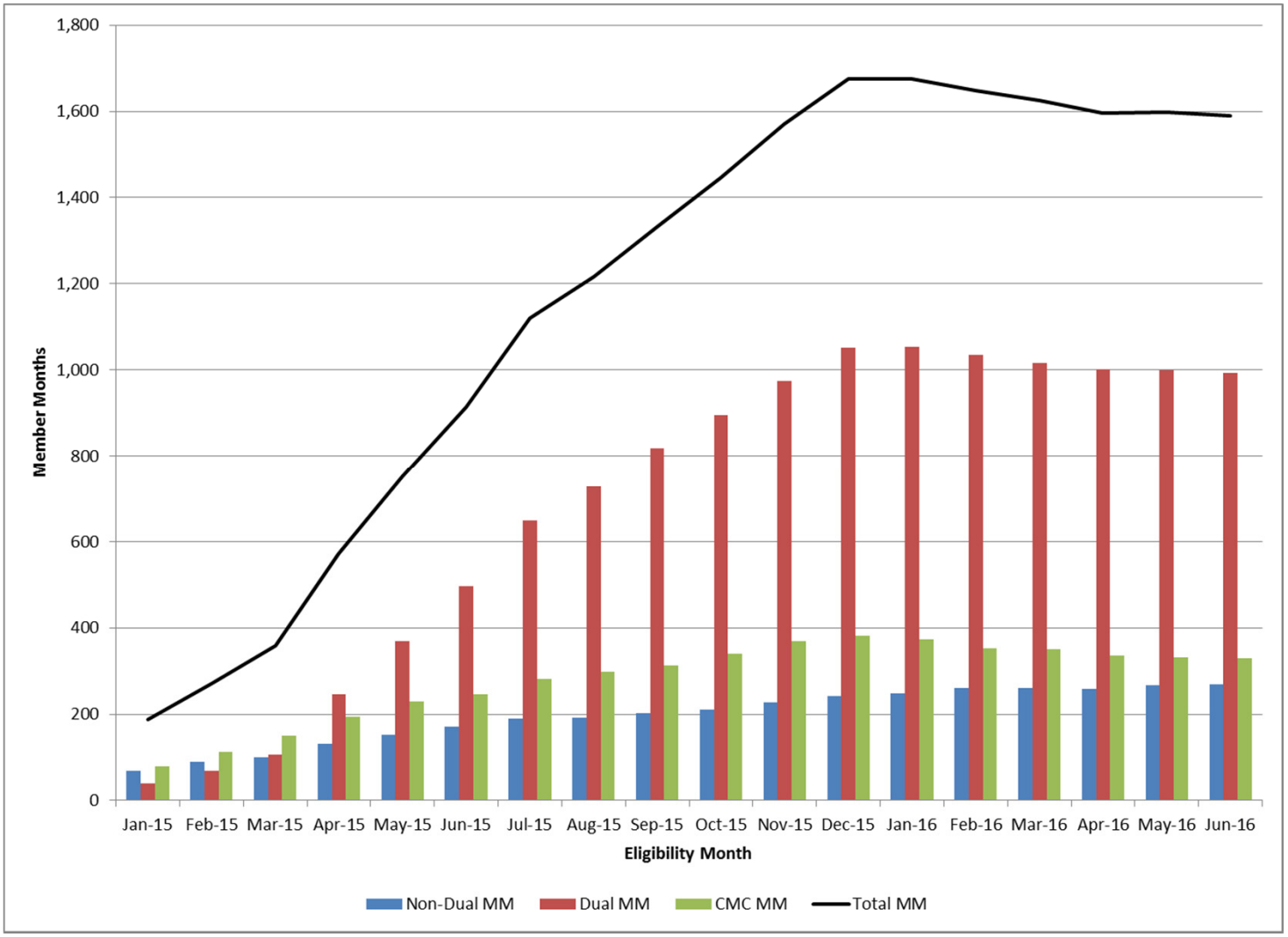
# Year Over Year Revenue Trend



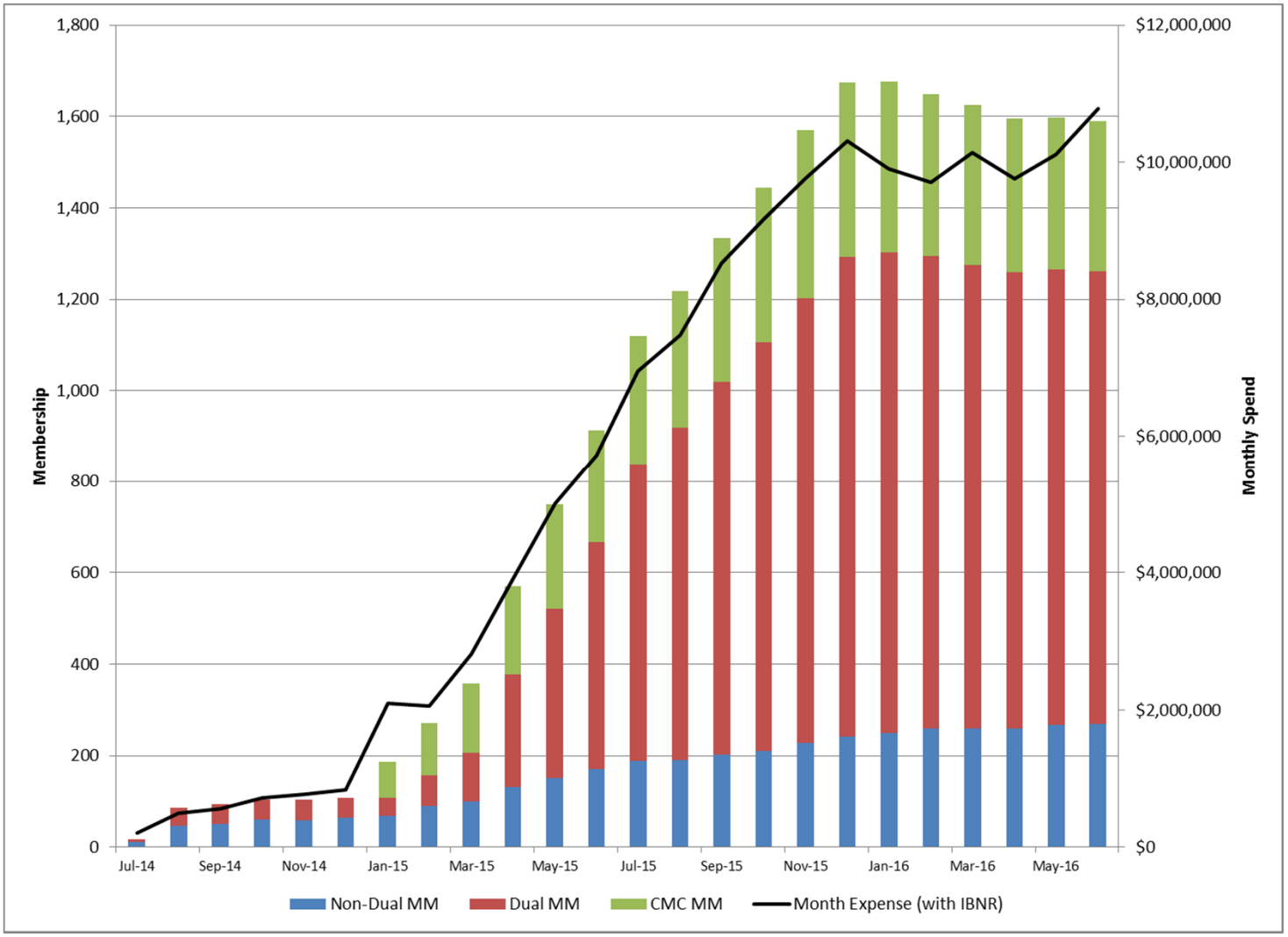

| | Medi-Cal | Medicare | Healthy Kids | Agnews |
|---|---|---|---|---|
| FY15 | $819,989,925 | $41,079,047 | $4,994,395 | $264,382 |
| FY16 | $1,050,759,591 | $113,530,256 | $4,545,795 | $0 |

*Medi-Cal revenue increased by 28% and Medicare revenue increased by 176%.*

# Long Term Care Membership
# Medi-Cal and CMC



# Medi-Cal Long Term Care Experience
# July 2014 – June 2016



# Enrollment Summary
# June and YTD

| | For the Month of Jun 2016 | | | Twelve Months Ending Jun 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Prior Year Actual** | **Change FY16 vs. FY15** |
| Medi-Cal | 259,919 | 241,992 | 7.4% | 3,037,938 | 2,982,434 | 1.9% | 2,584,745 | 17.5% |
| Healthy Kids | 4,435 | 3,994 | 11.0% | 52,025 | 51,029 | 2.0% | 57,356 | ( 9.3%) |
| Medicare | 8,203 | 9,159 | ( 10.4%) | 101,943 | 105,066 | ( 3.0%) | 39,516 | 158.0% |
| Agnews | 110 | 114 | ( 3.5%) | 1,320 | 1,346 | ( 1.9%) | 1,359 | ( 2.9%) |
| Total | 272,667 | 255,259 | 6.8% | 3,193,226 | 3,139,875 | 1.7% | 2,682,976 | 19.0% |

# Enrollment by Network - YTD

**Santa Clara County Health Authority**
**Jun 2016**

| | Medi-Cal | | Healthy Kids | | CMC | | AG | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contract Physicians | 23,203 | 9% | 253 | 6% | 8,203 | 100% | 110 | 100% | 31,769 | 12% |
| SCVHHS, Safety Net Clinics, FQHC Clinics | 139,020 | 53% | 2,941 | 66% | 0 | 0% | 0 | 0% | 141,961 | 52% |
| Palo Alto Medical Foundation | 7,471 | 3% | 35 | 1% | 0 | 0% | 0 | 0% | 7,506 | 3% |
| Physicians Medical Group | 46,951 | 18% | 1,050 | 24% | 0 | 0% | 0 | 0% | 48,001 | 18% |
| Premier Care | 16,017 | 6% | 156 | 4% | 0 | 0% | 0 | 0% | 16,173 | 6% |
| Kaiser | 27,257 | 10% | 0 | 0% | 0 | 0% | 0 | 0% | 27,257 | 10% |
| Total | 259,919 | 100% | 4,435 | 100% | 8,203 | 100% | 110 | 100% | 272,667 | 100% |
| Enrollment @ 6-30-15 | 234,497 | | 4,541 | | 7,187 | | 112 | | 246,337 | |
| Net % Change from Beginning of FY | 10.8% | | -2.3% | | 14.1% | | -1.8% | | 10.7% | |

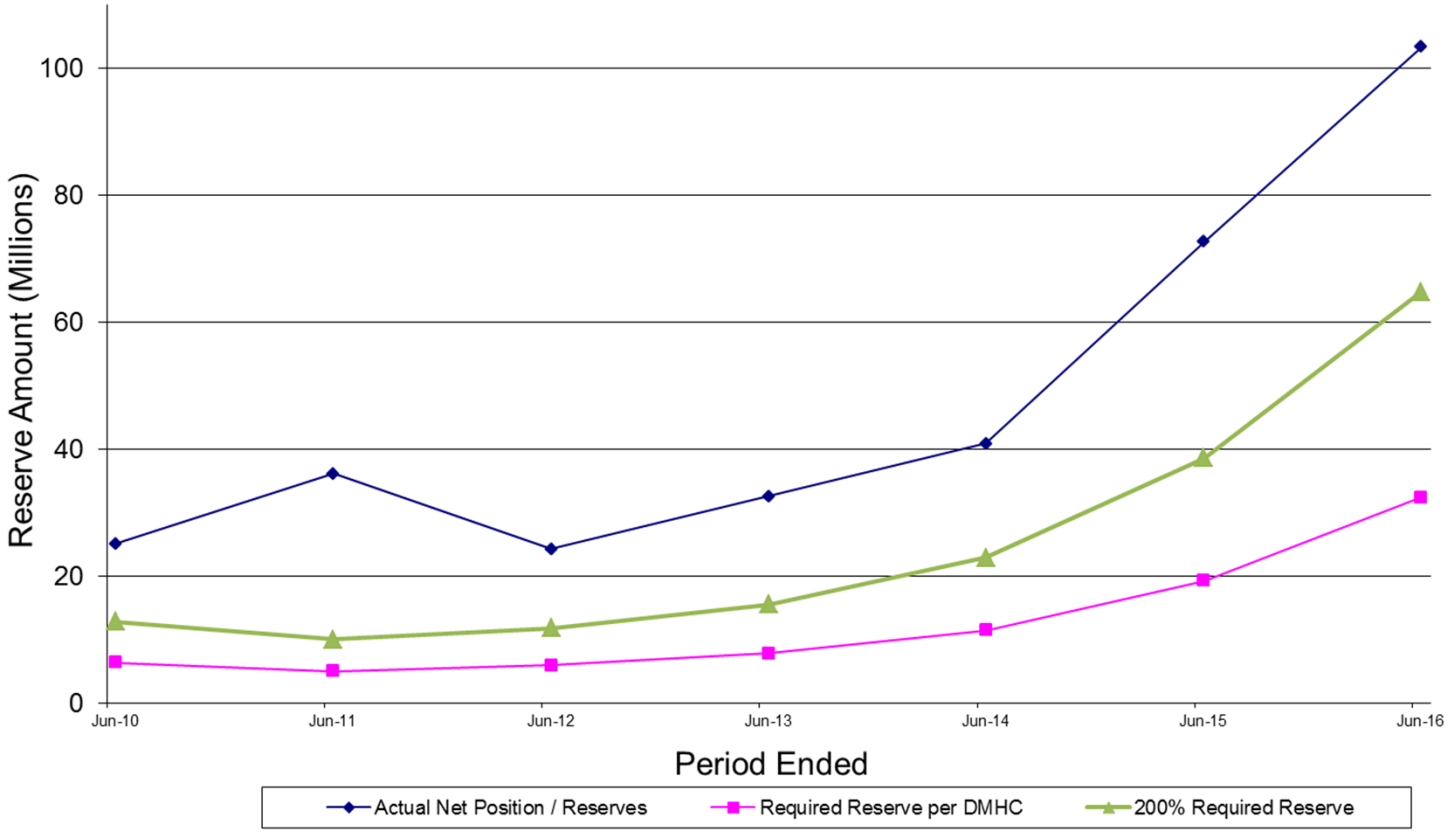
Membership has increased 10.7% since the beginning of the Fiscal Year, primarily as a result of Medi-Cal Expansion, which started January 1, 2014 and has grown to 83,166 members.

# Enrollment by Aid Category

| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 2015-07 | 2015-08 | 2015-09 | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 | 2016-06 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 27,844 | 27,331 | 27,080 | 27,148 | 27,229 | 27,493 | 27,509 | 27,485 | 27,857 | 27,436 | 27,431 | 27,482 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 | 105,341 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 8,642 | 8,730 | 8,858 | 8,909 | 9,103 | 9,235 | 9,241 | 9,158 | 9,150 | 9,145 | 9,144 | 9,101 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 | 10,840 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 9,541 | 7,791 | 6,032 | 4,575 | 3,837 | 3,461 | 3,211 | 2,863 | 2,556 | 2,301 | 2,045 | 1,828 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 | 81,785 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 | 38 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 | 269 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 | 236,684 |
| | | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 | 14,502 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 4,727 | 4,932 | 5,235 | 5,544 | 5,852 | 6,042 | 6,049 | 6,070 | 6,058 | 6,050 | 6,018 | 6,037 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 1,238 | 1,303 | 1,370 | 1,458 | 1,483 | 1,638 | 1,638 | 1,654 | 1,701 | 1,711 | 1,787 | 1,814 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 | 992 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 16,612 | 17,635 | 19,002 | 20,332 | 21,698 | 22,779 | 22,819 | 23,008 | 23,106 | 23,068 | 23,223 | 23,345 |
| | | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 | 260,029 |
| | | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 4,496 | 4,598 | 4,375 | 4,362 | 4,325 | 4,273 | 4,186 | 4,114 | 4,158 | 4,328 | 4,375 | 4,435 |
| | | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 | 7,874 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 | 329 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 7,543 | 7,698 | 7,912 | 8,354 | 8,906 | 9,699 | 9,159 | 8,886 | 8,728 | 8,488 | 8,367 | 8,203 |
| | | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** | **272,667** |

# Tangible Net Equity at June 30, 2016

TNE is $103.4 million or 319% of the Required TNE of $32.4m per the Department of Managed Health Care (DMHC). The Plans reserves are roughly $50.3 million below the current reserve target of two months' Medi-Cal capitation revenue.



Santa Clara
Family Health Plan

*The Spirit of Care*

# Financial Statements
## For One Month Ended July 2016
(Unaudited)

# Table of Contents

# Santa Clara Family Health Plan
# CFO Finance Report
# For the Month and Year to Date Ended July 31, 2016

## Summary of Financial Results (*Revised Budget*)

For the month and YTD July 2016, SCFHP recorded a net surplus of $0.15 million compared to a budgeted net surplus of $0.93 million resulting in an unfavorable variance from budget of $0.78 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 – Jul 2016

Favorable/ (Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 97,586,480 | $ 94,987,743 | $ 2,598,738 | 2.7% | Revenue | $ 97,586,480 | $ 94,987,743 | $ 2,598,738 | 2.7% |
| 93,604,133 | 90,377,481 | (3,226,652) | -3.6% | Medical Expense | 93,604,133 | 90,377,481 | (3,226,652) | -3.6% |
| 3,982,347 | 4,610,262 | (627,915) | -13.6% | Gross Margin | 3,982,347 | 4,610,262 | (627,915) | -13.6% |
| 3,703,622 | 3,593,180 | (110,442) | -3.1% | Administrative Expense | 3,703,622 | 3,593,180 | (110,442) | -3.1% |
| 278,726 | 1,017,082 | (738,356) | -72.6% | Net Operating Income | 278,726 | 1,017,082 | (738,356) | -72.6% |
| (130,283) | (85,842) | (44,441) | -51.8% | Non-Operating Income/Exp | (130,283) | (85,842) | (44,441) | -51.8% |
| $ 148,442 | $ 931,240 | $ (782,798) | -84.1% | Net Surplus/ (Loss) | $ 148,442 | $ 931,240 | $ (782,798) | -84.1% |

## Member Months

For the month and YTD July 2016, overall member months were higher than budget by 2,725 (+1.0%). For the fiscal year, membership in Medi-Cal increased by 1.5%, membership in the Healthy Kids program decreased by 1.2%, and membership in CMC program decreased by 1.2%.

Member months, and changes from prior year, are summarized on Page 11.

## Revenue

The Health Plan recorded net revenue of $97.6 million for the month and YTD July 2016, compared to budgeted revenue of $95.0 million, resulting in a favorable variance from budget of $2.6 million, or 2.7%. The favorable variance was due to higher than budgeted member months resulting in higher expansion revenue and IHSS revenue. The Plan also received additional retroactivity related revenue. These positive variances were partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to Risk Adjustment Factor payment.

A statistical and financial summary for all lines of business is included on page 9 of this report.

## Medical Expenses

For the month and YTD July 2016, medical expense was $93.6 million compared to budget of $90.4 million, resulting in an unfavorable budget variance of $3.2 million, or -3.6%. 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 lower Professional FFS and Pharmacy expenses.

## Administrative Expenses

Overall administrative costs were over budget by $0.1 million (-3.1%) for the month and YTD July 2016. Personnel costs were over budget due to open positions being filled by consulting and temporary staffing resources as well as the overall vacancy rate being lower than budget. Some of this unfavorability was offset by lower information service expenses and legal expenses.

Overall administrative expenses were 3.8% of revenues for the year to date July 2016.

## Balance Sheet (Page 6)

Current assets at July 31, 2016 totaled $610.0 million compared to current liabilities of $499.7 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 as of July 31, 2016. Working capital increased by $0.3 million for the one month year to date ended July 31, 2016.

Cash as of July 31, 2016, increased by $10.6 million compared to the cash balance as of year-end June 30, 2016. The cash position increased largely due to the increase in medical cost reserves and other payables. Net receivables increased by $29.2 million during the same one month period ended July 31, 2016 largely due to an increase in CCI rate recast receivable and IHSS/MCO receivables.

Liabilities increased by $40.0 million during the one month period ended July 2016. Liabilities increased primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State, increase in medical cost reserves, and increase in IHSS/MCO payables.

Capital Expenses increased by $52 thousand for the one month ended July 31, 2016.

# Tangible Net Equity

Tangible Net Equity (TNE) was $103.5 million at July 31, 2016 or 320% of the minimum Required TNE per the Department of Managed Health Care (DMHC) of $32.4 million. A chart showing TNE trends is shown on page 14 of this report.

At the December 2011 Board of Director's meeting, a policy was adopted for targeting the organization's capital reserves to equal two months of Medi-Cal capitation revenue.

As of July 31, 2016, the Plan's reserves are below the current reserve target by about $49.4 million (see calculation below).

Calculation of targeted reserves as of July 31, 2016

| | |
|---|---|
| Estimate of two months' capitation based on July 2016 (rounded) $147,776,000<br>(July 2016 Medi-Cal capitation of $73,887,811 x 2 = $147,775,623) | |
| Less: Unrestricted Net Equity per balance sheet (rounded) | $ 98,384,000 |
| Approximate reserves below target | $ 49,392,000 |

**Santa Clara County Health Authority**
**Balance Sheet**

| | JUL 16 | JUN 16 | MAY 16 | JUN 15 |
|---|---|---|---|---|
| **Assets** | | | | |
| **Current Assets** | | | | |
| Cash and Marketable Securities | $ 156,693,435 | $ 146,082,070 | $ 226,333,649 | $ 110,520,927 |
| Premiums Receivable | 437,631,910 | 408,392,699 | 240,947,195 | 177,531,031 |
| Due from Santa Clara Family Health Foundation - net | | | | 3,612 |
| Prepaid Expenses and Other Current Assets | 15,704,546 | 15,310,308 | 2,445,165 | 1,917,101 |
| Total Current Assets | 610,029,891 | 569,785,077 | 469,726,008 | 289,972,670 |
| **Long Term Assets** | | | | |
| Equipment | 13,769,810 | 13,717,799 | 13,249,656 | 11,879,173 |
| Less: Accumulated Depreciation | (8,936,053) | (8,775,886) | (8,632,945) | (7,363,871) |
| Total Long Term Assets | 4,833,757 | 4,941,913 | 4,616,711 | 4,515,302 |
| **Total Assets** | $ 614,863,648 | $ 574,726,990 | $ 474,342,719 | $ 294,487,972 |
| **Deferred Outflow of Resources** | $ 1,293,524 | $ 1,293,524 | 1,367,331 | 1,367,331 |
| **Total Deferred Outflows and Assets** | 616,157,172 | 576,020,514 | 475,710,050 | 295,855,303 |
| **Liabilities and Net Position** | | | | |
| **Current Liabilities** | | | | |
| Trade Payables | $ 3,645,802 | $ 4,824,017 | $ 3,138,974 | $ 3,547,100 |
| Deferred Rent | 138,257 | 142,408 | 144,469 | 167,134 |
| Employee Benefits | 1,015,476 | 1,013,759 | 1,046,300 | 973,066 |
| Retirement Obligation per GASB 45 | 50,592 | | 556,515 | |
| Advance Premium - Healthy Kids | 66,827 | 65,758 | 65,866 | 65,828 |
| Liability for ACA 1202 | 5,503,396 | 5,503,985 | 503,985 | 5,069,225 |
| Payable to Hospitals (SB90) | 55,140 | 55,140 | 55,140 | 55,140 |
| Payable to Hospitals (SB208) | (35,535) | (35,535) | (35,535) | (35,535) |
| Payable to Hospitals (AB 85) | 1,289,030 | 1,717,483 | 1,691,053 | 4,615,251 |
| Due to Santa Clara County Valley Health Plan and Kaiser | 7,293,954 | 6,604,472 | 3,594,104 | 12,550,402 |
| MCO Tax Payable - State Board of Equalization | 18,546,956 | 10,769,953 | 11,304,960 | 8,909,559 |
| Due to DHCS | 120,850,476 | 107,213,315 | 89,784,938 | 22,173,221 |
| Liability for In Home Support Services (IHSS) | 253,234,802 | 238,387,141 | 181,522,714 | 69,537,810 |
| Premium Deficiency Reserve (PDR) | 2,374,525 | 2,374,525 | 13,088,054 | 13,088,054 |
| Medical Cost Reserves | 85,646,537 | 81,126,598 | 71,784,407 | 70,819,543 |
| Total Current Liabilities | 499,676,235 | 459,763,019 | 378,245,943 | 211,535,798 |
| **Non-Current Liabilities** | | | | |
| Noncurrent Premium Deficiency Reserve | 5,919,500 | 5,919,500 | 4,911,946 | 4,911,946 |
| Net Pension Liability GASB 68 | 5,095,514 | 5,020,514 | 5,708,971 | 4,883,971 |
| Total Liabilities | 510,691,249 | 470,703,033 | 388,866,860 | 221,331,715 |
| **Deferred Inflow of Resources** | 1,942,120 | 1,942,120 | 1,892,634 | 1,892,634 |
| **Net Position / Reserves** | | | | |
| Invested in Capital Assets | 4,833,757 | 4,941,913 | 4,616,711 | 4,515,302 |
| Restricted under Knox-Keene agreement | 305,350 | 305,350 | 305,350 | 305,350 |
| Unrestricted Net Equity | 98,236,254 | 67,383,691 | 67,708,893 | 30,416,972 |
| Current YTD Income (Loss) | 148,442 | 30,744,408 | 12,319,603 | 37,393,330 |
| Net Position / Reserves | 103,523,804 | 103,375,361 | 84,950,557 | 72,630,954 |
| **Total Liabilities, Deferred Inflows, and Net Assets** | $ 616,157,172 | $ 576,020,514 | $ 475,710,050 | $ 295,855,303 |
| **Solvency Ratios:** | | | | |
| Working Capital | $ 110,353,656 | $ 110,022,058 | $ 91,480,066 | $ 78,436,872 |
| Working Capital Ratio | 1.2 | 1.2 | 1.3 | 1.4 |
| Average Days Cash on Hand | 50 | 47 | 78 | 55 |

**Santa Clara County Health Authority**
**Income Statement for the One Month Ending July 31, 2016**

| | For the Month of Jul 2016 | | | | | For One Month Ending Jul 31, 2016 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | % of Revenue | Budget | % of Revenue | Variance | Actual | % of Revenue | Budget | % of Revenue | Variance |
| **REVENUES** | | | | | | | | | | |
| MEDI-CAL | $ 87,810,114 | 90.0% | $ 85,994,635 | 90.5% | $ 1,815,479 | $ 87,810,114 | 90.0% | $ 85,994,635 | 90.5% | $ 1,815,479 |
| HEALTHY KIDS | $ 414,410 | 0.4% | $ 393,308 | 0.4% | $ 21,103 | $ 414,410 | 0.4% | $ 393,308 | 0.4% | $ 21,103 |
| MEDICARE | $ 9,361,956 | 9.6% | $ 8,599,800 | 9.1% | $ 762,156 | $ 9,361,956 | 9.6% | $ 8,599,800 | 9.1% | $ 762,156 |
| **TOTAL REVENUE** | $ 97,586,480 | 100.0% | $ 94,987,743 | 100.0% | $ 2,598,738 | $ 97,586,480 | 100.0% | $ 94,987,743 | 100.0% | $ 2,598,738 |
| **MEDICAL EXPENSES** | | | | | | | | | | |
| MEDI-CAL | $ 83,053,576 | 85.1% | $ 82,008,562 | 86.3% | $ (1,045,013) | $ 83,053,576 | 85.1% | $ 82,008,562 | 86.3% | $ (1,045,013) |
| HEALTHY KIDS | $ 334,643 | 0.3% | $ 379,663 | 0.4% | $ 45,021 | $ 334,643 | 0.3% | $ 379,663 | 0.4% | $ 45,021 |
| MEDICARE | $ 10,215,915 | 10.5% | $ 7,989,255 | 8.4% | $ (2,226,660) | $ 10,215,915 | 10.5% | $ 7,989,255 | 8.4% | $ (2,226,660) |
| **TOTAL MEDICAL EXPENSES** | $ 93,604,133 | 95.9% | $ 90,377,481 | 95.1% | $ (3,226,652) | $ 93,604,133 | 95.9% | $ 90,377,481 | 95.1% | $ (3,226,652) |
| **MEDICAL OPERATING MARGIN** | $ 3,982,347 | 4.1% | $ 4,610,262 | 4.9% | $ (627,915) | $ 3,982,347 | 4.1% | $ 4,610,262 | 4.9% | $ (627,915) |
| **ADMINISTRATIVE EXPENSES** | | | | | | | | | | |
| SALARIES AND BENEFITS | $ 1,640,808 | 1.7% | $ 1,466,419 | 1.5% | $ (174,389) | $ 1,640,808 | 1.7% | $ 1,466,419 | 1.5% | $ (174,389) |
| RENTS AND UTILITIES | $ 107,545 | 0.1% | $ 111,941 | 0.1% | $ 4,396 | $ 107,545 | 0.1% | $ 111,941 | 0.1% | $ 4,396 |
| PRINTING AND ADVERTISING | $ 23,971 | 0.0% | $ 43,858 | 0.0% | $ 19,887 | $ 23,971 | 0.0% | $ 43,858 | 0.0% | $ 19,887 |
| INFORMATION SYSTEMS | $ 205,389 | 0.2% | $ 281,362 | 0.3% | $ 75,972 | $ 205,389 | 0.2% | $ 281,362 | 0.3% | $ 75,972 |
| PROF FEES / CONSULTING / TEMP STAFFING | $ 971,613 | 1.0% | $ 927,818 | 1.0% | $ (43,795) | $ 971,613 | 1.0% | $ 927,818 | 1.0% | $ (43,795) |
| DEPRECIATION / INSURANCE / EQUIPMENT | $ 203,336 | 0.2% | $ 175,870 | 0.2% | $ (27,466) | $ 203,336 | 0.2% | $ 175,870 | 0.2% | $ (27,466) |
| OFFICE SUPPLIES / POSTAGE / TELEPHONE | $ 481,469 | 0.5% | $ 503,180 | 0.5% | $ 21,711 | $ 481,469 | 0.5% | $ 503,180 | 0.5% | $ 21,711 |
| MEETINGS / TRAVEL / DUES | $ 64,389 | 0.1% | $ 77,952 | 0.1% | $ 13,563 | $ 64,389 | 0.1% | $ 77,952 | 0.1% | $ 13,563 |
| OTHER | $ 5,100 | 0.0% | $ 4,780 | 0.0% | $ (321) | $ 5,100 | 0.0% | $ 4,780 | 0.0% | $ (321) |
| **TOTAL ADMINISTRATIVE EXPENSES** | $ 3,703,622 | 3.8% | $ 3,593,180 | 3.8% | $ (110,442) | $ 3,703,622 | 3.8% | $ 3,593,180 | 3.8% | $ (110,442) |
| **OPERATING SURPLUS (LOSS)** | $ 278,726 | 0.3% | $ 1,017,082 | 1.1% | $ (738,356) | $ 278,726 | 0.3% | $ 1,017,082 | 1.1% | $ (738,356) |
| **GASB 45-POST EMPLOYMENT BENEFITS EXPENSE** | $ (50,592) | -0.1% | $ (50,592) | -0.1% | $ - | $ (50,592) | -0.1% | $ (50,592) | -0.1% | $ - |
| **GASB 68 - UNFUNDED PENSION LIABILITY** | $ (75,000) | -0.1% | $ (75,000) | -0.1% | $ - | $ (75,000) | -0.1% | $ (75,000) | -0.1% | $ - |
| **INTEREST & OTHER INCOME** | $ (4,691) | 0.0% | $ 39,750 | 0.0% | $ (44,441) | $ (4,691) | 0.0% | $ 39,750 | 0.0% | $ (44,441) |
| **NET SURPLUS (LOSS) FINAL** | $ 148,442 | 0.2% | $ 931,240 | 1.0% | $ (782,798) | $ 148,442 | 0.2% | $ 931,240 | 1.0% | $ (782,798) |

**Administrative Expense**
**Actual vs. Budget**
**For the Current Month & Fiscal Year to Date - Jul 2016**
Favorable/(Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 1,640,808 | $ 1,466,419 | $ (174,389) | -11.9% | Personnel | $ 1,640,808 | $ 1,466,419 | $ (174,389) | -11.9% |
| 2,062,814 | 2,126,760 | 63,947 | 3.0% | Non-Personnel | 2,062,814 | 2,126,760 | $ 63,947 | 3.0% |
| 3,703,622 | 3,593,180 | (110,442) | -3.1% | Total Administrative Expense | 3,703,622 | 3,593,180 | (110,442) | -3.1% |

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

**One Month Ended Jul 31, 2016**

| | Medi-Cal | CMC | Healthy Kids | **Grand Total** |
|---|---|---|---|---|
| **P&L (ALLOCATED BASIS)** | | | | |
| REVENUE | 85,493,122 | 11,678,948 | $414,410 | **$97,586,480** |
| MEDICAL EXPENSES | 80,745,319 | 12,524,171 | 334,643 | **$93,604,133** |
| (MLR) | 94.4% | 107.2% | 80.8% | **95.9%** |
| GROSS MARGIN | 4,747,803 | (845,224) | 79,768 | **3,982,347** |
| ADMINISTRATIVE EXPENSES | 3,207,134 | 443,242 | 53,245 | **3,703,622** |
| *(% MM allocation except CMC)* | | | | |
| OPERATING INCOME/(LOSS) | 1,540,669 | (1,288,465) | 26,522 | **278,726** |
| OTHER INCOME/(EXPENSE) | (114,138) | (15,592) | (553) | **(130,283)** |
| *(% of Revenue Allocation)* | | | | |
| NET INCOME/ (LOSS) | $1,426,530 | ($1,304,057) | $25,969 | **$148,442** |
| **PMPM (ALLOCATED BASIS)** | | | | |
| REVENUE | $324.06 | $1,440.42 | $94.61 | **$353.18** |
| MEDICAL EXPENSES | 306.06 | 1,544.67 | 76.40 | **338.77** |
| GROSS MARGIN | 18.00 | (104.25) | 18.21 | **14.41** |
| ADMINISTRATIVE EXPENSES | 12.16 | 54.67 | 12.16 | **13.40** |
| OPERATING INCOME/(LOSS) | 5.84 | (158.91) | 6.06 | **1.01** |
| OTHER INCOME / (EXPENSE) | (0.43) | (1.92) | (0.13) | **(0.47)** |
| NET INCOME / (LOSS) | $5.41 | ($160.84) | $5.93 | **$0.54** |
| **ALLOCATION BASIS:** | | | | |
| *MEMBER MONTHS - YTD* | *263,821* | *8,108* | *4,380* | ***276,309*** |
| *Member MONTHS by LOB* | *95.5%* | *2.9%* | *1.6%* | ***100%*** |
| *Revenue by LOB* | *87.6%* | *12.0%* | *0.4%* | ***100%*** |

**Santa Clara Family Health Plan**
**Statement of Cash Flows**
**For One Month Ended Jul 31, 2016**

| | | |
|---|---|---|
| Cash flows from operating activities | | |
| Premiums received | $ | 89,761,433 |
| Medical expenses paid | $ | (73,547,052) |
| Administrative expenses paid | $ | (5,546,314) |
| Net cash from operating activities | $ | 10,668,067 |
| Cash flows from capital and related financing activities | | |
| Purchases of capital assets | $ | (52,011) |
| Cash flows from investing activities | | |
| Interest income and other income, net | $ | (4,691) |
| Net (Decrease) increase in cash and cash equivalents | $ | 10,611,365 |
| Cash and cash equivalents, beginning of year | $ | 146,082,070 |
| Cash and cash equivalents at Jul 31, 2016 | $ | 156,693,435 |
| Reconciliation of operating income to net cash from operating activities | | |
| Operating income (loss) | $ | 153,133 |
| Adjustments to reconcile operating income to net cash from operating activities | | |
| Depreciation | $ | 160,167 |
| Changes in operating assets and liabilities | | |
| Premiums receivable | $ | (29,239,211) |
| Due from Santa Clara Family Health Foundation | $ | - |
| Prepaids and other assets | $ | (394,238) |
| Deferred outflow of resources | $ | - |
| Accounts payable and accrued liabilities | $ | (1,558,029) |
| State payable | $ | 21,414,163 |
| Santa Clara Valley Health Plan payable | $ | 689,482 |
| Net Pension Liability | $ | 75,000 |
| Medical cost reserves and PDR | $ | 4,519,939 |
| Deferred inflow of resources | $ | - |
| Total adjustments | $ | 10,514,934 |
| Net cash from operating activities | $ | 10,668,067 |

## Santa Clara Family Health Plan Enrollment Summary

| | For the Month of Jul 2016 | | | One Month Ending Jul 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** | **Prior Year Actual** | **Change FY17 vs. FY16** |
| Medi-Cal | 263,821 | 261,091 | 1.0% | 263,821 | 261,091 | 1.0% | 238,201 | 10.8% |
| Healthy Kids | 4,380 | 4,466 | ( 1.9%) | 4,380 | 4,466 | ( 1.9%) | 4,496 | ( 2.6%) |
| Medicare | 8,108 | 8,028 | 1.0% | 8,108 | 8,028 | 1.0% | 7,543 | 7.5% |
| Total | 276,309 | 273,584 | 1.0% | 276,309 | 273,584 | 1.0% | 250,240 | 10.4% |

**Santa Clara Health Authority**
**July 2016**

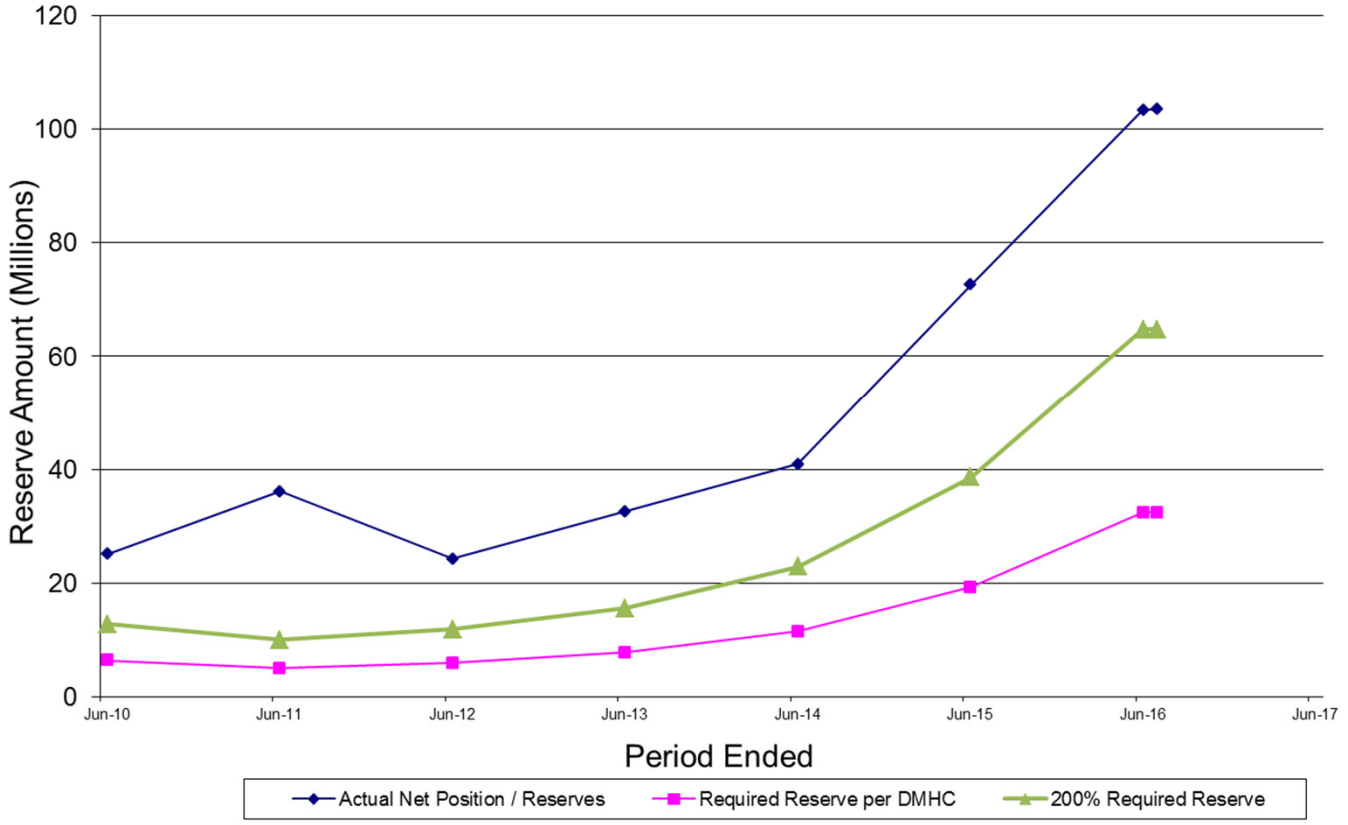
| Network | Medi-Cal | | Healthy Kids | | CMC | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contact Physicians | 24,132 | 9% | 267 | 6% | 8,108 | 100% | 32,507 | 12% |
| SCVVHS, Safety Net Clinics, FQHC Clinics | 140,753 | 53% | 2,834 | 65% | - | 0% | 143,587 | 52% |
| Palo Alto Medical Foundation | 7,553 | 3% | 37 | 1% | - | 0% | 7,590 | 3% |
| Physicians Medical Group | 47,856 | 18% | 1,083 | 25% | - | 0% | 48,939 | 18% |
| Premier Care | 16,284 | 6% | 159 | 4% | - | 0% | 16,443 | 6% |
| Kaiser | 27,243 | 10% | - | 0% | - | 0% | 27,243 | 10% |
| **Total** | **263,821** | **100%** | **4,380** | **100%** | **8,108** | **100%** | **276,309** | **100%** |
| Enrollment at June 30, 2016 | 260,029 | | 4,435 | | 8,203 | | 272,667 | |
| Net Change from Beginning of FY17 | 1.5% | | -1.2% | | -1.2% | | 1.3% | |

# Santa Clara Family Health Plan
# Enrollment by Aid-Category

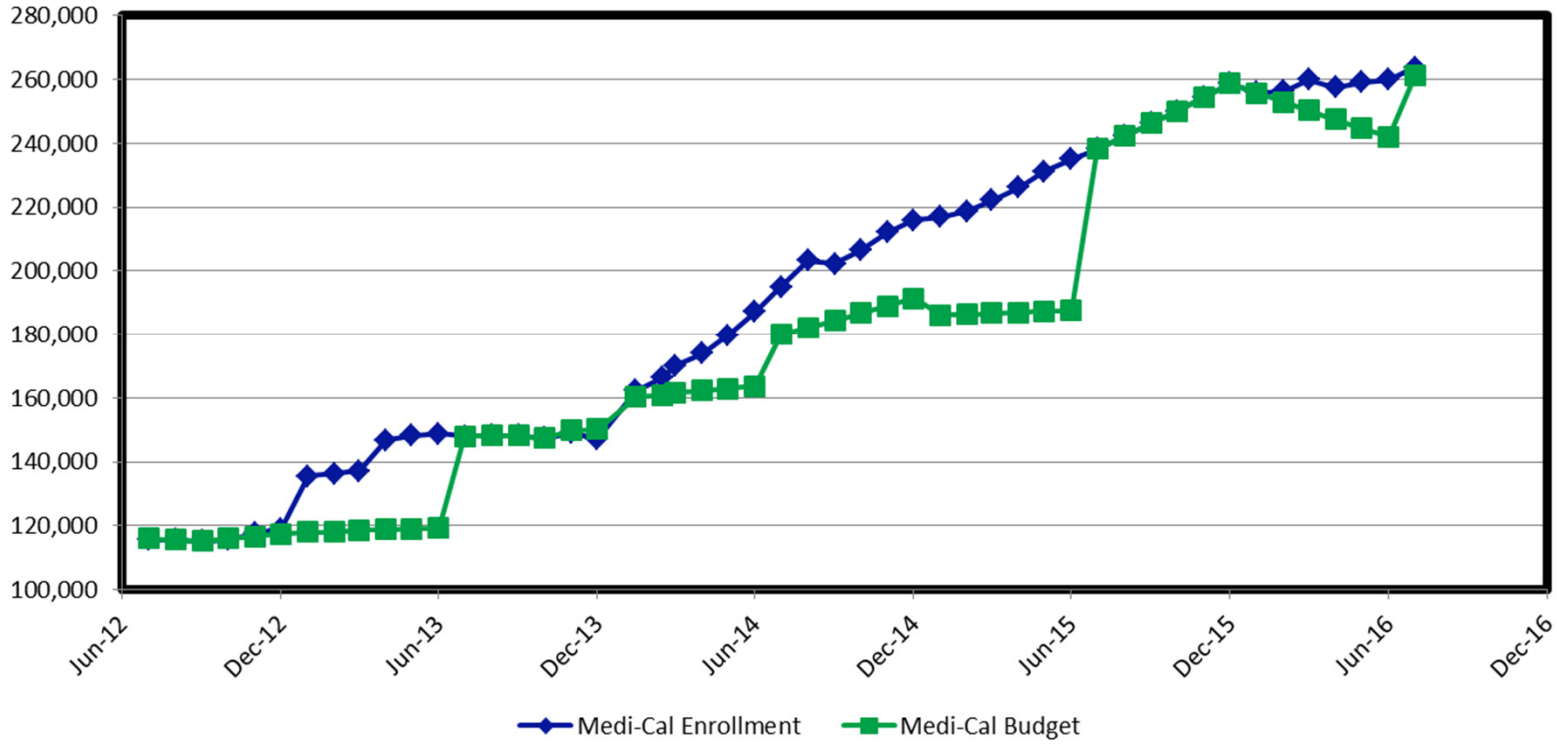
| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 2015-07 | 2015-08 | 2015-09 | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 | 2016-06 | 2016-07 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 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 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 | 105,341 | 105,840 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 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 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 | 10,840 | 10,816 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 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 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 | 81,785 | 82,982 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 | 38 | 40 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 | 269 | 266 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 | 236,684 | 240,455 |
| | | | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 | 14,502 | 14,541 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 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 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 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 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 | 992 | 975 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 | 260,029 | 263,821 |
| | | | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 | 7,874 | 7,784 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 | 329 | 324 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** | **272,667** | **276,309** |

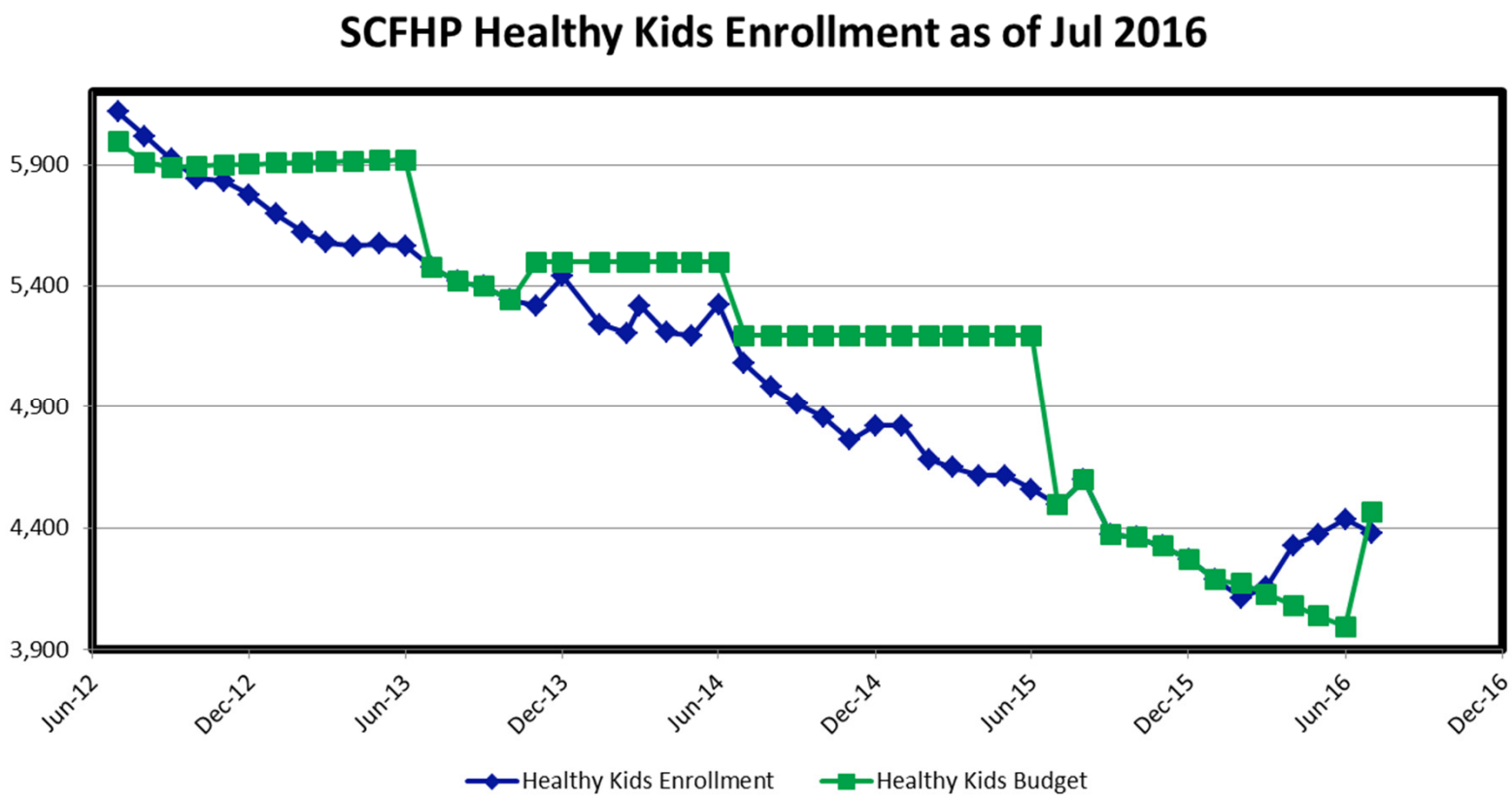
**Santa Clara County Health Authority**
**Tangible Net Equity - Actual vs. Required**
**As of Period Ended:**

| | 6/30/2010 | 6/30/2011 | 6/30/2012 | 6/30/2013 | 6/30/2014 | 6/30/2015 | 6/30/2016 | 7/31/2016 |
|---|---|---|---|---|---|---|---|---|
| **Actual Net Position / Reserves** | 25,103,011 | 36,093,769 | 24,208,576 | 32,551,161 | 40,872,580 | 72,630,954 | 103,375,361 | 103,523,804 |
| **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 | 32,375,000 |
| **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 | 64,750,000 |



## SCFHP Medi-Cal Enrollment as of Jul 2016




SCFHP Healthy Kids Enrollment as of Jul 2016
5,900
5,400
4,900
4,400
3,900
Jun-12
Dec-12
Jun-13
Dec-13
Jun-14
Dec-14
Jun-15
Dec-15
Jun-16
Dec-16
Healthy Kids Enrollment
Healthy Kids Budget

# July 2016
# Financial Summary

SCCHA Governing Board Meeting

September 22, 2016

# Fiscal Year 2016-17 Highlights

- **Net Surplus –** July and YTD $0.1m surplus ($0.8m unfavorable to budget)
- **Enrollment –** July and YTD 2016 membership: 276,309 (1.0% favorable to budget).
  - Continued growth in Adult (over 19) and Medi-Cal Expansion membership. Agnews membership no longer being tracked separately. CMC membership has been trending downward since January.
- **Revenue –** over budget by $2.6 m (+2.7%)
  - Increase is due to higher than budgeted months resulting in higher expansion revenue and IHSS revenue. There was also additional retroactivity related revenue. These positive variances were partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to Risk Adjustment Factor payment.
- **Medical Expenses –** over budget by $3.2m (-3.6%)
  - Increase is due to higher than budgeted member months. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by lower Professional FFS and Pharmacy expenses.
- **Administrative Expenses –** over budget by $0.1m (-3.1%)
  - Personnel costs were over budget due to open positions being filled by consulting and temporary staffing resources as well as the overall vacancy rate being lower than budget. Some of this unfavorability was offset by lower information service expenses and legal expenses.
- **Other Expenses –** over budget by $44 thousand due to prior FY interest adjustment in July.
- **Balance Sheet**
  - Net receivables from DHCS for IHSS and CCI rate recast continued to increase. IHSS receivable have a corresponding increase in payables.
  - Medi-Cal Expansion rate overpayment over-payment continues; albeit, the difference is lower in FY16 due to reduced FY17 payment rate. This and an increase in medical cost reserves improved the cash position.
  - TNE of $103.5M or 320% of Required TNE of $32.4m per DMHC.

# Consolidated Performance
# July 2016 and Year to Date

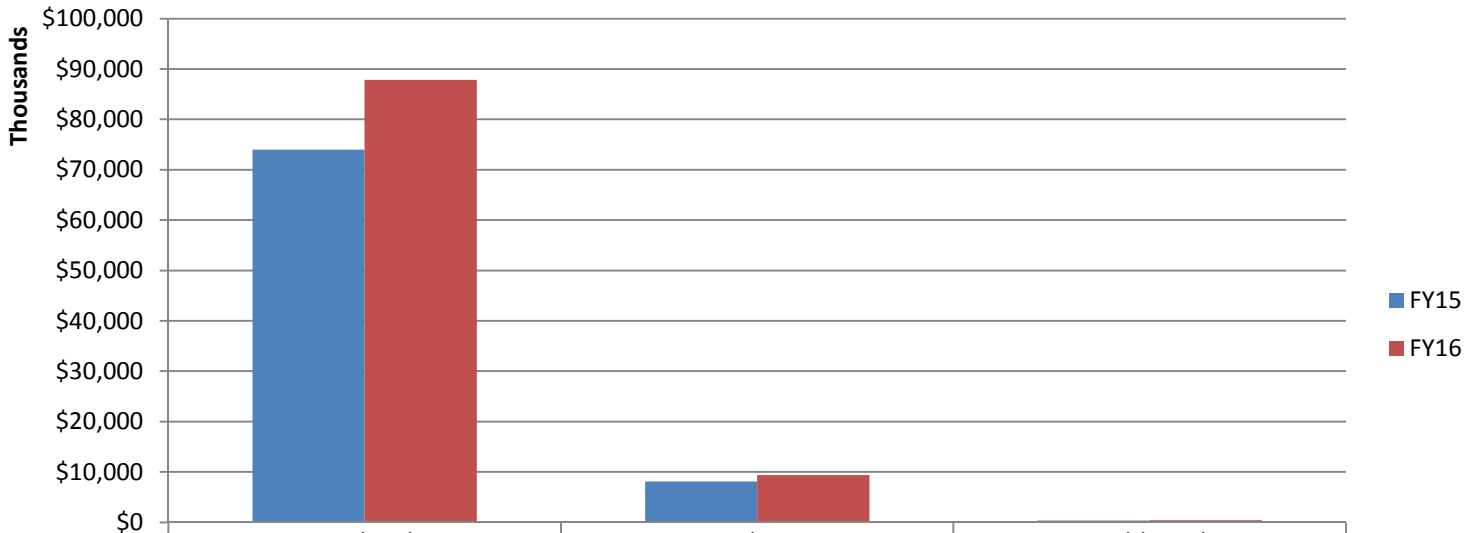
| | Month of Jul | FYTD through Jul |
|---|---|---|
| **Revenue** | $97.6 million | $97.6 million |
| **Medical Costs** | $93.6 million | $93.6 million |
| **Medical Loss Ratio** | 95.9% | 95.9% |
| **Administrative Costs** | $3.7 million (3.8%) | $3.7 million (3.8%) |
| **Other Income/ Expense** | ($130,283) | ($130,283) |
| **Net Surplus (Loss)** | $148,442 | $148,442 |
| | | |
| Cash on Hand | | $156.7 million |
| Net Cash Available to SCFHP | | $3.2 million |
| Receivables | | $437.6 million |
| Current Liabilities | | $499.7 million |
| Tangible Net Equity | | $103.5 million |
| Pct. Of Min. Requirement | | **320%** |

# Consolidated Performance

**Summary Operating Results - Actual vs. Budget**
**For the Current Month & Fiscal Year to Date - Jul 2016**
Favorable/(Unfavorable)

| Current Month | | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| Actual | Budget | Variance $ | Variance % | | Actual | Budget | Variance $ | Variance % |
| $ 97,586,480 | $ 94,987,743 | $ 2,598,738 | 2.7% | Revenue | $ 97,586,480 | $ 94,987,743 | $ 2,598,738 | 2.7% |
| 93,604,133 | 90,377,481 | (3,226,652) | -3.6% | Medical Expense | 93,604,133 | 90,377,481 | (3,226,652) | -3.6% |
| 3,982,347 | 4,610,262 | (627,915) | -13.6% | Gross Margin | 3,982,347 | 4,610,262 | (627,915) | -13.6% |
| 3,703,622 | 3,593,180 | (110,442) | -3.1% | Administrative Expense | 3,703,622 | 3,593,180 | (110,442) | -3.1% |
| 278,726 | 1,017,082 | (738,356) | -72.6% | Net Operating Income | 278,726 | 1,017,082 | (738,356) | -72.6% |
| (130,283) | (85,842) | (44,441) | -51.8% | Non-Operating Income/Exp | (130,283) | (85,842) | (44,441) | -51.8% |
| $ 148,442 | $ 931,240 | $ (782,798) | -84.1% | Net Surplus/ (Loss) | $ 148,442 | $ 931,240 | $ (782,798) | -84.1% |

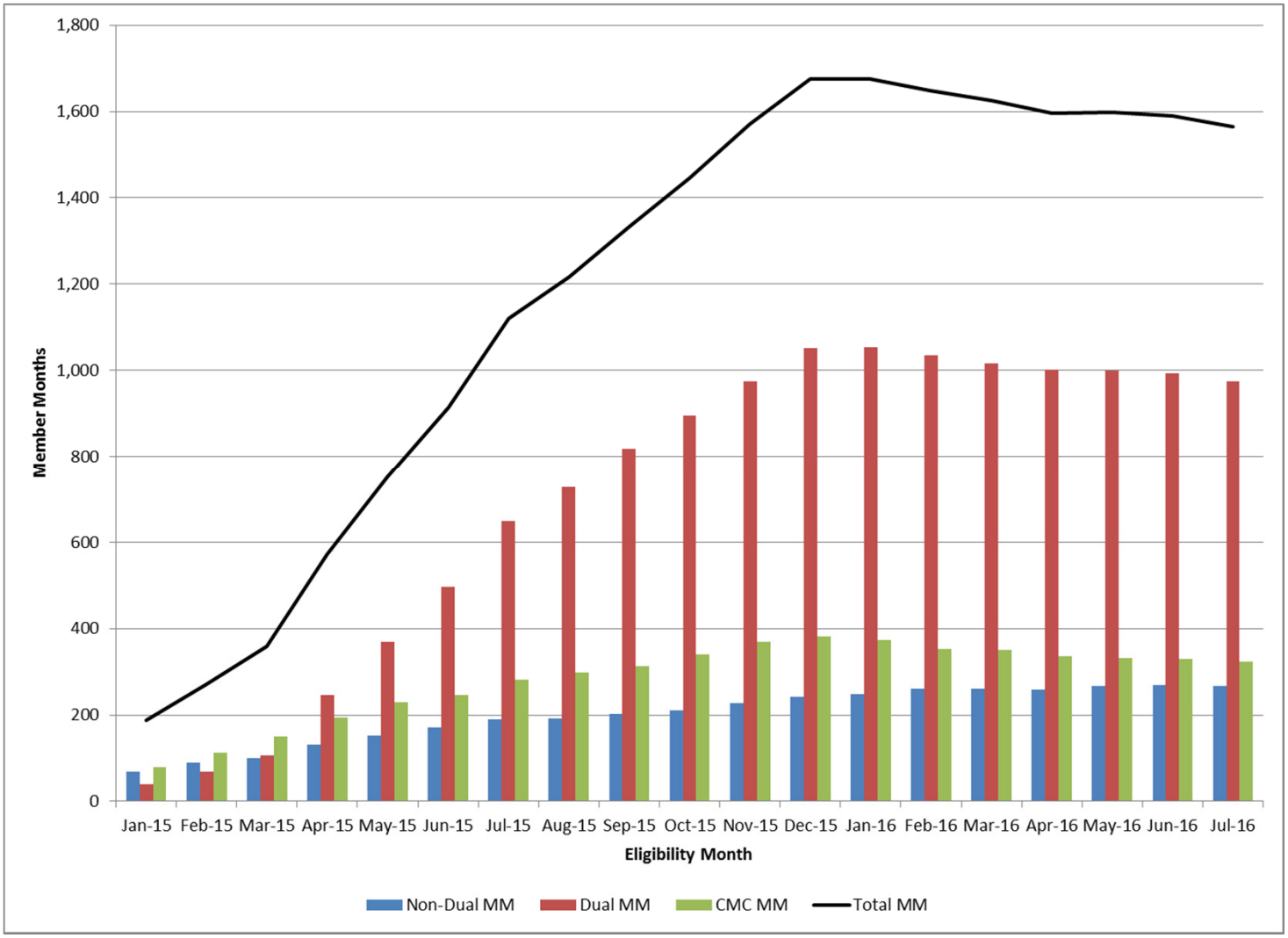
# Year Over Year Revenue Trend



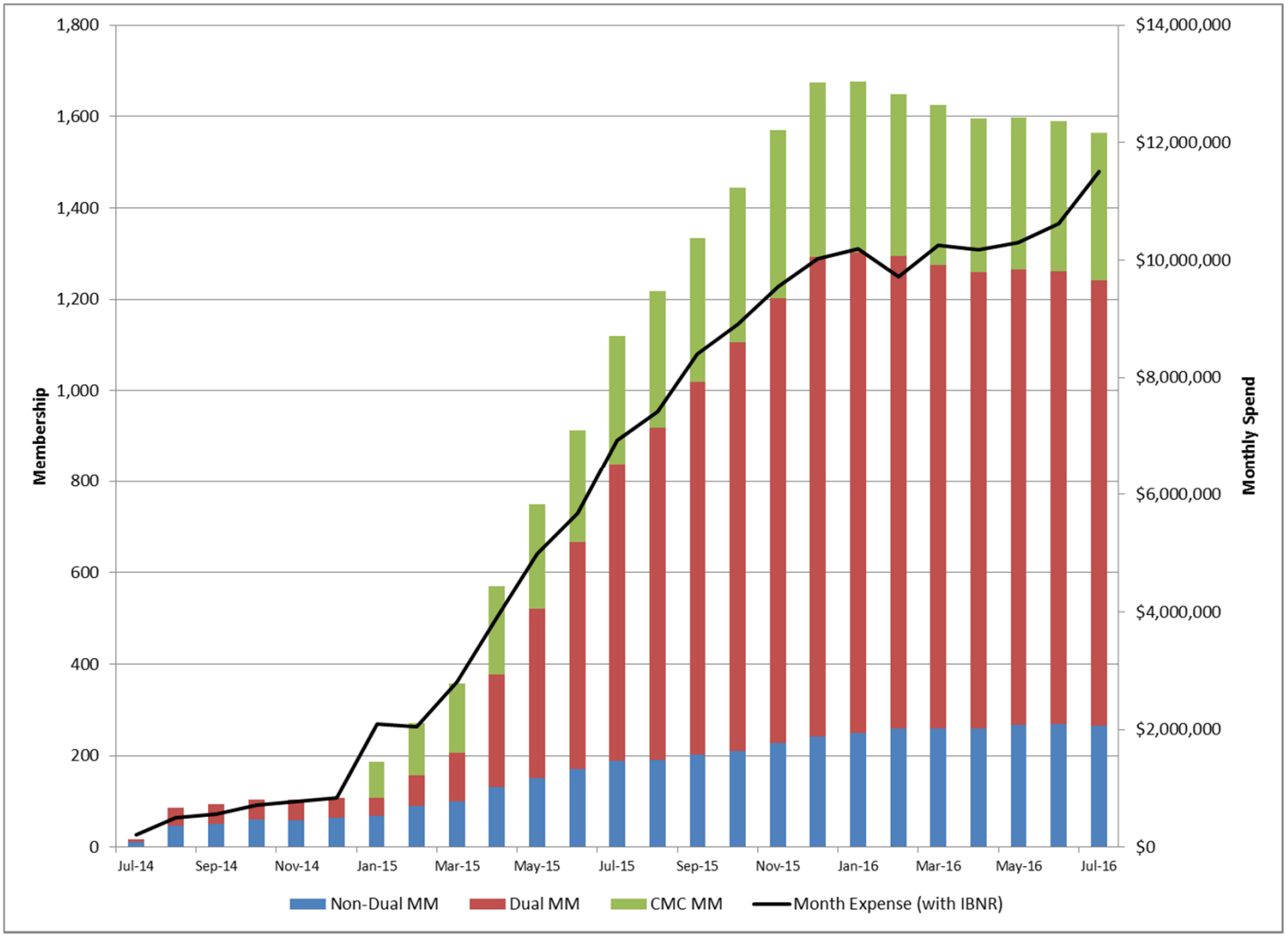

| | Medi-Cal | Medicare | Healthy Kids |
|---|---|---|---|
| FY15 | $74,013,434 | $8,091,637 | $390,404 |
| FY16 | $87,810,114 | $9,361,956 | $414,410 |

*Medi-Cal revenue increased by 19% and Medicare revenue increased by 16%.*

# Long Term Care Membership
# Medi-Cal and CMC



# Medi-Cal Long Term Care Experience
# July 2014 – July 2016



# Enrollment Summary
# July and YTD

| | For the Month of Jul 2016 | | | One Month Ending Jul 2016 | | | | |
|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | Actual | Budget | Variance | Prior Year Actual | Change FY17 vs. FY16 |
| Medi-Cal | 263,821 | 261,091 | 1.0% | 263,821 | 261,091 | 1.0% | 238,201 | 10.8% |
| Healthy Kids | 4,380 | 4,466 | ( 1.9%) | 4,380 | 4,466 | ( 1.9%) | 4,496 | ( 2.6%) |
| Medicare | 8,108 | 8,028 | 1.0% | 8,108 | 8,028 | 1.0% | 7,543 | 7.5% |
| Total | 276,309 | 273,584 | 1.0% | 276,309 | 273,584 | 1.0% | 250,240 | 10.4% |

# Enrollment by Network - YTD

**Santa Clara Health Authority**
**July 2016**

| Network | Medi-Cal | | Healthy Kids | | CMC | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total | Enrollment | % of Total |
| Direct Contact Physicians | 24,132 | 9% | 267 | 6% | 8,108 | 100% | 32,507 | 12% |
| SCVVHS, Safety Net Clinics, FQHC Clinics | 140,753 | 53% | 2,834 | 65% | - | 0% | 143,587 | 52% |
| Palo Alto Medical Foundation | 7,553 | 3% | 37 | 1% | - | 0% | 7,590 | 3% |
| Physicians Medical Group | 47,856 | 18% | 1,083 | 25% | - | 0% | 48,939 | 18% |
| Premier Care | 16,284 | 6% | 159 | 4% | - | 0% | 16,443 | 6% |
| Kaiser | 27,243 | 10% | - | 0% | - | 0% | 27,243 | 10% |
| **Total** | **263,821** | **100%** | **4,380** | **100%** | **8,108** | **100%** | **276,309** | **100%** |
| Enrollment at June 30, 2016 | 260,029 | | 4,435 | | 8,203 | | 272,667 | |
| Net Change from Beginning of FY17 | 1.5% | | -1.2% | | -1.2% | | 1.3% | |

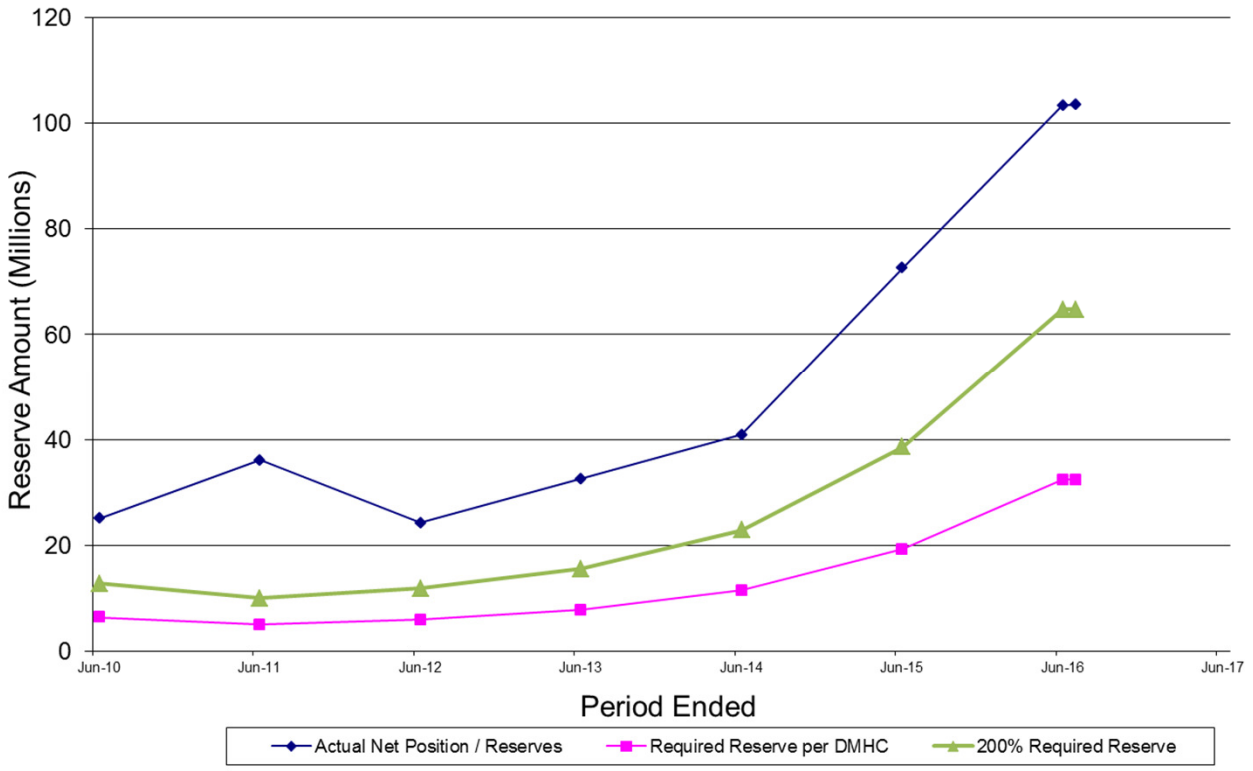
Membership has increased 1.3% since the beginning of the Fiscal Year, primarily as a result of Medi-Cal Expansion, which started January 1, 2014 and has grown to 84,361 members.

# Enrollment by Aid Category

| | 2015-01 | 2015-02 | 2015-03 | 2015-04 | 2015-05 | 2015-06 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult (over 19) | 31,337 | 30,489 | 30,078 | 29,351 | 28,694 | 28,174 | 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 |
| Adult (under 19) | 80,858 | 82,029 | 83,777 | 85,840 | 88,550 | 90,811 | 92,782 | 95,564 | 97,888 | 99,822 | 101,801 | 103,082 | 102,500 | 103,017 | 104,739 | 104,442 | 105,204 | 105,341 | 105,840 |
| Aged - Medi-Cal Only | 8,208 | 8,425 | 8,366 | 8,522 | 8,664 | 8,731 | 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 |
| Disabled - Medi-Cal Only | 11,687 | 11,648 | 11,613 | 11,516 | 11,533 | 11,455 | 11,426 | 11,348 | 11,297 | 11,250 | 11,263 | 11,130 | 11,105 | 11,065 | 10,996 | 10,952 | 10,892 | 10,840 | 10,816 |
| Child (HF conversion) | 17,664 | 16,784 | 15,827 | 14,420 | 12,762 | 11,153 | 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 |
| Adult Expansion | 58,718 | 59,291 | 61,035 | 63,336 | 66,475 | 68,720 | 71,183 | 73,695 | 75,814 | 77,756 | 79,406 | 81,235 | 79,284 | 79,392 | 81,324 | 79,933 | 80,940 | 81,785 | 82,982 |
| Other | 44 | 50 | 49 | 53 | 52 | 51 | 48 | 47 | 55 | 47 | 45 | 45 | 40 | 40 | 42 | 42 | 40 | 38 | 40 |
| Long Term Care | 68 | 90 | 101 | 131 | 152 | 171 | 189 | 191 | 202 | 211 | 228 | 242 | 249 | 260 | 260 | 259 | 267 | 269 | 266 |
| Total Non-Duals | 208,584 | 208,806 | 210,846 | 213,169 | 216,882 | 219,266 | 221,655 | 224,697 | 227,226 | 229,718 | 232,912 | 235,923 | 233,139 | 233,280 | 236,924 | 234,510 | 235,963 | 236,684 | 240,455 |
| | | | | | | | | | | | | | | | | | | | |
| Aged | 4,295 | 5,381 | 6,274 | 7,339 | 8,340 | 9,299 | 9,998 | 10,673 | 11,579 | 12,436 | 13,389 | 14,048 | 14,078 | 14,249 | 14,332 | 14,306 | 14,419 | 14,502 | 14,541 |
| Disabled | 2,461 | 2,913 | 3,251 | 3,659 | 4,030 | 4,444 | 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 |
| Other | 841 | 883 | 951 | 1,009 | 1,066 | 1,151 | 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 |
| Long Term Care | 39 | 68 | 106 | 247 | 369 | 496 | 649 | 727 | 818 | 894 | 974 | 1,051 | 1,054 | 1,035 | 1,015 | 1,001 | 999 | 992 | 975 |
| Total Duals | 7,636 | 9,245 | 10,582 | 12,254 | 13,805 | 15,390 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| Total Medi-Cal | 216,220 | 218,051 | 221,428 | 225,423 | 230,687 | 234,659 | 238,267 | 242,332 | 246,228 | 250,050 | 254,610 | 258,702 | 255,958 | 256,288 | 260,030 | 257,578 | 259,186 | 260,029 | 263,821 |
| | | | | | | | | | | | | | | | | | | | |
| Healthy Kids | 4,793 | 4,665 | 4,623 | 4,584 | 4,595 | 4,541 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| CMC Non-Long Term Care | 5,477 | 6,049 | 6,397 | 7,033 | 6,607 | 6,941 | 7,261 | 7,399 | 7,599 | 8,014 | 8,537 | 9,317 | 8,786 | 8,533 | 8,378 | 8,152 | 8,035 | 7,874 | 7,784 |
| CMC - Long Term Care | 80 | 113 | 151 | 193 | 229 | 246 | 282 | 299 | 313 | 340 | 369 | 382 | 373 | 353 | 350 | 336 | 332 | 329 | 324 |
| Total CMC | 5,557 | 6,162 | 6,548 | 7,226 | 6,836 | 7,187 | 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 |
| | | | | | | | | | | | | | | | | | | | |
| **Total Enrollment** | **226,570** | **228,878** | **232,599** | **237,233** | **242,118** | **246,387** | **250,306** | **254,628** | **258,515** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** | **272,667** | **276,309** |

# Tangible Net Equity at July 31, 2016

TNE is $103.5 million or 320% of the Required TNE of $32.4m per the Department of Managed Health Care (DMHC). The Plans reserves are roughly $49.4 million below the current reserve target of two months' Medi-Cal capitation revenue.



# Reserve & Liquidity Strategies

**Santa Clara Family Health Plan**
**Governing Board Meeting**
**September 22, 2016**

**Dave Cameron,**
**Chief Financial Officer**

# Introduction

- **Prior Discussions of Reserve Policies:**
  - Board set initial reserve target in December 2011
  - Board requested review of reserve policy in June 2015
  - Board requests from two recent Board presentations on reserves:
    - Review TNE (Tangible Net Equity) options for the reserve target
    - Incorporate a liquidity target
- **Goals for Today's Presentation:**
  - Review need for financial reserves
  - Discuss current reserve policy/target & options
  - Discuss concurrent need for a liquidity target
  - Review recommendations

# Why Does SCFHP Need Reserves?

1. To Meet Regulatory Requirements for Tangible Net Equity (TNE)

2. To Provide **Financial Solvency** to Mitigate Volatility
    1. Underfunding of programs (e.g. SPD roll-out in 2011/2012)
    2. Delayed program payments
    3. Benefit & program changes (e.g., hepatitis C, mental health, autism)
    4. Large and/or sustained adverse Events (H1N1, unusual inpatient costs, etc.)

3. To Provide **Liquidity** to Sustain SCFHP and Its Providers During Periods of Insufficient or Delayed Revenue
    1. Delayed rates on new programs or benefits: Cal Medi-Connect (CMC) & Managed Long-Term Services & Supports (MLTSS)
    2. Delayed payments due to State budget stalemates (2008-2010)
    3. DHCS efficiency factors resulting in rate reductions
    4. Future rate actions that do not cover claims trends

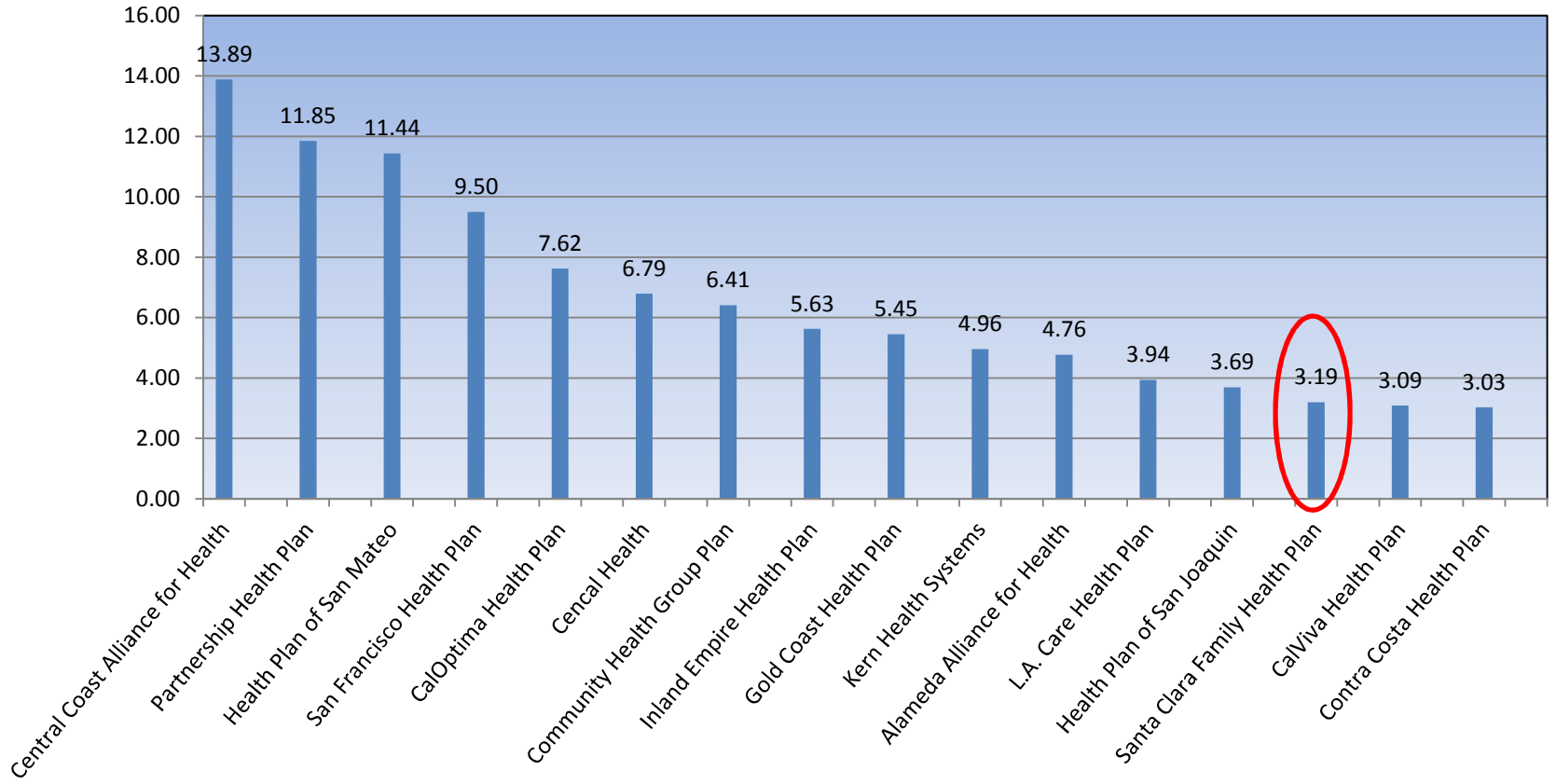
4. Financial Solvency and Liquidity Provide for Future Membership Growth and Infrastructure Investments
    1. Pilot programs/expansion (CMC/MLTSS)
    2. Facilities expansion
    3. Investments for new programs (Health Homes or Whole Person Care pilots, etc.)

# Current Policy & Future Options

- Established By the Board in December 2011:
  - Represents two months of Medi-Cal premium revenue
  - SCFHP has not met this target since it was established
  - Currently at approximately 1.1 months of premium revenue
- Other Plans are Currently Evaluating Their Reserve & Liquidity Policies
- Options for TNE or Reserves Policy
  - A multiple of capitation revenue (current SCFHP approach, used by other plans)
  - A multiple of medical + administrative expenses (used by other plans)
  - A multiple of required minimum TNE
    - This approach is benchmarked off the DMHC Minimum Required TNE
    - Simple and allows easy understanding of the Plan's solvency risk

# Public Plan TNE % as of 06/30/16

Public Plan Unweighted Average = 626%; SCFHP = 319%




SCFHP is Near the Low End of the TNE Range of All Public Plans.

# Financial Solvency - Target

## Tangible Net Equity (TNE) - Definitions

- Minimum Required TNE is based on % of fee-for-service (FFS) claims
  - SCFHP's Minimum Required TNE is currently $32.4 million
- Below 200% of Required Minimum TNE, plan on DMHC's "Watch List"and can require monthly reporting and increased scrutiny
- Below 130% of Required Minimum TNE, plan is considered in financial jeopardy and DMHC can take control of health plan (e.g., Alameda Alliance for Health)

## TNE Comparison (Page 5 Graph)

- At 06/30/16, SCFHP at $103.4 million or 319% of Required Minimum TNE
  - Local plans range from 303% to 1389% at 06/30/16
  - Unweighted average of public plans = 626%
  - SCFHP is on the low end of public plan reserve levels
- Actual TNE is not correlated to plan size

<u>It is Reasonable for SCFHP to Set a Reserve Target at 350-500% of Minimum Required TNE</u>

# Liquidity - Financial Stability

- There is No “Liquidity” Requirement in the State Contract
- DMHC Requires Plans have a “Current Ratio” of at least 1.0
  - Current Ratio = Current Assets Divided by Current Liabilities
  - Currently, SCFP’s Current Ratio is 1.24
  - Current Ratio provides a measure of the plan’s ability to meet short-term financial obligations
  - However
    - Current Assets include non-cash accounts like “Premiums Receivable” from the State or Federal Governments
    - Current Liabilities include Pass-Through Amounts Owing Back to the State and others
  - Therefore, Current Ratio is not a true measure of liquidity
- Typically, Medi-Cal Rates are Paid 18-24 Months After the Fact and Cal Medi-Connect Even Longer.
  - Lengthy Rate Approval Timeframes Necessitate Higher Liquidity
- “Cash is King” – Need to Establish a Liquidity Target That Will Provide Financial Stability to the Plan and its Provider Partners

# Liquidity – Why Important?

It is Important to Establish a Liquidity Target Because TNE and Current Ratio are Accounting-Based Measures; But Only Cash Pays Expenses

- TNE and Current Ratios can be achieved with little-to-no cash in the bank (assets can also be in the form of Premium Receivables or Fixed Assets (e.g., real estate) that may not be readily converted to cash

- Sufficient Liquidity Meets Several Essential Needs:
  - Ensures that Plan can keep operating to serve our members
  - Ensures that Plan can continue to pay our providers
  - Supports staff who care for our members and serve our providers
- There Have Been Times When the State or Federal Government Has Delayed Payments to Plans (e.g., State Budget Impasses)
- The Plan Needs to be Ready to Serve the Community Even When Revenue is Not Received

# Liquidity - Target

Many Medi-Cal Managed Care Plans are Establishing Liquidity Targets to Ensure Adequate Funds are Available to Make Payments Should a Short-Term Funding Gap Occur.

SCFHP Should Establish a Liquidity target of 45-60 Days of expenses. This Will Enable Provider Payments and Plan Operations to Continue - (Enrollment, Provider & Member Support, Medical Authorizations, etc.)

For Ease of Monitoring, "Liquidity" Will Be Defined as **Net Cash Available to SCFHP** (currently Cash & Investments of $146.1 million less Pass-Through Liabilities of $131.8 million = Net Cash Available to SCFHP of $14.3 million)

This Definition is Easy to Observe and Will Be Presented on Monthly Balance Sheet Reports.

# Recommendations

- Establish a Reserve Target Range of 350%-500% of Minimum Required TNE
  - Consistent with other plans
  - Sufficient solvency to withstand cost shocks or rate reductions
  - Currently represents a Reserve Target of $113-$163 million

- Establish a Liquidity Target Range of 45-60 days of Medical and Administrative Expenses (based on budgeted operating expenses)
  - Ensures stability to the Plan
  - Ensures payment stability to providers in periods of interrupted capitation revenue
  - Currently represents a Liquidity Target of $138-184 million

Staff To Provide an Annual Review of the Reserve Policy to the Board Concurrent with the Approval of the Annual Operating Budget

# How to Obtain These Targets

- Currently For SCFHP:
  - With TNE of $103.4 million, SCFHP is $10-$59 million below the Recommended Reserve Target
  - With Cash Available to SCFHP of $14.3 million, SCFHP is $124-$170 million below the Recommended Liquidity Target.
    - The Plan temporarily has an unusually high amount of receivables, largely from DHCS.
    - Once these receivables are paid, Cash Available to SCFHP will significantly increase.

- Both Targets Could Be Achieved With Approximately Two to Five Years of Sustained Profitability

Santa Clara
Family Health Plan

# FY 2015-16 FOCUS
## Improve Infrastructure & Achieve Operational Excellence

| | Plan Objectives | Success Measures | Year-End Status |
|---|---|---|---|
| 1 | Enhance compliance program for audit readiness | Conduct gap analyses and complete corrective action plans | ○ Interviewed consultants; engaged WeiserMazars in November<br>○ State and CMS Survey Readiness Assessments conducted; reports issued March 3rd and April 14th<br>○ Overhauled policy and procedure structure and content organization-wide to meet regulatory and accreditation requirements<br>○ Adopted new Board Committee and reporting structure<br>○ Ongoing work plan to foster audit-ready processes<br>○ Developed compliance dashboard |
| 2 | Develop and initiate project plan to achieve NCQA accreditation for CMC in 2018 | Draft project plan in 4Q'15 and conduct gap analysis in 1Q'16 | ○ Preliminary project plan drafted; revisions underway to incorporate gap analysis<br>○ NCQA Accreditation Readiness Assessment conducted by WeiserMazars; report issued April 15th |
| 3 | Negotiate agreement with SEIU | Signed agreement by June 2016 | ○ Memorandum of Understanding with SEIU ratified in April 2016<br>○ Compensation Committee and re-benchmarking of all positions underway<br>○ Continuing to develop positive working relationship with SEIU |
| 4 | Evaluate and pursue integration opportunities with Valley Health Plan and Valley Medical Center | Evaluate twelve opportunities and pursue where indicated | ○ Developed Collaboration Work Plan with consideration of 19 potential opportunities<br>○ Fostered an ongoing spirit of collaboration, including monthly meetings with the VHP CEO, in addition to topic-specific meetings<br>○ Board Team and staff met with the County five times; agreed to pursue joint strategic planning in 4Q'16 |

| | | | |
|---|---|---|---|
| 5 | **Upgrade systems to meet operational needs of the plan** | • Complete preparations for ICD-10 by October 1, 2015<br>• Complete implementation of QNXT for CMC in 4Q'15<br>• Finalize recommendation for Medi-Cal system by 1Q'16 | ○ Preparations for ICD-10 completed by October 1, 2015<br>○ Finished implementation of all known major issues in CMC QNXT in 2Q'16<br>○ Medi-Cal system RFQ issued; Board authorized in June; contract signed with TriZetto June 30th for system and de-hosting |
| 6 | **Maximize members served through quality and service** | • Five Medi-Cal HEDIS measures increase to next percentile tier, including two achieving 90th percentile benchmark<br>• No Medi-Cal HEDIS measures below 10th percentile<br>• Benchmark Portal Center of Excellence recertification by 2Q'16 | ○ Five Medi-Cal HEDIS measures increased to next percentile tier, with three achieving 90th percentile<br>○ One Medi-Cal HEDIS measure below 10th percentile (new methodology for Cervical Cancer Screening---no plan higher than prior year 10th percentile)<br>○ Decision to focus on NCQA call center service standards rather than pursue Benchmark Portal recertification |
| 7 | **Achieve budgeted financial performance** | Achieve FY 2015-16 Net Surplus of $11.6 million | ○ FY 2015-16 Net Surplus of $21 million<br>*(does not include PDR adjustment)* |
| | | | |

**Critical Priority**

| | | |
|---|---|---|
| **Membership Growth:** | June '16 – 272,667 members | 10.7% increase in members (26,280) |
| | June '15 – 246,387 members | 19.0% increase in member months |
| **Revenue Growth:** | FY 2015-16 – $1,168.8 million | $ 266.5 million increase in revenue |
| | FY 2014-15 – $ 902.3 million | 29.5% increase in revenue |
| **Employee Hiring:** | June '16 – 164 staff/25 temps | 22.5% turnover rate (35 departures) |
| | June '15 – 137 staff/26 temps | 75 new hires |

**Opportunities:**

- Finish restructuring and hiring to meet programmatic and compliance needs.
- Automate reporting for ongoing tracking, trending, and root cause analysis.
- Refine, document, and train to, compliant processes.

Santa Clara Family Health Plan

SANTA CLARA VALLEY MEDICAL CENTER

Valley Health Plan

# COLLABORATION WORK PLAN
## September 2016

| | Potential Opportunities | Considerations | Status |
|---|---|---|---|
| 1 | **Provision of specialty drugs** | | **COMPLETE**<br>• Valley joined Diplomat as a specialty drug vendor for Santa Clara Family Health Plan (SCFHP) (Sept. '15) |
| 2 | **Share Durable Medical Equipment RFP** | ○ Valley Health Plan (VHP) engaging in the Durable Medical Equipment RFP process | **COMPLETE**<br>• SCFHP provided copy of 2013 RFP upon request (Sept. '15) |
| 3 | **Health Plan Alliance membership** | ○ The trade association for provider-owned health plans does not allow plans in same geographic area to both join without permission | **COMPLETE**<br>• SCFHP gave Health Plan Alliance permission to enroll VHP (Sept. '15)<br>• SCFHP and VHP sharing a joint membership and splitting the dues 50/50 (Jan. '16) |
| 4 | **Medical Director collaboration** | ○ SCFHP & VHP do not have multiple medical directors to over-read for each other, requiring sending cases out | **COMPLETE**<br>• Dr. Jeff Robertson, MD & Dr. Dolly Goel MD are now serving as Independent Review Officers on other lines of business |
| 5 | **Share Pharmacy Benefit Management RFP** | ○ SCFHP engaged SBG Consulting Group to assist with the Pharmacy Benefit Management RFP for a 2017 effective date | **CLOSED**<br>• In researching procurement rules, Bruce Butler identified that staff had already proceeded to Board approval of the RFP |

| | | | |
|---|---|---|---|
| **6** | **Partial IT integration** | ○ SCFHP planning to move Medi-Cal off Monument Express<br>○ SCFHP considering hosting QNXT<br>○ SCFHP and VHP have common TriZetto service staff<br>○ SCFHP supporting VHP QNXT conversion with dedicated consultant rewriting custom data feeds | **IN PROCESS**<br>• Joint meeting to discuss synergies (Dec. '15)<br>• Considering opportunities for shared training<br>• SCFHP executed agreement with TriZetto to move to in-house hosting and implement QNXT for Medi-Cal, with pricing consideration for joint VHP members (June '16) |
| **7** | **Assignment of PCPs for Valley clinic members** | ○ Develop process to assign Primary Care Physicians (PCP) to Valley clinic members to improve timely access to specialists | **IN PROCESS**<br>• Monthly meetings being held (Oct. '15)<br>• Joint work group identified new procedures and timeline for implementation<br>• SCFHP only assigning new members to PCPs, not clinics, unless specifically requested by member (Feb. '16)<br>• Gardner patients reassigned to PCP (April '16)<br>• Alviso, Comprecare and Saint James patients reassigned to PCP (May '16)<br>• Indian Health Center patients reassigned to PCP (June '16)<br>• Remaining clinic patients scheduled to be reassigned later this year |

| | | | |
|---|---|---|---|
| **8** | **Transition Healthy Kids to Valley Kids** | ○ As Healthy Kids qualify for full Medi-Cal in 2016, consider transitioning residual members (<1,000) to Valley Kids<br>○ Concern that members may lose dental, vision, and physician relationships | **IN PROCESS**<br>• Initial joint meeting with Santa Clara Valley Health & Hopsital System (SCVHHS) and Social Services Agency (SSA) to discuss transition to Medi-Cal and communication plan (Sept. '15)<br>• Provide SSA Healthy Kids membership file to identify number of children for targeted outreach and enrollment into Medi-Cal (Mar. '16)<br>• Ongoing outreach to Healthy Kids members (direct mail, outbound call campaigns); messaging includes need to apply for Medi-Cal, can choose to stay with same provider in Medi-Cal<br>• Ongoing, collaborative meetings with SCVHHS and DHCS regarding transition<br>• Children in the Children's Health Insurance Program must remain in Healthy Kids, as Valley Kids is not a Knox-Keene Plan<br>• Consider moving undocumented children >266% FPL from Healthy Kids to Valley Kids (~500 members) |
| **9** | **Further medical management collaboration** | ○ Share more pharmacy data to assist with medical management<br>○ Share HEDIS scores and develop interventions to improve rates<br>○ Access electronic medical records | **IN PROCESS**<br>• Pharmacy data file developed for McKesson Case Management and IMI Health Consulting HEDIS programs, with monthly file updates<br>• SCVHHS facilitated an opportunity for limited time access to HealthLink for HEDIS efforts |

| | | | |
|---|---|---|---|
| **10** | **Seek to improve member experience related to brand clarity** | ○ Research call routing and seek process improvements<br>○ Review correspondence for branding clarity | **IN PROCESS**<br>• VHP approved use of Valley Health Network (VHN) when acting as delegated provider group for SCFHP (March '16)<br>• ID cards begin using VHN (April '16)<br>• Transitioned to VHN in Provider Directories (June '16)<br>• Review and revision of correspondence to incorporate VHN underway |
| **11** | **Increase market share** | ○ Identify enrollment/renewal dates<br>○ Identify churn<br>○ Get SSA involved—timeliness of app processing | **IN PROCESS**<br>• Discussions took place with SSA regarding the complexities of the redetermination process<br>• Ongoing meetings with representatives of involved organizations regarding retention |
| **12** | **Develop joint health education programs** | ○ Collaborate on health education programs to maximize return on the collective investment in health educator staff and programs | **IN PROCESS**<br>• Kick-off meeting held December '15<br>• New SCSCFHP health educator and Quality Improvement Manager reaching out to VHP<br>• Discussions underway regarding opportunities to work together |
| **13** | **SCFHP to consider implementing Cactus for credentialing** | ○ In researching credentialing systems, SCFHP will consider implementing the Cactus system, for efficiency in operating on the same system as VHP | **IN PROCESS**<br>• The RFP process is underway at SCFHP to assess vendor ability to provide required functionality |
| **14** | **Collaborate on Whole Person Care (WPC)** | ○ SCFHP to participate with SCVHHS on the WPC pilot program in Santa Clara County, which seeks to coordinate care for high utilizers of multiple systems, transition aged youth and older adults | **IN PROCESS**<br>• SCFHP submitted a Letter of Participation in support of the County's WPC Pilot Program Application |

| | | | |
|---|---|---|---|
| **15** | **Participate on the Hospital Council Medi-Cal Task Force** | ○ Jointly contribute to discussion of the Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities, seeking to identify best practices and remove barriers that prevent the delivery of coordinated, high quality, appropriate and efficient health care | **IN PROCESS**<br>• Rene Santiago (SCVHHS), Christine Tomcala (SCFHP), and Dolores Alvarado (Community Health Partnership), are representing Santa Clara County at the Task Force meetings |
| **16** | **Address Behavioral Health data challenges** | ○ Seek to identify and address data challenges to effectively serve the behavioral health needs of SCFHP members, in a compliant manner | **IN PROCESS**<br>• Ongoing meetings with SCFHP and County Mental Health staff have identified, and continue to address, issues related to definitions, processes, billing and IT systems |
| **17** | **SCVMC/SCFHP marketing collaboration** | ○ SCFHP and SCVMC marketing directors seeking potential areas of collaboration | **IN PROCESS**<br>• SCFHP and VHP marketing directors discussed potential areas to work together, e.g., member education on pediatric urgent care options, member education on role of PCP, CMC outreach, and HEDIS measures (August ’16) |
| **18** | **SCVHHS/SCFHP Case Management Collaboration** | ○ SCFHP and SCVHHS seeking potential areas of collaboration regarding case management resources | **IN PROCESS**<br>• SCFHP and VHP exploring possible coordination of vendor relationships for case management services in order to accelerate system wide progress and coordination in the Medi-Cal 2020 Waiver |
| **19** | **VHP/SCFHP Utilization Management Collaboration** | ○ SCFHP and VHP seeking potential areas of collaboration regarding utilization management activity | **IN PROCESS**<br>• SCFHP and VHP exploring possible coordination of vendor relationships for after-hours coverage of pre-authorization calls (e.g. inpatient admissions from hospital Emergency Departments, etc.) |

Santa Clara Family Health Plan

DRAFT

# FY 2016-17 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<br>• Continue strengthening Fraud Waste & Abuse Program through June 2017<br>• Develop organizational Risk Analysis in 1Q'17<br>• Update Business Continuity Plan in 1Q'17 | **Chris Turner** – Interim COO |
| 2 | **Upgrade systems to meet operational needs of the plan** | • De-host by 3Q'16<br>• Implement QNXT for Medi-Cal & Healthy Kids by July 1, 2017<br>• Select and implement CMC web portals by 1Q'17<br>• Select and initiate implementation of CMC CM system by 2Q'17 | **Jonathan Tamayo** – CIO |
| 3 | **Pursue benchmark quality performance** | • Achieve provisional NCQA accreditation for CMC by June 2017<br>• Five Medi-Cal HEDIS measures increase to next percentile tier, including two achieving 90th percentile benchmark<br>• No Medi-Cal HEDIS measures below 10th percentile | **Jeff Robertson, MD** – CMO |
| 4 | **Develop reporting and analytics structure** | • Routinely generate essential dashboards/key monitoring metrics<br>• Implement risk adjustment initiatives by 4Q'16<br>• Develop quality withhold initiatives | **Dave Cameron** – CFO |
| 5 | **Foster membership growth and retention** | • Develop and implement CMC and Medi-Cal retention activities<br>• Initiate marketing and outreach program for CMC by January2017<br>• Transition eligible Healthy Kids to Medi-Cal | **Chris Turner** – Interim COO |
| 6 | **Establish complex care delivery expertise** | • Implement Model of Care for CMC & SPD by January 2017 | **Jeff Robertson, MD** – CMO |
| 7 | **Collaborate with Valley Health Plan and Valley Medical Center** | • Support Whole Person Care initiative<br>• Engage in joint strategic planning with the County | **Christine Tomcala** – CEO |
| 8 | **Convene Compensation Committee with SEIU** | **Re-write all job descriptions and benchmark pay ranges by 4Q'16** | **Sharon Valdez** – VP, HR |
| 9 | **Achieve budgeted financial performance** | **Achieve FY 2016-17 Net Surplus of $11.7 million** | **Dave Cameron** – CFO |

**Critical Priority**

Santa Clara Family Health Plan

# 2016-2020 STRATEGIC PLAN FRAMEWORK

## Quality Improvement

*Support improved quality outcomes among provider networks and delegated entities*

- **Improvement Initiatives** to increase patient access, care coordination, and health promotion.
- **Quality Incentive Programs** and redesigned contract arrangements to promote higher quality and value
- **National Committee Quality Accreditation** to meet the highest standards
- **HEDIS Score Improvement** through targeted initiatives and efforts

## Complex Care Delivery

*Successfully implement model of care for members with complex conditions*

- **Managed Long Term Care Services & Supports** continued program development
- **Enhanced Internal Complex Care Delivery Expertise** to support care for members with complex conditions
- **Strengthened Behavioral Health Program** including enhancing internal capacity and expanding the external provider network
- **Strengthened Community Partnerships** to more effectively address the social determinants of health
- **ACA 2703 Health Homes Implementation** to pilot comprehensive systems of care for most vulnerable members

## Growth

*Explore opportunities to add new health plan products and grow membership*

- **Exploration of Medicare Product Options** for Cal Medi-Connect opt-outs & new Medicare enrollees, such as Medicare Advantage, including Chronic SNP, DSNP, or other products for dual eligibles
- **New Program Options Exploration** such as service area expansions or other new products
- **Marketing and Outreach** to maximize program enrollment and retention

## Value-Based Care

*Expand contracting, reimbursement, and other arrangements that incentivize value-based care*

- **Alternative Reimbursement/Incentive Arrangements and Contracts** that align incentives, promote higher quality, and encourage innovation
- **Pharmacy Contracts and Management** that contain costs and enhance oversight
- **Innovation Pilots** to explore new and emerging models of care
- **Contractual Arrangements & Score Cards** that increase accountability, promote shared savings, and increase capacity

## Internal Optimization

*Enhance internal systems to support integrated operations and sophisticated business analysis in a value-based care environment*

- **Data Analytics and Reporting Functionality** to enable robust analytics, reporting, and compliance
- **Single Claims Operating System** to enable integration with ancillary sub-systems across all departments and lines of business
- **Fraud Waste & Abuse Program** to improve efficiency and quality
- **Risk Adjusted Payment & Quality Withholds** to achieve appropriate levels of revenue
- **Provider Network and Delegated Entity Accountability** for quality, cost, and compliance

## BUILDING BLOCKS

| | |
|---|---|
| **Financial Strength** | **Culture of Compliance** |
| **Effective Workforce** | **Positive County, State and Federal Relationships** |

## Mission

Santa Clara Family Health Plan is dedicated to improving the health and well-being of the residents of our region. Our mission is to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with select providers, we act as a bridge between the health care system and those who need coverage.

## The Spirit of Care

*The Spirit of Care* is the guiding principle of Santa Clara Family Health Plan. It is our commitment that our members will receive the care they need and the respect they deserve. It goes beyond the specific medical need of an individual and takes into account the mental, spiritual, and cultural implications of health-care decisions.

## Core Values

- We believe that health status cannot improve without parallel improvements in economic opportunities and social status.
- Economic status is the single greatest determinant of community health.
- We believe that as a publicly-funded, local health plan, we have a unique responsibility to work toward improving the health status of our community.
- We must always be a voice for promoting community health, using a comprehensive approach to health care and wellness.
- We believe that to achieve our mission, we must be a well-run, financially viable business that makes a significant investment in our community.
- We believe that our services must be easy to use, and our processes must be easy to understand and follow.
- We believe that our services must be culturally and linguistically appropriate, and that we must teach our members how to use the health-care system.
- We believe that respect for our members, providers, and staff is fundamental to our operations.
- We believe that our network of providers and staff must put our values into action. Our providers and staff must meet high standards of medical service and customer service.
- We believe that the safety-net providers and the traditional providers of quality care to low-income individuals are essential partners of our health plan.

## Distinguishing Characteristics

- We are a community-based local health plan.
- We are separate from county government.
- We are a public agency acting on behalf of the people of our community.
- We conduct business in public.
- We are accountable to our members and to the residents of this region.
- We work closely with our safety-net providers and with our community providers.
- We help to ensure the providers' continuing financial viability.
- We help our providers give members high-quality, comprehensive, and culturally and linguistically appropriate services.
- We work in the community to promote health and well-being for all.
- We have a governing board of stakeholders from the community.

**Santa Clara Family Health Plan**
**Fiscal Year 2015-2016 Team Incentive Compensation**
**February 9, 2016**

D R A F T

| **Performance Level** | **Payout** *(% of salary/ wages)* | **Net Operating Surplus** | **Compliance Metrics** *(% of dashboard metrics in compliance)* |
|---|---|---|---|
| *weighting* | | *20%* | *80%* |
| Maximum | 5% | ≥ $11.6 mill. | 99% - 100% |
| Target | 3% | ≥ $11.3 mill. | 97% - 98.9% |
| Minimum | 1% | ≥ $11.0 mill. | 95% - 96.9% |

**Calculation:**

- 0.20 (Net Operating Surplus Payout %) + 0.80 (Compliance Metrics 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 2015 through June 2016. (Does not include PTO cash out.)

**Process:**

- Santa Clara Family Health Plan must achieve the designated **Minimum 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 2015-16 performance year.
- Compliance Metrics will be calculated as the percent of June 2016 compliance dashboard measures that meet or exceed regulatory requirements.
- 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
Family Health Plan

# Board Approval
# for
# Provider Credentialing RFP

September 2016

# Provider Credentialing Overview

- Planned to field RFP in FY 15-16, as budgeted
  - Unanticipated delays pushed implementation to FY 16-17.
  - Not anticipated current budget.
- Credentialing department currently uses the claims payment system, Xpress, and excel tracking logs as the “credentialing” system
- Xpress is a claims payment system and does not have the functionality to ensure compliance with credentialing and directory requirements.
- Xpress will be sun setting after implementation of QNXT.
- Need one database for provider credentialing.

# Regulatory Requirements

- Implementing a credentialing system will ensure compliance with the following regulations regarding provider data and provider directories:
  - Medicare Managed Care, chapter 4
  - Medicaid Final Rule, section 438.10
  - CMS 2017 CA. Medicare-Medicaid Plan (MMP)Model Document for provider and hospital directories
  - NCQA Health Plan Standards and Guidelines
  - Senate Bill 1367.26, health care coverage and provider directories
  - SCFHP's DHCS contract requirements

# Departments Workflow

- Complete the entire credentialing process within one system.
- Improve procedures between the Credentialing Department and the Quality Department, which conducts the Facility Site Reviews (FSRs) and Potential Quality Issues (PQIs).
- Ensure timely and thorough reports for the QIC, Credentialing Committee and regulatory compliance.

# Request for Proposal

- Three vendors are participating.
- Price range for License $80 - $210k
- Price range for Implementation $90 - $150
- At the high end for License and Implementation $360k

# Board Approval

- Proposed Board Action:
  - Augment the fiscal year 2016 - 2017 budget and authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected credentialing system vendor in an amount not to exceed $360k for licensing and implementation.

# Santa Clara County Health Authority
# Updates to Pay Schedule
# September 22, 2016

| Job Title | Pay Rate | Minimum | Midpoint | Maximum |
|---|---|---|---|---|
| Appeals and Grievance Intake Specialist | Annually | 43,867 | 53,737 | 63,877 |
| Data Warehouse Architect | Annually | 83,102 | 108,033 | 133,403 |
| Eligibility Lead | Annually | 48,363 | 60,454 | 72,545 |
| Health Services Project Manager | Annually | 83,102 | 108,033 | 133,403 |
| LTSS Nurse Case Manager | Annually | 72,112 | 91,943 | 111,774 |
| Member Services Director | Annually | 112,569 | 149,153 | 185,738 |
| Provider Database Analyst | Annually | 55,618 | 69,522 | 83,427 |
| Supervisor, Case Management | Annually | 83,102 | 108,033 | 132,964 |
| Vendor Oversight Analyst | Annually | 62,706 | 79,951 | 97,195 |
| Human Resources Generalist | Annually | 62,706 | 79,951 | 97,195 |

**Santa Clara Family Health Plan**
**Operations Report**
**June, July, August 2016**

**Santa Clara Family Health Plan**
**Operations Report**
**June - August, 2016**

## Membership
## August 2016

| Member Months | 2015-10 | 2015-11 | 2015-12 | 2016-01 | 2016-02 | 2016-03 | 2016-04 | 2016-05 | 2016-16 | 2016-07 | 2016-08 | 2016-09 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Agnews** | **111** | **111** | **110** | **110** | **110** | **109** | **109** | **110** | **110** | **107** | **107** | **107** |
| Santa Clara Family Health Plan | 111 | 111 | 110 | 110 | 110 | 109 | 109 | 110 | 110 | 107 | 107 | 107 |
| **Healthy Kids** | **4,362** | **4,325** | **4,273** | **4,186** | **4,114** | **4,158** | **4,328** | **4,375** | **4,435** | **4,380** | **4,224** | **2,962** |
| Palo Alto Medical Foundation | 42 | 40 | 37 | 36 | 36 | 33 | 31 | 34 | 35 | 37 | 38 | 38 |
| Physicians Medical Group | 1,064 | 1,050 | 1,029 | 1,000 | 999 | 1,015 | 1,041 | 1,041 | 1,050 | 1,083 | 1,081 | 818 |
| Premier Care | 138 | 140 | 151 | 147 | 147 | 152 | 141 | 153 | 156 | 159 | 173 | 163 |
| Santa Clara Family Health Plan | 192 | 193 | 184 | 186 | 168 | 188 | 202 | 227 | 253 | 267 | 254 | 217 |
| Valley Health Plan | 2,926 | 2,902 | 2,872 | 2,817 | 2,764 | 2,770 | 2,913 | 2,920 | 2,941 | 2,834 | 2,678 | 1,726 |
| **Medi-Cal** | **249,939** | **254,499** | **258,592** | **255,848** | **256,178** | **259,921** | **257,469** | **259,076** | **259,919** | **263,714** | **268,026** | **269,400** |
| Kaiser | 25,666 | 25,967 | 26,310 | 26,079 | 26,367 | 26,786 | 26,974 | 27,240 | 27,257 | 27,244 | 27,366 | 27,348 |
| Network 00 | 8,359 | 9,070 | 9,576 | 9,601 | 9,668 | 9,779 | 9,869 | 9,969 | 10,043 | 10,097 | 10,147 | 10,240 |
| Palo Alto Medical Foundation | 6,883 | 7,009 | 7,123 | 7,001 | 7,174 | 7,346 | 7,362 | 7,428 | 7,472 | 7,555 | 7,596 | 7,585 |
| Physicians Medical Group | 44,619 | 45,013 | 45,444 | 45,074 | 46,010 | 46,645 | 46,401 | 46,658 | 46,951 | 47,859 | 48,577 | 48,705 |
| Premier Care | 15,270 | 15,461 | 15,640 | 15,472 | 15,658 | 15,790 | 15,782 | 15,890 | 16,017 | 16,284 | 16,529 | 16,641 |
| Santa Clara Family Health Plan | 12,416 | 12,366 | 12,548 | 12,416 | 12,273 | 12,552 | 12,529 | 12,879 | 13,157 | 13,919 | 14,695 | 15,179 |
| Valley Health Plan | 136,726 | 139,613 | 141,951 | 140,205 | 139,028 | 141,023 | 138,552 | 139,012 | 139,022 | 140,756 | 143,116 | 143,702 |
| **Grand Total** | **254,412** | **258,935** | **262,975** | **260,144** | **260,402** | **264,188** | **261,906** | **263,561** | **264,464** | **268,201** | **272,357** | **272,469** |
| **CMC** | **8,354** | **8,906** | **9,699** | **9,159** | **8,886** | **8,728** | **8,488** | **8,367** | **8,203** | **8,108** | **8,025** | **7,909** |
| Santa Clara Family Health Plan | 8,354 | 8,906 | 9,699 | 9,159 | 8,886 | 8,728 | 8,488 | 8,367 | 8,203 | 8,108 | 8,025 | 7,909 |
| **Grand Total** | **262,766** | **267,841** | **272,674** | **269,303** | **269,288** | **272,916** | **270,394** | **271,928** | **272,667** | **276,309** | **280,382** | **280,378** |

## Long Term Services Supports (LTSS) Operations August 2016:

**Total LTSS Members by Line of Business (LOB)**

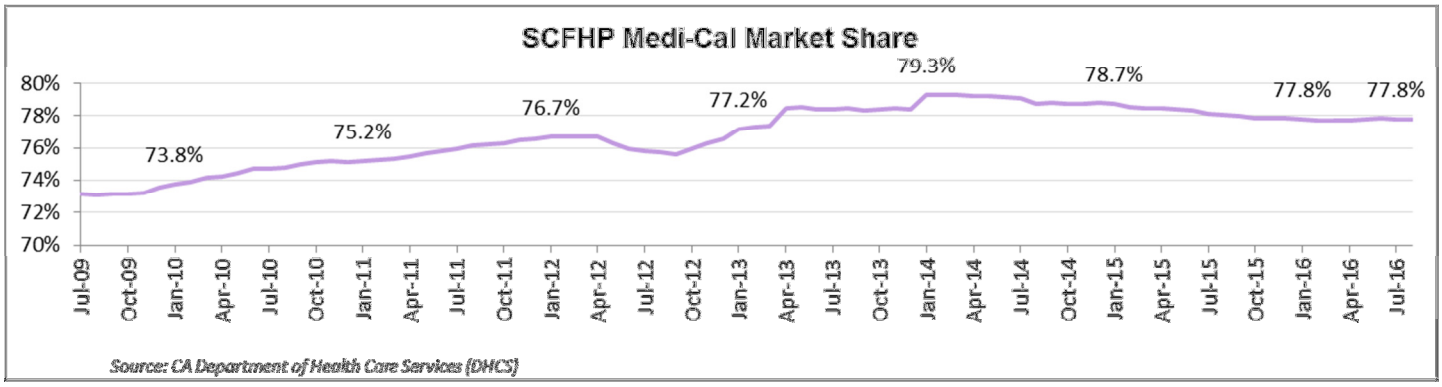
| Long Term Services Support Program (LTSS) | Cal MediConnect | Medi-Cal | Total Members in LTSS Programs |
|---|---|---|---|
| Community-Based Adult Services (CBAS) | 63 | 511 | 538 |
| In-Home Supportive Services (IHSS) | 2793 | 9370 | 11541 |
| Long Term Care (LTC) | 322 | 1233 | 1708 |
| Multipurpose Senior Services Program (MSSP) | 45 | 227 | 272 |

**In-Home Supportive Services (IHSS)** are personal care services for people who are disabled, blind or aged 65+ and unable to live at home safely without help.
**Community-Based Adult Services (CBAS)** is daytime health care at centers that provide nursing, therapy, activities and meals for people with certain chronic health conditions.
**Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people age 65 and older.
**Long-Term Care Facilities** provide residential long-term custodial or skilled nursing care.

**Santa Clara Family Health Plan**
**Operations Report**
**June - August, 2016**

**Marketing and Communications Department**

**As of August 1, 2016**




**As of August 1, 2016**

**Compliance**

| Material | Action | Regulatory Agency |
|---|---|---|
| Cal MediConnect Part D | Formularies (all threshold languages) – July, August, September documents created, posted on website; print versions implemented<br><br>Step Therapy and Prior Authorization documents – July, August, Sept files posted on website<br><br>Drug recall notice template submitted to HPMS | CMS, DHCS |
| Cal MediConnect 2016 Member Materials | Provider/Pharmacy Directories (all threshold languages) – 2016 template edited, submitted, approved; July, August, September documents created, posted on website<br><br>Provider/Pharmacy Directory template edited based on CMS PPD Monitoring Results; submitted to HPMS; pending approval<br><br>Member ID Card edited, submitted, approved<br><br>Wrote and submitted response to CMS request for best practices for specific provider directory requirements | CMS, DHCS |
| Cal MediConnect 2016 Member Notices | Pharmacy termination notice – Rx transferred – submitted in HPMS; approved<br>Pharmacy termination notice – Pharm termed (template) – submitted in HPMS; approved<br>Member notice – mid-year benefit changes – submitted in HPMS; approved | CMS, DHCS |

| Material | Action | Regulatory Agency |
|---|---|---|
| Cal MediConnect 2016 Website | Updated Find a Doctor page based on CMS monitoring feedback and SB 137 implementation; pending approval<br><br>Mid-year benefit changes; pending approval | CMS, DHCS |
| Cal MediConnect 2017 Member Materials | Approved by DMHC, DHCS, CMS: EOC, Summary of Benefits, Formulary, Provider and Pharmacy Directory, welcome letters (passive and voluntary), member materials cover letter, ID card letter, renewing member notice, provider/pharmacy directory notice, ANOC envelope notice<br><br>Approved by DMHC; Pending Approval by DHCS and CMS: ANOC, ID Card<br><br>Pending Approval by DHCS/CMS: Durable Medical Equipment list | DMHC, DHCS, CMS |
| ACA Section 1557 Compliance | Language Assistance Services – submitted in HPMS; approved<br><br>Notice of non-Discrimination with Language Assistance Services tag lines written; does not require separate submission | DHCS, CMS |
| SB 272 Public Records/Enterprise Systems | Developed and published new web page to meet regulatory requirement | DHCS |
| Medi-Cal EOC | Cover letter – submitted; approved<br><br>2016-2017 EOC Mailed to all current Medi-Cal members<br><br>EOC Errata – Acupuncture – written, submitted; approved | DHCS |
| Medi-Cal Provider/Pharmacy Directory | SB 137 compliant directory submitted, approved, posted on website | DHCS |
| Healthy Kids Provider/Pharmacy Directory | SB 137 compliant directory submitted, approved, posted on website<br><br>Liberty Dental directory posted on website | DHCS |
| Winning Health Member Newsletter | Summer 2016 MC/HK and CMC issues – mailed, in-home<br><br>Fall 2016 MC/HK and CMC issues – topics selected, articles written, first proofs | CMS, DHCS |
| Medi-Cal Marketing | 2016-2017 Medi-Cal Marketing Plan submitted<br><br>2016-2017 HCO Plan Comparison Chart submitted | DHCS |

| Material | Action | Regulatory Agency |
|---|---|---|
| Medi-Cal Pharmacy Term | Mailed pharmacy term notices to 93 members | DHCS |
| Medi-Cal SPD HRAs | Mailed HRAs to 1601 members | DHCS |
| Medi-Cal Behavioral Health Transition | Mailed BHT transition – 62 June, 10 July, 8 August | DHCS |
| Cal MediConnect Deeming | Mailed notices to members – 58 June, 64 July, 70 August | CMS, DHCS |
| Healthy Kids | Completed monthly mailings for statements (1560 June, 1152 July, 1195 August), reinstatements (16 June, 8 August), renewals (226 June, 231 July, 183 August), terminations (357 June, 172 July, 325 August) | DHCS, DMHC |

**Outreach**

| COMPLETED EVENTS – 2016 | | | | |
|---|---|---|---|---|
| **Date** | **Event** | **Audience** | **Primary Messaging** | **Approximate # of Attendees** |
| 03/16/2016 | Health Plan Fair, PMGSJ | Families | Medi-Cal; Healthy Kids, CMC | 130 |
| 03/19/2016 | Rocketship Mosaic Health and Safety Fair (information) | Families | Medi-Cal; Healthy Kids | 200 |
| 03/24/2016 | Hospice of the Valley Compassion in Action Conference | Healthcare professionals | CMC | 60+ |
| 03/25/2016 | Santa Clara County Medical Association – CMC presentation | Providers | CMC | 40 |
| 04/03/2016 | Vietnamese Reach for Health Coalition Community Forum | Adults | CMC, Medi-Cal | 150-200 |
| 04/07/2016 | Alum Rock Counseling Center annual luncheon – sponsor | CBOs | Safety Net | 200 |
| 4/13/2016 | West Valley Community Services Fair – materials only | Adults, Families | Medi-Cal, Healthy Kids, Medi-Cal Expansion, MLTSS | |
| 04/16/2016 | 6th Annual Caregivers Conference – Aging Services Collaborative | Caregivers | CMC, SPD | 200 |

**Santa Clara Family Health Plan**
**Operations Report**
**June - August, 2016**

| COMPLETED EVENTS – 2016 | | | | |
|---|---|---|---|---|
| **Date** | **Event** | **Audience** | **Primary Messaging** | **Approximate # of Attendees** |
| 04/17/2016 | Healthy Living Fair 2016 – Our Lady of Guadalupe Church, San Jose (sponsored by Congregation Shir Hadash) | Adults, Families | Medi-Cal; Healthy Kids; Medi-Cal Expansion; MLTSS | 200 |
| 05/01/2016 | March of Dimes – March for Babies | Families | Medi-Cal, Healthy Kids | 3500 |
| 05/24/2016 | Mountain View Senior Resource Fair | Seniors | CMC, MLTSS | 200 |
| 6/11/2015 | Chinese American Coalition for Compassionate Care – materials only | Adults, caregivers | CMC, MLTSS | 150 |
| 6/11/2016 | VHC Clinic Opening | Families, Adults, Community | Medi-Cal, Healthy Kids, Medi-Cal Expansion, MLTSS | 500 |
| 8/2/2016 | Homeless Community Health Assessment Outreach, Focus Care, St Joseph's Cathedral | Homeless Community | CMC | 100 |
| 8/7/2016 | Senior Health & Wellness Fair, Golden Castle/MidPen Housing | Seniors | CMC, MLTSS | 200 |

| SCHEDULED EVENTS – 2016 | | | | |
|---|---|---|---|---|
| **Date** | **Event** | **Audience** | **Primary Messaging** | **Approximate # of Attendees** |
| 9/27/2016 | Community Health Partnership – Outreach and Enrollment Peer Network meeting – Healthy Kids Program Update | Enrollment Counselors | Healthy Kids Program transition – SB 75 and C-CHIP | 30 |
| 9/28/2016 | SC Methodist Retirement Foundation Residents – Wesley Manor – presentation | Seniors | CMC, MLTSS | 100 |
| 9/29/2016 | SC Methodist Retirement Foundation Residents – Liberty Tower – presentation | Seniors | CMC, MLTSS | 50 |
| 9/29/2016 | Senior Resource and Wellness Fair, SCC DADS, at Mexican Heritage Plaza | Seniors | CMC, MLTSS | 500 |
| 9/30/2016 | El Camino Hospital Medicare/Medi-Cal Info Session | Adults, Families | Medi-Cal, Medi-Cal Expansion, | 50 |
| 10/1/2016 | Gilroy Community Health Day – South County Collaborative | Adults, Families | Medi-Cal, Medi-Cal Expansion, MLTSS | 400 |
| 10/7/2016 | Centennial Recreation Center Senior Resource Fair | Seniors | CMC, MLTSS | 100 |
| 10/9/2016 | PCNC Health Fair – Premier Care of Northern California | Adults, Families | Medi-Cal, Medi-Cal Expansion, Healthy Kids | 300-500 |
| 11/6/2016 | Diabetes Health Fair, American Diabetes Association | Adults | Medi-Cal, Medi-Cal Expansion, CMC, MLTSS | 400-500 |

**Communications (additional deliverables not noted in Compliance section, above)**

| Item | Audience |
|---|---|
| Provider communications<br><br>• Website additions/updates as noted below<br>• Provider Attestation Form – developed, finalized; individual forms created<br>• LTSS Notification Form – updated<br>• Provider memos<br>  • Electronic Billing Guidelines<br>  • Summer Member Newsletter<br>  • Medical Transportation Code Conversion<br>  • Notification of Upcoming Attestation<br>  • Illegal Balance Billing<br>  • Home Health | Providers |
| CCI Sustainability<br><br>• Streamlined enrollment script drafted<br>• Submitted retention update to CMS/DHCS<br>• IT project initiated for systems implementation; specified CRM requirements; initial review of Salesforce | SCFHP |
| General Member Communications<br><br>• Case management outreach event for homeless at St Joseph's – developed flyers, forms<br>• Case management letters for Optum – edited 15 letters<br>• Drafted case management letters for Advance Directives and Authorized Representative forms<br>• MC/HK ID card layout changes – finalized, to fulfillment vendor<br>• Drug recall and pharmacy contract termination letters – written, finalized<br>• Opioid member letter – drafted, to translation | Members |
| Consumer Advisory Committee<br><br>• Chaired June meeting, developed agenda, presentation materials | Members, Community |
| Healthy Kids<br><br>• Transition to Medi-Cal – 2nd letters approved by DHCS; translated; mailed to members<br>• Scripts for outbound calls; outbound calling campaigns | Members |
| Health Education<br><br>• 2016 swim program letters – managed fulfillment and tracking of requests<br>• Diabetic Eye Exam incentive program – flyer developed, approved, translated; mailed to 6926 members; 2.33% response rate<br>• Cervical Cancer Screening incentive program – flyer developed, approved, translated; mailed to 11,489 members<br>• High Blood Pressure incentive program – flyer drafted, to DHCS for approval | Members, Providers |
| Member Orientation videos<br><br>• Edited scripts and storyboards for three videos<br>• What is Medi-Cal video storyboard submitted to DHCS for approval; approved | Members, Community |

| Item | Audience |
|---|---|
| Member Communication Alerts for internal SCFHP staff<br><br>• Cervical Cancer Screening – updated | SCFHP |
| Community/Outreach<br><br>• Developed appreciation ad for AACI event<br>• St Joseph's homeless outreach – developed window notice for use by St Joseph's, flyers, stickers | Community, Members, Providers |

**Website and Social Media Posts**

| Item | Audience |
|---|---|
| Home Page Carousel and footer<br><br>• Medi-Cal for All Children (SB 75) updated | Community, Members |
| Governing Board and Committees<br><br>• Quality Improvement Committee description updated | Community, Members |
| Meetings and Agendas – Brown Act Compliance<br><br>• Bylaws Committee Special Meeting – added meeting date, agenda, agenda packet for 6/16/2016<br>• CCI Stakeholder Advisory Committee – added meeting dates – 8/17/2016, 11/16/2016; posted minutes for 2/17/2016<br>• CMC Consumer Advisory Board – added meeting dates – 7/27/2016, 8/31/2016, 9/28/2016, 10/26/2016, 11/30,2016, 12/28/2016; posted agenda for 7/27/2016, 8/31/2016; posted minutes for 10/22/2015, 12/30/2015, 1/27/2016, 2/24/2016, 5/25/2016, 7/27/2016<br>• Consumer Advisory Committee – added meeting dates – 9/13/2016, 12/13/2016<br>• Executive Committee – added meeting dates – 7/28/2016, 8/25/2016, 10/27/2016, 11/17/2016; posted packet for 7/28/2016; posted minutes for 10/22/2016, 12/17/2016, 2/25/2016, 3/24/2016, 5/26/2016<br>• Governing Board – added meeting dates – 9/22/2016, 12/15/2016; posted minutes 1/28/2016, 4/28/2016; posted agenda and packet 6/23/2016<br>• Provider Advisory Council – added meeting dates – 7/27/2016, 10/6/2016; added agenda for 7/27/2016<br>• Quality Improvement Committee – added meeting dates – 8/10/2016, 11/9/2016<br>• Unified Managed Care Strategy Team – posted minutes for 11/6/2015, 4/1/2016 | Community, Members, Providers |
| Cal MediConnect Member page edits<br><br>• NCDs – added "Stem Cell Transplantation"<br>• Mid-year benefit changes – acupuncture and continuity of care | Members, Providers, Community |
| Healthy Kids landing page – Updated SB 75<br><br>Medi-Cal landing page – Updated eligibility information | Members |

| Item | Audience |
|---|---|
| For Members<br><br>• 2016-2017 EOC posted<br>• Health Education – published new page<br>• Find a Doctor – edited for updated disclaimers | Members |
| For Providers<br><br>• Claims dispute – added form, added language about submitting like claims<br>• Waiver of Liability statement added<br>• Provider Orientation – updated packet<br>• Smoking Cessation and Anxiety – webinar information posted<br>• Clinical and Preventive Guidelines<br>• Healthy Education Referral Form<br>• MLTSS contacts | Providers |
| Community – News, Events, Newsletters, Resources<br><br>• Summer meals and snacks for kids<br>• Diabetic Eye Exam | Members, Community, Providers |
| Website management – troubleshoot issues with provider claims dispute form, provider data discrepancy, Tagalog grievance form; adjusted link accessibility tags | SCFHP |
| Website monthly review: All CMC pages reviewed, in compliance with all regulatory requirements, including CMS Medicare Marketing Guidelines | SCFHP |
| Social Media<br><br>• Drafted Policies and Procedures<br>• Created approval process for likes, reactions, comments, shares, original posting on SCFHP<br>• Facebook posts | Members, Community |

**Projects**

| Item |
|---|
| CCI Sustainability, including streamlined enrollment, set up of outreach team |
| Cal MediConnect – Development and implementation of all 2017 member materials, notices, website |
| SB 137 Provider Directory implementation – DMHC filing, PDF directory and online search content changes, quarterly updates to pdf and weekly to online search |
| Healthy Kids – systems and process changes, outreach – SB 75, CCHIP |
| Valley PCP Assignment |
| Behavioral Health Treatment transition |

## Pharmacy Department
**June - August, 2016**

### Cal MediConnect Dashboard

- PA volume is trending down which is normal seasonal variation.
- Consistent on time PA completion

| | GOAL (if applicable) | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|
| **Cal MediConnect** | | | | | | |
| Total PA volume | | 130 | 148 | 119 | 114 | 109 |
| Standard PAs | | | | | | |
| # Standard PA requests | | 104 | 113 | 91 | 88 | 89 |
| # Approved PAs | | 53 | 61 | 55 | 59 | 58 |
| # Denied PAs | | 28 | 19 | 20 | 20 | 15 |
| PA approval rate | | 51% | 54% | 60% | 67% | 65% |
| # Standard PAs completed within 72 hrs | | 104 | 113 | 91 | 88 | 89 |
| % Standard PAs completed within 72 hrs | | 100% | 100% | 100% | 100% | 100% |
| Expedited PAs | | | | | | |
| # Expedited PA requests | | 26 | 35 | 28 | 26 | 20 |
| # Approved PAs | | 19 | 17 | 17 | 15 | 13 |
| # Denied PAs | | 5 | 15 | 5 | 7 | 6 |
| PA approval rate | | 73% | 49% | 61% | 58% | 65% |
| # Expedited PAs completed within 24 hrs | | 26 | 35 | 28 | 26 | 20 |
| % Expedited PAs completed within 24 hrs | | 100% | 100% | 100% | 100% | 100% |
| PA audit sample size | | 20 | 20 | 20 | 20 | 20 |
| PA audit pass | | 20 | In Progress | In Progress | In Progress | In Progress |
| PA audit fail | | 0 | | | | |
| PA pass rate | 100% | 100% | | | | |
| MTM Eligible Members (YTD) | | 8889 | 8,934 | 8,984 | 9,050 | Waiting for Data |
| MTM Qualified Members (YTD) | | 1621 | 1,702 | 1,800 | 1,865 | |
| MTM CMR Completion (YTD) | | 107 | 148 | 166 | 222 | |
| MTM CMR Completion Rate (YTD) | 22% (at year end) | 7% | 9% | 9% | 12% | |
| Total claims | | 53,804 | 54,749 | 52,240 | 51,756 | 52,849 |
| Approved claims | | 28,726 | 29,194 | 28,284 | 29,193 | 28,422 |
| Rejected claims | | 25,078 | 25,555 | 23,956 | 22,563 | 24,427 |
| Claim approval rate | | 53% | 53% | 54% | 56% | 54% |
| Transition fills | | 36 | 26 | 32 | 19 | 12 |
| PDE rejection rate | <0.26% | 0.39% | 0.46% | 1.12% | 0.72% | 0.65% |
| Denied claims - % reviewed | | 100% | 100% | 100% | 100% | 100% |
| Formulary, PA, & ST posted on website by 1st of the month | | 1-Apr | 29-Apr | 31-May | 30-Jun | 29-Jul |
| Formulary upload to CMS | | 4-Apr | 2-May | 3-Jun | 5-Jul | 2-Aug |

**Medi-Cal Dashboard**

- PA volume is trending down which is normal seasonal variation but increased in August.
- Consistent on time PA completion

| | GOAL (if applicable) | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|
| **Medi-Cal** | | | | | | |
| PA volume | | 1795 | 1741 | 1772 | 1624 | 2019 |
| Standard PAs | | | | | | |
| # Standard PA requests | | 1639 | 1584 | 1606 | 1471 | 1805 |
| # Approved PAs | | 874 | 836 | 895 | 845 | 1033 |
| # Denied PAs | | 490 | 486 | 468 | 363 | 506 |
| PA approval rate | | 53% | 53% | 56% | 57% | 57% |
| # Standard PAs completed within 1 business day | | 1638 | 1573 | 1603 | 1471 | 1805 |
| % Standard PAs completed within 1 business day | 95% | 99.9% | 99.3% | 99.8% | 100.0% | 100.0% |
| Expedited PAs | | | | | | |
| # Expedited PA requests | | 156 | 157 | 166 | 153 | 214 |
| # Approved PAs | | 87 | 99 | 110 | 96 | 126 |
| # Denied PAs | | 35 | 24 | 27 | 32 | 48 |
| PA approval rate | | 56% | 63% | 66% | 63% | 59% |
| # Expedited PAs completed within 1 business day | | 156 | 157 | 166 | 153 | 214 |
| % Expedited PAs completed within 1 business day | 95% | 100% | 100% | 100% | 100% | 100% |
| PA audit sample size | | 20 | 20 | 20 | 20 | 20 |
| PA audit pass | | In Progress | In Progress | In Progress | In Progress | In Progress |
| PA audit fail | | | | | | |
| PA pass rate | 100% | | | | | |

**Pharmacy Costs**

- Healthy Kids PMPM is trending down from the beginning of the year.
- CMC PMPM is trending up from the beginning of the year.
- Medi-Cal PMPM is stable throughout the year.

| | Month | May-16 | Jun-16 | Jul-16 | Aug-16 | Running Year Avg |
|---|---|---|---|---|---|---|
| **Medi-Cal (includes Agnews; includes HF starting Jan 2013)** | Mbr Months | 231,946 | 232,772 | 236,577 | 240,767 | 230,988 |
| | Generic ($) | 2,810,001 | 2,783,313 | 2,643,351 | 2,930,486 | $ 2,760,772 |
| | Generic (vol) | 154,490 | 149,243 | 142,246 | 156,823 | 149,255 |
| | Brand ($) | 6,356,903 | 7,113,922 | 6,880,131 | 7,694,620 | $ 6,926,943 |
| | Brand (vol) | 17,351 | 16,911 | 15,807 | 18,530 | 17,609 |
| | Claim admin fee | $ 182,151 | $ 176,123 | $ 167,536 | $ 185,874 | $ 176,876 |
| | **Total** | **$ 9,349,055** | **$ 10,073,357** | **$ 9,691,019** | **$ 10,810,980** | **$ 9,864,592** |
| | **PMPM** | **$ 40.31** | **$ 43.28** | **$ 40.96** | **$ 44.90** | **$ 42.70** |
| | # of Rx PMPM | 0.74 | 0.71 | 0.67 | 0.73 | 0.72 |
| | % Generic ($) | 32% | 29% | 29% | 29% | 30% |
| | % Generic (vol) | 90% | 90% | 90% | 89% | 89% |
| | Avg Cost/Rx | $ 54.41 | $ 60.63 | $ 61.31 | $ 61.65 | $ 59.15 |
| **Healthy Kids** | **Month** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Running Year Avg** |
| | Mbr Months | 4,375 | 4,435 | 4,380 | 4,224 | 4,295 |
| | Generic ($) | 13,066 | 14,229 | 8,024 | 7,752 | $ 11,599 |
| | Generic (vol) | 510 | 432 | 347 | 326 | 457 |
| | Brand ($) | 16,602 | 15,854 | 10,896 | 14,055 | $ 16,847 |
| | Brand (vol) | 53 | 55 | 36 | 44 | 59 |
| | Claim admin fee | $ 597 | $ 516 | $ 406 | $ 392 | $ 547 |
| | **Total** | **$ 30,264** | **$ 30,600** | **$ 19,326** | **$ 22,199** | **$ 28,993** |
| | **PMPM** | **$ 6.92** | **$ 6.90** | **$ 4.41** | **$ 5.26** | **$ 6.76** |
| | # of Rx PMPM | 0.13 | 0.11 | 0.09 | 0.09 | 0.12 |
| | % Generic ($) | 45% | 48% | 43% | 36% | 42% |
| | % Generic (vol) | 91% | 89% | 91% | 88% | 89% |
| | Avg Cost/Rx | $ 53.75 | $ 62.83 | $ 50.46 | $ 60.00 | $ 56.49 |
| **CMC (January 2015 onwards)** | **Month** | **May-16** | **Jun-16** | **Jul-16** | **Aug-16** | **Running Year Avg** |
| | Mbr Months | 8,169 | 8,069 | 7,980 | 7,888 | 8,324 |
| | Generic ($) | 742,389 | 697,341 | 679,631 | 727,455 | $ 738,451 |
| | Generic (vol) | 24,312 | 23,328 | 22,161 | 23,367 | 23,988 |
| | Brand ($) | 2,154,822 | 2,124,925 | 2,215,470 | 2,214,944 | $ 2,177,855 |
| | Brand (vol) | 4,665 | 4,596 | 4,329 | 4,724 | 4,667 |
| | Claim admin fee | $ 51,463 | $ 49,593 | $ 47,046 | $ 49,890 | $ 50,891 |
| | **Total** | **$ 2,948,674** | **$ 2,871,859** | **$ 2,942,148** | **$ 2,992,289** | **$ 2,967,196** |
| | **PMPM** | **$ 360.96** | **$ 355.91** | **$ 368.69** | **$ 379.35** | **$ 356.58** |
| | # of Rx PMPM | 3.55 | 3.46 | 3.32 | 3.56 | 3.44 |
| | % Generic ($) | 27% | 26% | 24% | 26% | 26% |
| | % Generic (vol) | 84% | 84% | 84% | 83% | 84% |
| | Avg Cost/Rx | $ 101.76 | $ 102.85 | $ 111.07 | $ 106.52 | $ 103.61 |

Cal MediConnect:

- PA volume is trending down which is normal seasonal variation.

## Claims Department
## June 2016

**COMPLIANCE: % OF CLAIMS PROCESSED WITHIN 64 CALENDAR DAYS (45 WORKING DAYS) (DMHC MINIMUM IS 95%)**

| **2016** | **2015** |
|---|---|
| June: 64% | June: 77% |

*Claims received in June are considered new and are still in progress (claims received in June will be processed in June and July). SCFHP has 64 calendar days from the day of receipt to process these claims.

**CLAIMS VOLUME**

| **2016** | **2015** |
|---|---|
| June: 45,263 | June: 47,205 |

**PERCENTAGE OF CLAIMS RECEIVED ELECTRONICALLY (EDI) (GOAL IS 85%)**

| **2016** | **2015** |
|---|---|
| June: 79% | June: 80% |

**AUTO ADJUDICATION PERCENTAGE (GOAL IS 85%)**

| **2016** | **2015** |
|---|---|
| June: 55% | June: 73% |

**ANALYST PRODUCTIVITY (# OF CLAIMS PROCESSED PER HOUR) (GOAL IS 12 PER HOUR)**

| **2016** | **2015** |
|---|---|
| June: 15 | June: 12 |

**AGE OF PENDED CLAIMS AT MONTH END (CLAIMS MUST BE PROCESSED WITHIN 64 CALENDAR DAYS)**

| **2016** | | **2015** | |
|---|---|---|---|
| **0-30 DAYS** | **OVER 30 DAYS** | **0-30 DAYS** | **OVER 30 DAYS** |
| June: 17,994 | 15,972* | June: 12,912 | 2680* |

*Claims over 30 calendar days old are **not** out of compliance. It is simply a claims aging measure designed to identify which claims need immediate resolution. SCFHP has 64 calendar days from the day of receipt of the claim to either pay or deny the claim.

## July 2016

**COMPLIANCE: % OF CLAIMS PROCESSED WITHIN 64 CALENDAR DAYS (45 WORKING DAYS) (DMHC MINIMUM IS 95%)**

| 2016 | 2015 |
|---|---|
| July: 70% | July: 81% |

*Claims received in July are considered new and are still in progress (claims received in July will be processed in July and August). SCFHP has 64 calendar days from the day of receipt to process these claims.

**CLAIMS VOLUME**

| 2016 | 2015 |
|---|---|
| July: 52,562 | July: 46,958 |

**PERCENTAGE OF CLAIMS RECEIVED ELECTRONICALLY (EDI) (GOAL IS 85%)**

| 2016 | 2015 |
|---|---|
| July: 76% | July: 78% |

**AUTO ADJUDICATION PERCENTAGE (GOAL IS 85%)**

| 2016 | 2015 |
|---|---|
| July: 55% | July: 67% |

**ANALYST PRODUCTIVITY (# OF CLAIMS PROCESSED PER HOUR) (GOAL IS 12 PER HOUR)**

| 2016 | 2015 |
|---|---|
| July: 13 | July: 13 |

**AGE OF PENDED CLAIMS AT MONTH END (CLAIMS MUST BE PROCESSED WITHIN 64 CALENDAR DAYS)**

| 2016 | | 2015 | |
|---|---|---|---|
| **0-30 DAYS** | **OVER 30 DAYS** | **0-30 DAYS** | **OVER 30 DAYS** |
| July: 17,405 | 14,266* | July: 10,405 | 5554* |

*Claims over 30 calendar days old are **not** out of compliance. It is simply a claims aging measure designed to identify which claims need immediate resolution. SCFHP has 64 calendar days from the day of receipt of the claim to either pay or deny the claim.

Note: Due to transition in management, the August 2016 report is not yet available

## Medical Management
## June - August 2016

**Inpatient/Outpatient : Inpatient Only**

| Month | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agnews (AM) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | |
| Healthy Kids (HK) | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 2 | 0 | 1 | 0 | 2 | 2 | 3 | 0 |
| Medi-Cal (MC) | 390 | 416 | 381 | 390 | 389 | 388 | 423 | 407 | 429 | 487 | 465 | 456 | 488 | 396 | 446 |
| Cal-MediConnect | 243 | 239 | 238 | 224 | 250 | 292 | 142 | 342 | 568 | 467 | 474 | 453 | 337 | 382 | 285 |
| **Total** | 634 | 656 | 620 | 616 | 640 | 680 | 566 | 752 | 998 | 955 | 939 | 911 | 827 | 781 | 731 |

**Inpatient/Outpatient : Outpatient Only**

| Month | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agnews (AM) | 4 | 8 | 6 | 4 | 7 | 6 | 9 | 3 | 5 | 3 | 4 | 4 | 0 | 2 | |
| Healthy Kids (HK) | 1 | 3 | 0 | 3 | 2 | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 1 | 2 | 1 |
| Medi-Cal (MC) | 558 | 596 | 658 | 542 | 552 | 483 | 536 | 520 | 569 | 645 | 614 | 558 | 543 | 586 | 603 |
| Cal-MediConnect | 242 | 177 | 234 | 207 | 270 | 208 | 191 | 350 | 359 | 408 | 308 | 388 | 339 | 370 | 292 |
| **Total** | 805 | 784 | 898 | 756 | 831 | 698 | 738 | 875 | 935 | 1059 | 929 | 953 | 883 | 960 | 896 |

**Inpatient/Outpatient : Inpatient and Outpatient**

| Month | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agnews (AM) | 4 | 8 | 6 | 5 | 7 | 6 | 9 | 4 | 6 | 3 | 4 | 4 | 0 | 2 | |
| Healthy Kids (HK) | 2 | 4 | 1 | 4 | 3 | 1 | 3 | 4 | 2 | 4 | 3 | 5 | 3 | 5 | 1 |
| Medi-Cal (MC) | 948 | 1012 | 1039 | 932 | 941 | 871 | 959 | 927 | 998 | 1132 | 1079 | 1014 | 1031 | 982 | 1049 |
| Cal-MediConnect | 485 | 416 | 472 | 431 | 520 | 500 | 333 | 692 | 927 | 875 | 782 | 841 | 676 | 752 | 577 |
| **Total** | 1439 | 1440 | 1518 | 1372 | 1471 | 1378 | 1304 | 1627 | 1933 | 2014 | 1868 | 1864 | 1710 | 1741 | 1627 |

**PAT Time Medi-Cal and Healthy Kids**

| Urgency | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Routine | 95% | 94% | 97% | 97% | 98% | 95% | 96% | 95% | 96% | 87% | 93% | 97% | 97% | 99% |
| Urent | 98% | 97% | 97% | 98% | 99% | 97% | 91% | 76% | 94% | 79% | 89% | 96% | 99% | 99% |
| Retro | 96% | 100% | 98% | 100% | 96% | 93% | 95% | 75% | 91% | 87% | 90% | 98% | 97% | 100% |

| Row Labels | Jun 15 | Jul 15 | Aug 15 | Sept 15 | Oct 15 | Nov 15 | Dec 15 | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient | 243 | 239 | 238 | 224 | 250 | 292 | 142 | 341 | 564 | 463 | 468 | 410 | 3874 |
| Outpatient | 242 | 177 | 234 | 207 | 270 | 208 | 191 | 351 | 359 | 407 | 305 | 360 | 3311 |
| **Grand Total** | **485** | **416** | **472** | **431** | **520** | **500** | **333** | **692** | **923** | **870** | **773** | **770** | **7185** |

**Quality Improvement**
**June - August 2016**

## Potential Quality Issues

Potential Quality of Care Issue - A Potential Quality of Care Issue (PQI) - is a means a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be confirmed without additional review. Such issues PQIs must be referred to the Quality Improvement Department for review. Not all PQIs are found to be quality of care problems.

12 cases identified

### *PQI Levels*

5 cases were closed

## Facility Site Review

Facility Site Review is a means of assessing a primary care provider's ability to meet state defined standards for the ability to;

- Provide appropriate primary health care services;
- Carry out processes that support continuity and coordination of care;
- Maintain patient safety standards and practices; and
- Operate in compliance with all applicable local, state, and federal laws and regulations.

16 sites were reviewed

10 sites needed a corrective action plan

## Customer Service
## July 2016

### Medi-Cal / Healthy Kids Calls

| | July 2016 | Target KPI * |
|---|---|---|
| Total Inbound Calls | 25,680 | ---------- |
| Average Talk Time | 5:06 minutes | ---------- |
| Average Speed of Answer | 110 seconds | <30 seconds |
| Service Level | 36% | 80% in <30 seconds |
| Abandonment Rate | 7.7% | <5% |
| Average Hold Time | 62 seconds | ≤ 25 seconds |

### Cal-Medi-Connect Calls

| | July 2016 | Target KPI * |
|---|---|---|
| Total Inbound Calls | 3,437 | ---------- |
| Average Talk Time | 5:32 minutes | ---------- |
| Average Speed of Answer | 20 seconds | <30 seconds |
| Service Level | 70% | 80% in <30 seconds |
| Abandonment Rate | 1.9% | <5% |
| Average Hold Time | 69 seconds | ≤ 25 seconds |

## Customer Service
## August 2016

### Medi-Cal / Healthy Kids Calls

| | May 2016 | Target KPI * |
|---|---|---|
| Total Inbound Calls | 31,032 | ---------- |
| Average Talk Time | 4:54 minutes | ---------- |
| Average Speed of Answer | 156 seconds | <30 seconds |
| Service Level | 20% | 80% in <30 seconds |
| Abandonment Rate | 8% | <5% |
| Average Hold Time | 68 seconds | ≤ 25 seconds |

### Cal-Medi-Connect Calls

| | May 2016 | Target KPI * |
|---|---|---|
| Total Inbound Calls | 2053 | ---------- |
| Average Talk Time | 5:26 minutes | ---------- |
| Average Speed of Answer | 35 seconds | <30 seconds |
| Service Level | 59% | 80% in <30 seconds |
| Abandonment Rate | 16.4% | <5% |
| Average Hold Time | 48 seconds | ≤ 25 seconds |
| | | |

## Provider Operations
## June – August 2016

**Provider Services**Provider Operations Department has 4 Provider Services Representatives - Art Shaffer, Abby Baldovinos, Claudia Graciano and Irene Walsh. Provider Calls are taken by all PSR's.

**Encounters by Provider Type**

| Provider Type* | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Agnews | 0.0% | 0 |
| ASC | 0.0% | 0 |
| Audiology & Hearing Aids | 0.0% | 0 |
| Autism | 0.0% | 0 |
| CBAS | 1.0% | 1 |
| Chiropractic | 0.0% | 0 |
| CHME | 0.0% | 0 |
| Community Clinics | 0.0% | 0 |
| Dialysis | 0.0% | 0 |
| DME/MS/Orth/Proth | 0.0% | 0 |
| Home Health | 0.0% | 0 |
| Home Infusion | 1.0% | 1 |
| Hospice | 0.0% | 0 |
| Hospital | 0.0% | 0 |
| IPC Healthcare PCP | 0.0% | 0 |
| Laboratory | 0.0% | 0 |
| LTC PCP | 0.0% | 0 |
| Mental Health | 0.0% | 0 |
| MSSP - Sourcewise | 0.0% | 0 |
| Non-contracted providers | 0.0% | 0 |
| NT 10 PCP | 3.1% | 3 |
| NT 10 Specialists | 13.3% | 13 |
| PAMF | 0.0% | 0 |
| PMG - PCP and SPEC | 68.4% | 67 |
| Premier Care - PCP and SPEC | 12.2% | 12 |
| PT/OT/ST | 0.0% | 0 |
| Radiology | 0.0% | 0 |
| Sleep Disorder | 0.0% | 0 |
| SNF | 1.0% | 1 |
| Stanford / LPCH | 0.0% | 0 |
| Transportation | 0.0% | 0 |
| Urgent Care | 0.0% | 0 |
| VMC Clinics | 0.0% | 0 |
| Wound Care | 0.0% | 0 |
| Other (please specify) | | 30 |
| | ***answered question*** | **98** |

**Encounters by Category**

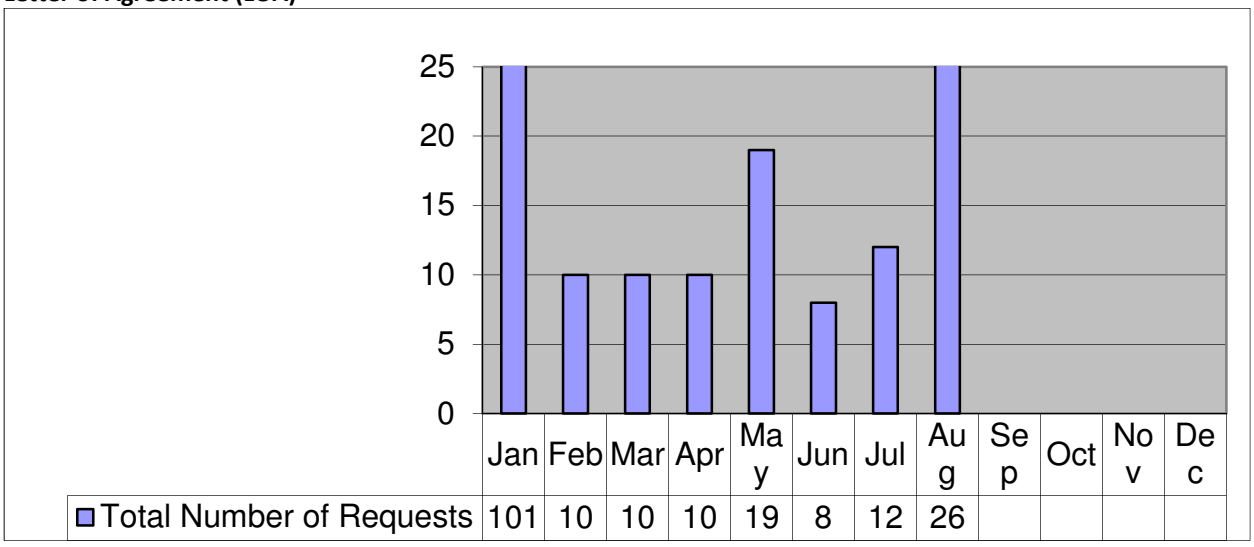
| Reason | | |
|---|---|---|
| **Answer Options** | **Response Percent** | **Response Count** |
| Access | 0.0% | 0 |
| Claims | 1.0% | 1 |
| Provider Network - General* | 99.0% | 97 |
| Provider Request for Member Reassignment | 0.0% | 0 |
| *Provider Education General Detail | | 33 |
| | *answered question* | 98 |

**Provider Database**

| Action | June-16 | July-16 | August-16 |
|---|---|---|---|
| **Providers Added** | 133 | 138 | 111 |
| **Providers Term** | 10 | 79 | 29 |
| **Other changes*** | 37 | 127 | 119 |
| **Lic verification** | 311 | 291 | 408 |
| **W-9** | 117 | 48 | 76 |

*Open, close panels, changed address, add LOB, add network, On Call changes.

**Letter of Agreement (LOA)**



Santa Clara
Family Health Plan
*The Spirit of Care*

# Santa Clara Family Health Plan

## Healthy Kids Program Transitions

September 20, 2016 Update

# Changes in Children's Coverage

- April 1, 2016
  - Covered CA/CalHEERS enhanced to enable screening and enrollment of eligible children in Healthy Kids C-CHIP programs (kids must be documented for C-CHIP eligibility)
- May 16, 2016
  - SB 75 expands Medi-Cal coverage to all children under 19 who meet eligibility requirements, regardless of immigration status

# Program Eligibility

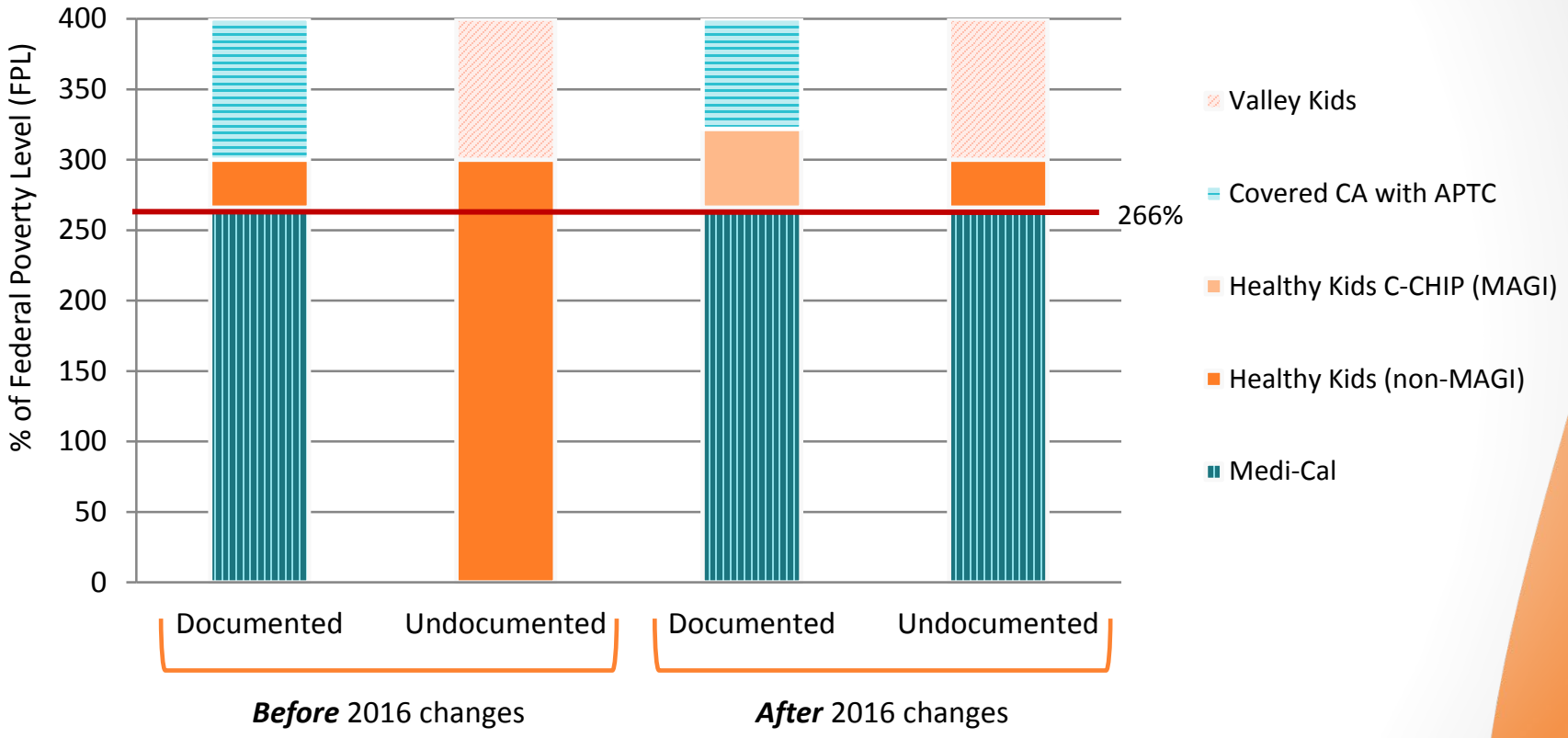
| Immigration Status | Income as % of Federal Poverty Level (FPL) | *Before* C-CHIP and Medi-Cal changes | *After* C-CHIP and Medi-Cal changes |
|---|---|---|---|
| Documented | <= 266% | Healthy Kids | Medi-Cal |
| Documented | > 266 - 322%* (MAGI) | Healthy Kids | Healthy Kids C-CHIP |
| Documented | > 322 - 400% | Covered CA w/ APTC** | Covered CA w/ APTC** |
| Undocumented | <= 266% | Healthy Kids | Medi-Cal |
| Undocumented | > 266 - 300%* (non-MAGI) | Healthy Kids | Healthy Kids |
| Undocumented | > 300 - 400% | Valley Kids | Valley Kids |

Indicates change in program eligibility for specific group due to C-CHIP or SB 75

* 322% of FPL using Modified Adjusted Gross Income (MAGI) is equivalent to 300% of FPL using non-MAGI calculation

** APTC = Advance Premium Tax Credit

# Program Eligibility




Santa Clara
Family Health Plan
*The Spirit of Care*

# C-CHIP Implementation

- Timeline
  - March 2016 – Covered CA/CalHEERS implemented support for enrollment in C-CHIP (Healthy Kids in Santa Clara County)
  - April 1 – first enrollment of C-CHIP children in Healthy Kids via CalHEERS
- Implementation
  - SCFHP: Implement systems and process changes for:
    - Enrollment data source and file
    - Enrollment and termination, including file transmittal to SVHHS Patient Access
    - Member accounting
    - Member invoicing and noticing
  - SVHHS Patient Access: As Covered CA Certified Enrollment Entity, facilitates application completion for members who are conditionally eligible
  - CalHEERS: Ongoing fixes/enhancements to address multiple issues (duplicate records, gender not in file, updated member contact information not being sent to plans, etc.)

# SB 75 Implementation

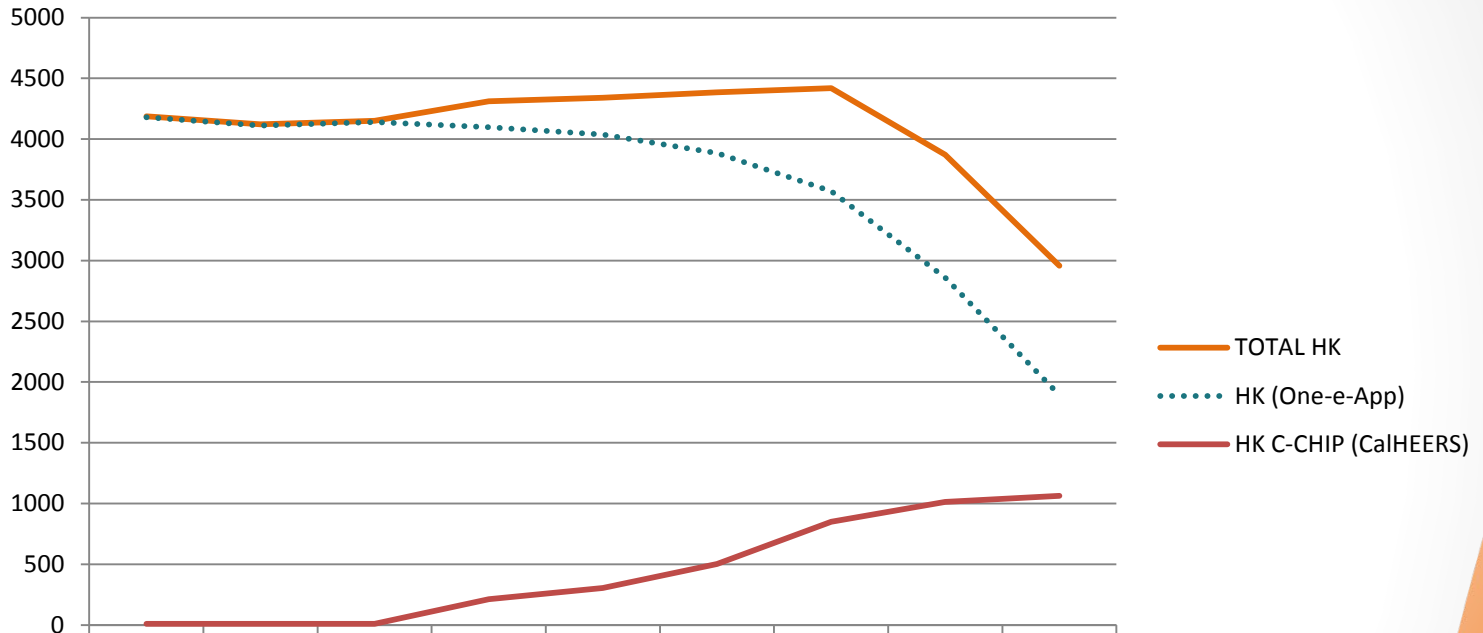
- May 16, 2016 – SB 75 implemented; children enrolled in Restricted Scope Medi-Cal as of May 16 were supposed to be automatically moved to Full Scope Fee-For-Service (FFS) Medi-Cal
- Approximately 80% of children in Restricted Scope MC as of May 16 were:
  a. Automatically enrolled in FFS MC effective June 1
  b. Mailed enrollment notifications and plan choice packets by the State, with 90 days from effective date to make a plan choice or be auto-assigned to a managed care plan
  c. Moved to the managed care plan of their choice effective the first of the month after they made a plan selection (Jul 1st, Aug 1st, Sep 1st)
  d. Moved to a managed care plan through auto-assignment effective September 1st if they did not choose a plan
- Approximately 20% of children in Restricted Scope MC as of May 16:
  a. Had incomplete paperwork so were not automatically enrolled Jun 1st in Full Scope MC
  b. Required follow-up by counties to complete their eligibility determination
  c. Were enrolled in FFS MC as counties completed eligibility determination
  d. Are following steps b. – d. above for enrollment into a managed care plan, with their 90 day choice window ending Oct 1 or possibly Nov 1

# Impact on Healthy Kids Enrollment*

| | Healthy Kids Enrollment | | |
|---|---|---|---|
| | May 1, 2016 | Sept 1, 2016 | % Change |
| HK OEA | 4036 | 1892 | - 53% |
| HK C-CHIP | 305 | 1064 | + 249% |
| **Total** | **4341** | **2956** | **- 32%** |

* Preliminary data due to retroactive enrollment changes

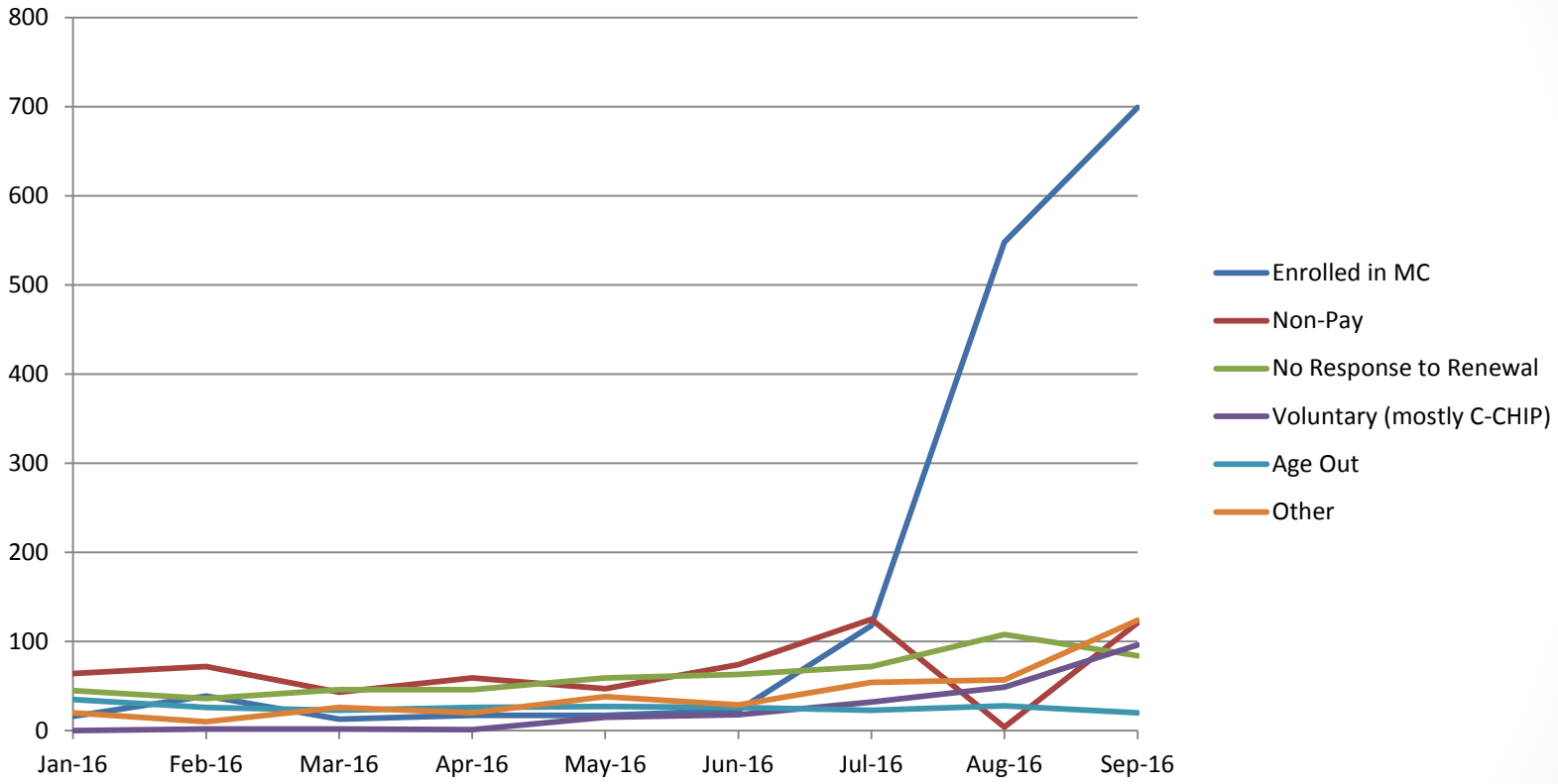
# Healthy Kids Enrollment Changes*




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL HK | 4188 | 4121 | 4151 | 4312 | 4341 | 4385 | 4419 | 3871 | 2956 |
| HK (One-e-App) | 4179 | 4112 | 4141 | 4099 | 4036 | 3884 | 3570 | 2859 | 1892 |
| HK C-CHIP (CalHEERS) | 9 | 9 | 10 | 213 | 305 | 501 | 849 | 1012 | 1064 |

* Preliminary data due to retroactive enrollment changes

# Healthy Kids Terms*




* Preliminary data due to retroactive enrollment changes

Santa Clara
Family Health Plan
*The Spirit of Care*

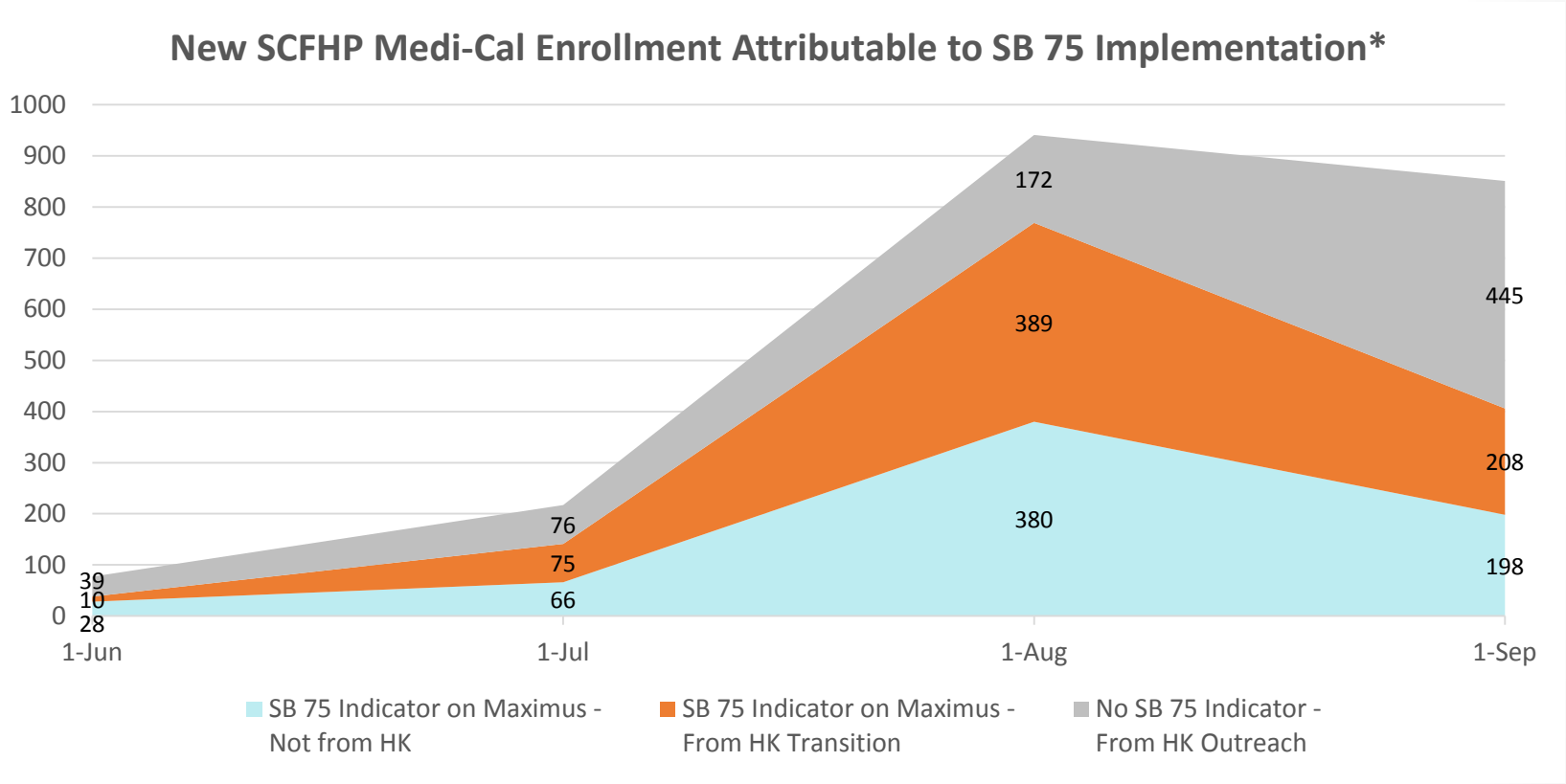
# Impact on Medi-Cal Enrollment*

| | Medi-Cal Enrollment | | | | |
|---|---|---|---|---|---|
| | Jun 1 | Jul 1 | Aug 1 | Sep 1 | Total |
| SB 75 indicator - from HK | 10 | 75 | 389 | 208 | 682 |
| SB 75 indicator - not from HK | 28 | 66 | 380 | 198 | 672 |
| No SB 75 – from HK | 39 | 76 | 172 | 445 | 898 |
| **Total** | **77** | **217** | **941** | **851** | **2252** |

* Preliminary data due to retroactive enrollment changes

Santa Clara Family Health Plan
*The Spirit of Care*

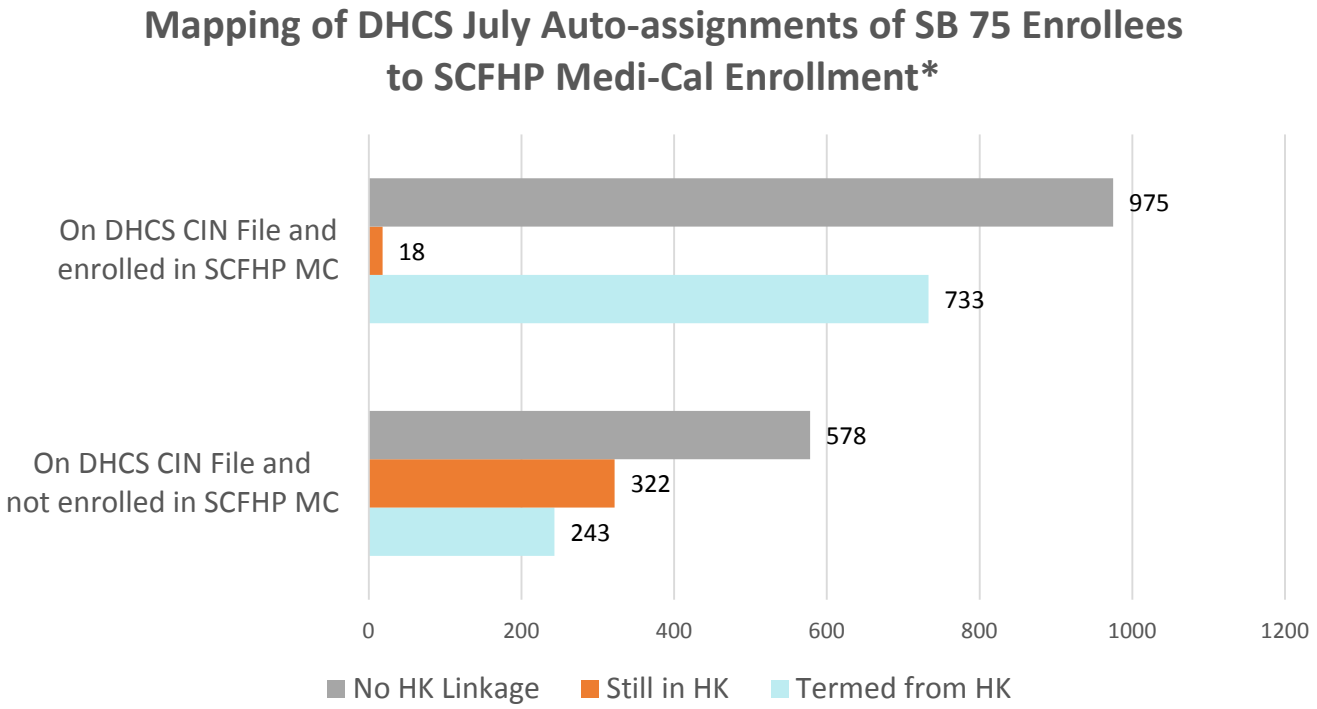
# Impact on SCFHP Medi-Cal Enrollment




* As of September 1, 2016; SB 75 transition continues in October and November
Total records on Maximus file with SB 75 indicator = 1354
HK counts are approximate due to absence of common fields between HK and MC records

Santa Clara Family Health Plan
*The Spirit of Care*

# SCFHP Medi-Cal Enrollment Changes




* 2869 records on July DHCS CIN file

As of September 1, 2016, 1726 enrolled in SCFHP Medi-Cal (60%); 1143 not enrolled with SCFHP

Transition process to FFS and then managed care plan is ongoing

HK counts are approximate due to data matching process

Santa Clara Family Health Plan
*The Spirit of Care*

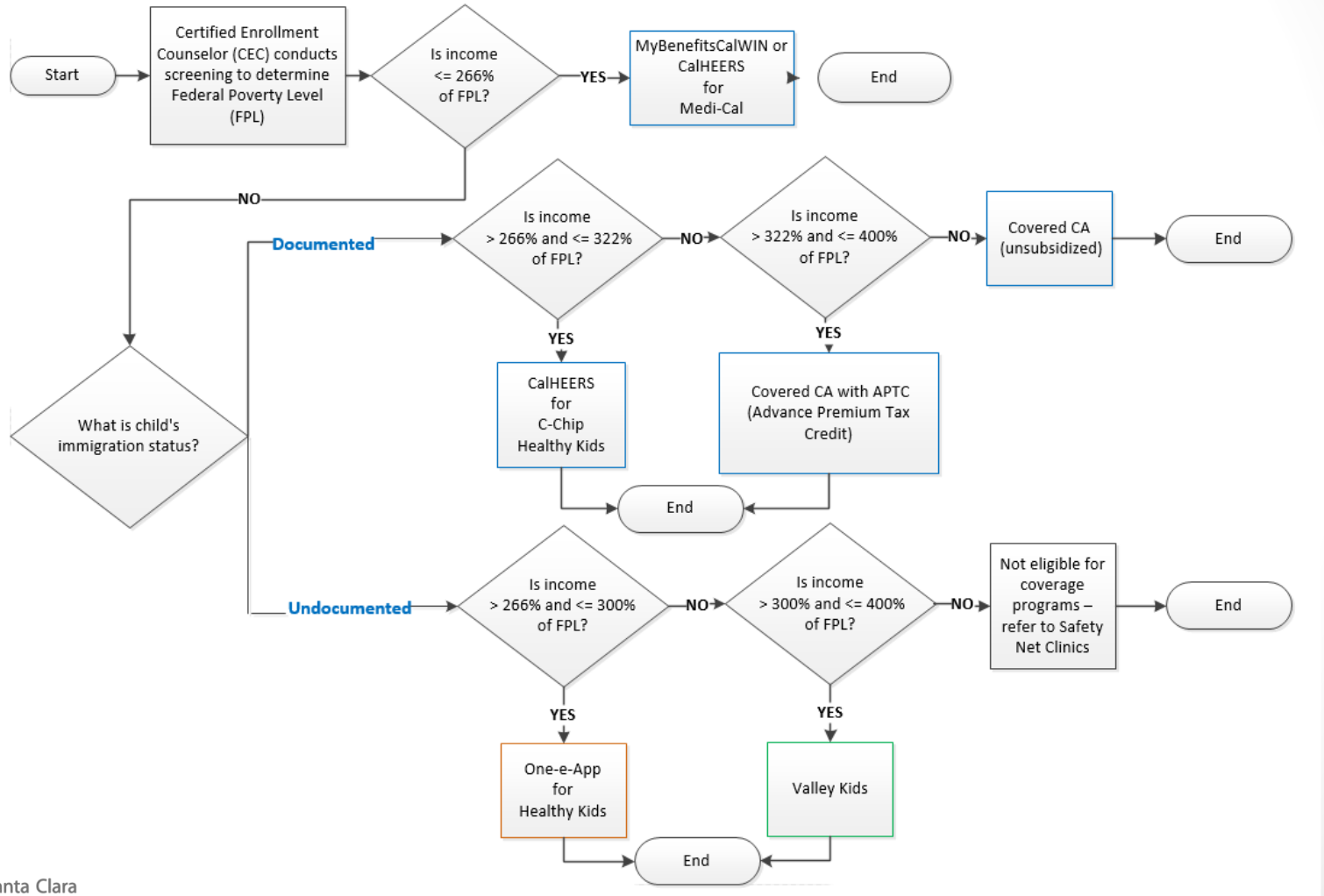
# Healthy Kids Transition Process

- Move Healthy Kids members now eligible for Medi-Cal or Healthy Kids C-CHIP to the appropriate program
- Transition Process
  - Phase 1: SB 75 launch
  - Phase 2: SB 75 transition
  - Phase 3: Realignment of beneficiaries with correct program
  - Phase 4: Potential shift to Valley Kids of non-C-CHIP Healthy Kids
  - Phase 5: Potential sunset of Healthy Kids

# Phase 1: Outreach & Process Changes

- Objective: Educate SCFHP HK members about SB 75, their move to MC, or the need to apply for MC
- Timeframe: April – June 2016
- Data match:  SCFHP HK enrollment, County MC enrollment
- Messaging
  - Members with confirmed linkage to Medi-Cal:
    - You are enrolled in restricted scope MC and will be transitioning to Full Scope MC; you can choose to stay with your same provider; instructions/assistance with how to choose a health plan
  - Members with possible or no linkage to Medi-Cal:
    - You may be eligible for Full Scope MC; you need to apply; instructions on how/where to get application assistance
- Deliverables
  - FAQs for community partners receiving inquiries
  - Talking points for SCFHP Call Center and Healthy Kids staff
  - SB 75 information posted on SCFHP website
  - SB 75 information and application assistance handout in SCFHP lobby kiosk
  - Direct mail in English and Spanish to all HK members
    - Members with confirmed linkage to Medi-Cal
    - Members with possible or no linkage to Medi-Cal
  - Community Clinic outreach to their HK members
  - Outreach to enrollment entities to revise application process to go through CalHEERS or MyBenefitsCalWIN - The Health Trust, SCVHHS Patient Access

# Kids Coverage Application Process Flow




Santa Clara Family Health Plan
*The Spirit of Care*

# Phase 2: Outreach

- Objective: Educate SCFHP HK members about SB 75, move to Medi-Cal, need to choose a managed care plan or need to apply for Medi-Cal
- Timeframe: July – September
- Data match:  SCFHP HK enrollment, County MC enrollment, CIN file from DHCS showing children enrolled in MC through SB 75 and auto-assigned to SCFHP if they did not make a positive plan selection
- Messaging
  - Members with confirmed linkage to Medi-Cal:
    - You are enrolled in restricted scope MC and will be transitioning to Full Scope MC; you can choose to stay with your same provider; instructions/assistance with how to choose a health plan
  - Members with possible or no linkage to Medi-Cal:
    - You may be eligible for Full Scope MC; you need to apply; instructions on how/where to get application assistance
- Deliverables
  - Scripts for outbound calls
  - Outbound call campaigns – SCFHP and Healthier Kids Foundation

# Phase 3: Outreach & Process Changes

- Objective: Ensure SCFHP HK members now eligible for MC or C-CHIP enroll in those programs
- Timeframe: October +
- Audience: All remaining non-C-CHIP Healthy Kids members
- Revised renewal process: Change from paper renewal form to renewing by completing application through CalHEERS or MyBenefitsCalWIN – process matches application process
  - SCFHP renewal notice to reflect change in process
  - Ensures enrollment in appropriate program – Medi-Cal or HK-C-CHIP or HK One-e-App
- Messaging:
  - The renewal process for HK has changed and is now done through CalHEERS or MyBenefitsCalWIN
  - Schedule an appointment with (list of resources); or call SCFHP and we can help you schedule an appointment
- Deliverables
  - FAQs for community partners receiving inquiries
  - Direct mail to all non-C-CHIP HK members
  - Revised renewal notice
- Note: Healthy Kids guarantees one year of coverage upon approval of applications, unless the program is terminated. Transition process will take 12+ months as current HK members cannot be required to complete the modified HK renewal process prior to their renewal dates.

# Phase 4: Potential Shift to Valley Kids

- Objective: Ensure children in Santa Clara County not covered by Medi-Cal or Covered CA are enrolled in the most appropriate local health coverage option.
  - Evaluate transitioning non-C-CHIP Healthy Kids members to Valley Kids
  - Healthy Kids C-CHIP member remain in Healthy Kids – County-State contract
- Timeframe: TBD
- Audience: All remaining non-C-CHIP Healthy Kids members
- Valley Kids program modifications
  - Benefits – Vision, dental, other
  - Funding changes
  - Range of FPLs modified from current 300-400% to be 266-400%
  - County Board of Supervisors resolution to implement changes, address funding
- Healthy Kids program modifications
  - Modify funding resolutions to include only C-CHIP funding; County Board of Supervisors resolution to implement changes
  - Enrollment in Healthy Kids is only through CalHEERS

# Phase 5: Potential Sunset of Healthy Kids

- Objective: Evaluate closing Healthy Kids December 31, 2019, with expiration of C-CHIP contract
  - Transition C-CHIP Healthy Kids to Covered CA
- Timeframe: Plan would need to be developed by October, 2018
- Audience: All remaining C-CHIP Healthy Kids members, assuming all non-C-CHIP member have transitioned to Valley Kids
- Requirements to close a plan include:
  - DMHC filings
  - Member noticing
  - Continuity of care plan