

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

Thursday, June 24, 2021, 12:00 PM – 2:30 PM  
Santa Clara Family Health Plan  
6201 San Ignacio Ave, San Jose, CA 95119

**Via Teleconference**

(669) 900-6833  
Meeting ID: 836 2235 2688  
Passcode: GOVBD0624  
<https://us06web.zoom.us/j/83622352688>

## AGENDA

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- |  |                                   |
|--|-----------------------------------|
| <p><b>1. Roll Call and Board Member Recognition</b><br/>Acknowledge outgoing Board members.</p>  | <p>Mr. Brownstein 12:00 5 min</p> |
| <p><b>2. Public Comment</b><br/>Members of the public may speak to any item not on the agenda; two minutes per speaker. The Governing Board reserves the right to limit the duration of the public comment period to 30 minutes.</p> <p><b><u>Announcement Prior to Recessing into Closed Session</u></b><br/>Announcement that the Governing Board will recess into closed session to discuss Item No. 3 below.</p>   | <p>Mr. Brownstein 12:05 5 min</p> |
| <p><b>3. Adjourn to Closed Session</b></p> <p>a. <b><u>Conference with Labor Negotiators</u></b> (Government Code Section 54957.6):<br/>It is the intention of the Governing Board to meet in Closed Session to confer with its management representatives regarding negotiations with SEIU Local 521.</p> <ul style="list-style-type: none"> <li>• Santa Clara County Health Authority Designated Representatives: Christine Tomcala, Neal Jarecki, Teresa Chapman, and Richard Noack</li> <li>• Employee Organization: SEIU Local 521</li> </ul> <p>b. <b><u>Contract Rates</u></b> (Welfare and Institutions Code Section 14087.38(n)):<br/>It is the intention of the Governing Board to meet in Closed Session to discuss plan partner rates.</p> | <p>12:10</p>                      |
| <p><b>4. Report from Closed Session</b></p>  | <p>Mr. Brownstein 12:35 5 min</p> |
| <p><b>5. Tentative Agreement with SEIU Local 521</b><br/><b>Possible Action:</b> Approve agreement with SEIU Local 521</p>   | <p>Mr. Brownstein 12:40 5 min</p> |

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

Items removed from the Consent Calendar will be considered as regular agenda items.

**Possible Action:** Approve Consent Calendar

- a. Approve minutes of the March 25, 2020 **Governing Board Meeting**
- b. Approve minutes of the May 20, 2021 **Special Governing Board Meeting**
- c. Accept minutes of the April 22, 2021 **Executive/Finance Committee Meeting**
  - Ratify acceptance of Claims Policies
    - CL.04 Skilled Nursing Facility
    - CL.05 Long Term Care
    - CL.08 General Physician/Professional Services
    - CL.11 Ambulatory Surgery Center
    - CL.14 Processing of Radiology Claims
    - CL.15 Processing of Anesthesia Claims
    - CL.16 Processing of Drugs & Biologicals Claims
    - CL.17 Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims
    - CL.18 Processing of Home Health Claims
    - CL.28 Other Health Coverage Cost Avoidance and Post-Payment Recovery
  - Ratify approval of the Provider Solution Vendor Selection
  - Ratify approval of the Trizetto NetworX Pricer and Modeler
  - Ratify approval of the February 2021 Financial Statements
  - Ratify approval of the Annual Investment Policy FA.07 v3: Investments, and accept Investment Policy Annual Review
  - Ratify approval of the Policy GO.04 v2: Donations and Sponsorships
- d. Accept minutes of the May 27, 2021 **Executive/Finance Committee Meeting**
  - Ratify acceptance of Claims Policies
    - CL.06 Inpatient Admission
    - CL.10 Provider Dispute Resolution
    - CL.12 Coordination of Benefits and Medicare-Medi-Cal Crossover Claims
    - CL.19 Processing of Rehabilitation Therapies Claims
    - CL.20 Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims
    - CL.24 Timely Processing of Non-Clean Claims
    - CL.25 Direct Members Reimbursement
    - CL.26 Claims Development of Non-Clean Non-Contracted Medicare Claims
    - CL.27 Non-Medical Transportation Services
  - Ratify acceptance of Financial Policies
    - FA.01 Finance-General
    - FA.02 Cash & Cash Receipts
    - FA.03 Cash Disbursements
    - FA.04 Accounts Receivable & Revenue
    - FA.05 Payroll & Employee Expenses
    - FA.06 Fixed Assets & Depreciation Expense

- FA.07 Investments
- FA.08 Treasury & Reporting
- FA.09 Financial Close & Reporting
- FA.10 Medical Expense & Incurred-But-Not Paid (IBNR)
- FA.11 Healthcare Economics
- Ratify approval of the Quarterly Investment Compliance Report
- Ratify approval of the March 2021 Financial Statements
- Ratify approval of the COVID-19 Funding request for the YMCA
- e. Accept minutes of the May 27, 2021 **Compliance Committee** Meeting
  - Ratify approval Compliance Policy
    - DE.09 v3 Delegation Revocation
- f. Accept minutes of the April 14, 2021 **Quality Improvement Committee** Meeting
  - Ratify approval of the Quality Improvement (QI) Program Evaluation 2020
  - Ratify approval of the QI Work Plan 2021
  - Ratify approval of QI Policies
    - QI.03 Distribution of QI Information
    - QI.04 Peer Review Process
    - QI.06 QI Study Design/Performance Improvement Program Reporting
    - QI.08 Cultural and Linguistically Competent Services
    - QI.09 Health Education Program and Delivery System
    - QI.11 Member Non-Monetary Incentives
    - QI.12 BIRT for Misuse of Alcohol
    - QI.13 Comprehensive Case Management
    - QI.15 Transitions of Care
    - QI.16 Managed Long Term Services and Support Care Coordination
    - QI.19 Care Coordination Staff Education and Training
    - QI.28 Health Home Program
    - QI.30 Health Risk Assessment
    - QI.31 Individual Care Plan
    - QI.32 Interdisciplinary Care Team
  - Ratify acceptance of the Grievance and Appeals Report Q4 2020
  - Ratify acceptance minutes of the Utilization Management Committee (UMC) – January 20, 2021
  - Ratify acceptance of the Consumer Advisory Board (CAB) – March 4, 2021
  - Ratify acceptance of the Pharmacy and Therapeutics (P&T) Committee Minutes – March 8, 2021
  - Ratify acceptance of the Credentialing Committee Report – February 3, 2021
- g. Accept minutes of the June 9, 2021 **Quality Improvement Committee** Meeting
  - Ratify approval of the Assessment of Member Cultural and Linguistic Needs and Preferences
  - Ratify approval of the 2020 Impact Analysis
  - Ratify approval of the 2021 Population Health Management (PHM) Strategy and Activities and Resource Grid

- Ratify approval of the QI Policies
    - QI.17 Behavioral Health Care Coordination
    - QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors
    - QI.20 Information Sharing with San Andreas Regional Center (SARC)
    - QI.21 Information Exchange Between SCFHP & Health Services Dept.
    - QI.22 Early Start Program (Early Intervention Services)
    - QI.23 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
    - QI.24 Outpatient Mental Health Services: Mental Health Parity
    - QI.25 Intensive Outpatient Health Services: Mental Health Services
    - QI.27 Informing Members of Behavioral Health Services
  - Ratify approval of the Grievance and Appeals Report QI 2021
  - Ratify acceptance of the Utilization Management Committee (UMC) Minutes – April 21, 2021
  - Ratify acceptance of the Credentialing Committee Report – April 7, 2021
  - h. Accept minutes of the May 12, 2021 **Provider Advisory Council Committee Meeting**
  - i. Accept minutes of the June 8, 2021 **Consumer Advisory Committee Meeting**
  - j. Approve **Publicly Available Salary Schedule**
  - k. Accept **Compliance Report**
  - l. Accept **FY'20-'21 Donations & Sponsorships Annual Report and Board Designated Project Funding Report**
  - m. Accept **2021 Employee Satisfaction Survey Highlights**
  - n. Accept **resignation of Dolores Alvarado**
  - o. **Elect Officers** to a two-year term:
    - Chairperson – Bob Brownstein
    - Vice-Chairperson – Sue Murphy
    - Secretary – Michele Lew
    - Treasurer – Neal Jarecki
  - p. Appoint **Alma Burrell and Michele Lew to the Executive/Finance Committee**
  - q. Appoint **Sue Murphy, Bob Brownstein, Darrell Evora, and Sherri Sager to a temporary, ad-hoc subcommittee to conduct the annual evaluation of the CEO**
  - r. Approve changing meeting times of the **Executive/Finance Committee to 10:30 am–12:30 pm**, and the **Quality Improvement Committee to Tuesday evening**
7. **CEO Update** Ms. Tomcala 12:50 10 min  
 Discuss status of current topics and initiatives.
8. **Government Relations Update** Mr. Haskell 1:00 10 min  
 Discuss state budget status and other local, state, and federal legislative and policy issues impacting the Plan and its members.



<p><b>9. April 2021 Financial Statements</b> Review April 2021 Financial Statements. <b>Possible Action:</b> Approve the April 2021 Financial Statements</p>	<p>Mr. Jarecki      1:10    10 min</p>
<p><b>10. Fiscal Year 2021-2022 Budget</b> Review proposed budget for FY'22. <b>Possible Action:</b> Approve FY'22 Budget</p>	<p>Mr. Jarecki      1:20    20 min</p>
<p><b>11. Innovation Fund Expenditures</b> a. Consider funding request from the <b>Steering Committee for the Health Equity Agenda project.</b> <b>Possible Action:</b> Approve expenditure from the Board Designated Innovation Fund for the Health Equity Agenda project b. Consider funding request from <b>FIRST 5 Santa Clara County for an Integrated Behavioral Health Pilot Project.</b> <b>Possible Action:</b> Approve expenditure from the Board Designated Innovation Fund for the FIRST 5 Integrated Behavioral Health Pilot Project</p>	<p>Ms. Tomcala      1:40    30 min</p>
<p><b>12. Preliminary Fiscal Year 2020-2021 Year in Review</b> Review preliminary performance on FY '21 Plan Objectives.</p>	<p>Ms. Tomcala      2:10    10 min</p>
<p><b>13. Fiscal Year 2021-2022 Plan Objectives</b> Review draft FY'22 Plan Objectives. <b>Possible Action:</b> Approve FY'22 Plan Objectives</p>	<p>Ms. Tomcala      2:20    10 min</p>
<p><b>14. Adjournment</b></p>	<p>2:30</p>

**Notice to the Public—Meeting Procedures**

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

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

Thursday, March 25, 2021, 12:00 PM – 2:30 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## MINUTES

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### Members Present

Bob Brownstein, Chair  
Dolores Alvarado  
Dave Cameron  
Darrell Evora  
Kathleen King  
Liz Kniss  
Michele Lew  
Sue Murphy  
Ria Paul, M.D.  
Debra Porchia-Usher  
Sherri Sager  
Jolene Smith

### Members Absent

Alma Burrell

### Staff Present

Christine Tomcala, Chief Executive Officer  
Neal Jarecki, Chief Financial Officer  
Laurie Nakahira, DO, Chief Medical Officer  
Jonathan Tamayo, Chief Information Officer  
Chris Turner, Chief Operating Officer  
Ngoc Bui-Tong, VP, Strategies & Analytics  
Teresa Chapman, VP, Human Resources  
Laura Watkins, VP, Marketing & Enrollment  
Barbara Granieri, Controller  
Tyler Haskell, Director, Government Relations  
Johanna Liu, Director, Quality & Process Improvement  
Khanh Pham, Director, Financial Reporting & Budgeting  
Mike Gonzalez, Manager, Community Resource Center  
Rita Zambrano, Executive Assistant  
Nancy Aguirre, Administrative Assistant  
Amy O'Brien, Administrative Assistant

### Others Present

Rafael Gomez, Pacific Health Consulting Group  
Bobbie Wunsch, Pacific Health Consulting Group  
Carlyn Obringer, Government & Community Engagement Manager at Blue Shield of California  
Christine Rutherford-Stuart, County of Santa Clara  
Tiffany Washington, Program Manager for Anthem Blue Cross

### 1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 12:03 PM. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.

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

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

- a. Approve minutes of the December 17, 2020 **Governing Board Meeting**
- b. Approve minutes of the March 11, 2021 **Special Governing Board Meeting**
- c. Accept minutes of the January 28, 2021 **Executive/Finance Committee Meeting**
  - Ratify approval of Claims Policies

- CL.07 Emergency Room Services
- CL.13 Processing of Family Planning Claims
- CL.22 Processing of Abortion Claims
- CL.27 Non-Medical Transportation Services
- Ratify approval of the November 2020 Financial Statements
- Review Quality Updates
  - CY'19 Med-Cal HEDIS Network Comparison Rates
  - CMC 2019 Population Health Management Impact Analysis
- d. Accept minutes of the February 25, 2021 **Executive/Finance Committee** Meeting
  - Ratify approval of Claims Policies
    - CL.01 Interest on the Late Payment of Claims
    - CL.02 Misdirected Claims
    - CL.03 Notice of Denial of Payment
    - CL.09 Claims Timeframes Turn-Around-Time
    - CL.21 Claims Processing & Adjudication
  - Ratify acceptance of the Network Detection and Prevention Update
  - Review Quality Update: Discuss CMC 2020 CAHPS results and Strategy
  - Ratify approval of the December 2020 Financial Statements
- e. Accept minutes of the February 25, 2021 **Compliance Committee** Meeting
- f. Accept minutes of the February 9, 2021 **Quality Improvement Committee** Meeting
  - Ratify approval of the Assessment of Network Adequacy MY2020
  - Ratify approval of the Quality Improvement (QI) Program Description 2021
  - Ratify approval of the Health Education (HE) Program Description 2021, Work Plan 2021, and Evaluation 2020
  - Ratify approval of the Cultural and Linguistics (C&L) Program Description 2021, Work Plan 2021, and Evaluation 2020
  - Ratify approval of the Population Health Assessment
  - Ratify approval of the Clinical, Behavioral, and Medical Preventative Practice Guidelines
  - Ratify approval of QI Policies:
    - QI.05 Potential Quality of Care Issues
    - QI.07 Physical Access Compliance
    - QI.10 Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)
    - QI.13 Comprehensive CM
    - QI.29 Nurse Advice Line
  - Ratify approval of the Grievance and Appeals Reports Q4 2020
  - Ratify acceptance of Committee Reports
    - Pharmacy and Therapeutics (P&T) Committee Minutes – September 17, 2020
    - P&T Committee Minutes – December 17, 2020
    - Utilization Management Committee - October 14, 2020
    - Credentialing Committee – December 2, 2020
- g. Accept minutes of the February 10, 2021 **Provider Advisory Council Committee** Meeting
- h. Accept minutes of the March 9, 2021 **Consumer Advisory Committee** Meeting
- i. Approve **Publicly Available Salary Schedule**
- j. Approve **Quarterly Investment Compliance Report**

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

**Motion:** Ms. Alvarado

**Second:** Ms. Kniss

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Debra Porchia-Usher, Ms. Sager, Ms. Smith

**Absent:** Ms. Burrell

#### 4. Strategic Plan Update

Bobbie Wunsch, Pacific Health Consulting Group, shared feedback received from the Board, noting there was a clear commitment to and accountability for equity as addressed in the vision, mission, values, and strategic plan. Ms. Wunsch presented the vision, mission, and values with new text highlighted in yellow. A discussion ensued, and Ngoc Bui-Tong, Vice President, Strategies and Analytics, made changes as suggested to the vision, mission, and values statements.

**It was moved, seconded, and** the Vision, Mission, Values were **unanimously approved** as amended.

**Motion:** Ms. Lew

**Second:** Mr. Evora

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Smith

**Absent:** Ms. Burrell

Ms. Wunsch presented the 2021-2023 Strategic Plan and discussion ensued. Ngoc Bui-Tong, VP, Strategies and Analytics, made changes as suggested to the strategic plan.

Board Members inquired if they provided Ms. Tomcala with realistic perspectives for setting strategic goals and noted they did not want to set the organization up for failure due to their overly ambitious expectations. The Board indicated it counts on Ms. Tomcala to balance the suggested discussion points with budget implications when setting direction. Ms. Tomcala stated the Board's input was directionally appropriate and the strategies were sound, and she believes progress could be made on each of the goals. She emphasized that the Plan is a very lean staffed organization, and we always seek to find the right balance of resource investment and goals.

Ms. Wunsch noted there would be some wordsmithing to the second success measure in goal two, and the updated version would be sent for final review.

**It was moved, seconded, and** the 2021-2023 Strategic Plan was **unanimously approved** as amended, with direction for staff to wordsmith the second success measure in the second goal.

**Motion:** Ms. Porchia-Usher

**Second:** Ms. King

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Smith

**Absent:** Ms. Burrell

#### 5. CEO Update

Ms. Tomcala presented the updated SCFHP COVID-19 Summary, and shared the percentage of Plan members age 65 and over by ethnicity, noting 57.3% are Asian. Ms. Tomcala reported the percentage of these members who received at least one COVAX dose (60%) compared to the County (65%), broken out by the top four ethnicities reflected in County data. She further shared Plan data on nine Asian sub-groups.

Ms. Tomcala also presented the March 2021 Board Dashboard and At a Glance.

Lastly, she invited Board members to join an event hosted by the SCFHP Diversity Committee celebrating Cesar Chavez Day, Wednesday, March 31, noting Blanca Alvarado would be speaking, with the assistance of Dolores Alvarado.

#### 6. Compliance Report

Tyler Haskell, Interim Compliance Officer, provided an update on the status of various audits. Included were the Medicare compliance program effectiveness audit, annual Department of Health Care Services Medi-Cal audit, and Department of Managed Health Care follow-up to our 2019 audit. Mr. Haskell also described the upcoming Medicare data validation audit, which will take place in April and May.

## 7. Government Relations Update

Tyler Haskell, Director of Government Relations, provided an update on relevant state and federal government activity. He first discussed the status of the state budget and state legislation that would impact the Plan. Then he gave an overview of the recently-enacted American Rescue Plan, specifically mentioning the inclusion of local government budget relief and funding for behavioral health services. Mr. Haskell also discussed the President's new infrastructure plan and health care provisions it may contain, including sweeping reforms to prescription drug laws.

*Dolores Alvarado left the meeting at 2:00 pm.*

## 8. January 2021 Financial Statements

Neal Jarecki, Chief Financial Officer, presented the January 2021 financial statements, which reflected a current month net surplus of \$2.3 million (\$4.8 million favorable to budget) and a fiscal year to date net surplus of \$7.1 million (\$8.1 million favorable to budget). Enrollment increased by 1,793 members from the prior month to 272,900 members (483 members favorable to budget). Year-to-date membership growth due to COVID-19 has not been as initially-pronounced as budgeted, but will be sustained for a longer period of time due to the continued public health emergency. Revenue reflected a favorable current month variance of \$15.9 million (17.5%) largely due to (1) additional capitation received due to the delayed carve-out of Medi-Cal pharmacy from managed care, and (2) other net favorable capitation rates and enrolment variances. Medical Expense reflected an unfavorable current month variance of \$11.4 million largely due to (1) additional expenses due to the delayed carve-out of Medi-Cal pharmacy from managed care, and (2) certain fee-for-service expenses in excess of budget, some of which are related to COVID. Administrative Expense reflected a favorable current month variance of \$256 thousand (4.5%) due largely to the timing of certain non-personnel expenses. The balance sheet reflected a Current Ratio of 1.26:1, versus the minimum required by DMHC of 1.00:1. Tangible Net Equity of \$215.9 million, which represented approximately two months of the Plan's total expenses, included unrestricted net assets of \$170 million. Year-to-date capital investments of \$3.3 million were made, predominately construction expenses of the Blanca Alvarado Community Resource Center.

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

**Motion:** Mr. Cameron

**Second:** Ms. Murphy

**Ayes:** Mr. Brownstein, Mr. Cameron, Mr. Evora, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Debra Porchia-Usher, Ms. Sager, Ms. Smith

**Absent:** Ms. Alvarado, Ms. Burrell

## 9. Fiscal Year 2020-21 Budget Update

Mr. Jarecki provided an update to the fiscal year 2020-21 budget. He noted that Board-approved budget of June 2020, which was based in-part on data from early in the pandemic, envisioned an annual net deficit of \$14M and an overall medical loss ratio (MLR) of 96.5%. The updated forecast is based on fiscal year-to-date results through January 2021 with updated projections the remaining five months of the fiscal year (February 2021 through June 2021). Many budget assumptions have changed as the COVID pandemic has unfolded. Enrollment is expected to increase as Medi-Cal disenrollments are suspended through at least the end of the fiscal year. Revenue projections have been updated to reflected revised enrollment and capitation rate changes. Medical expenses have been revised and include certain COVID-related cost and trend changes. Administrative expenses remain largely as budgeted. The current forecast reflects a net surplus of \$5.9 million an overall MLR of 94.4%. Mr. Jarecki cautioned that significant budget uncertainties will continue.

**10. Adjournment**

The meeting was adjourned at 2:30 PM.

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Susan G. Murphy, Secretary

Special Meeting of the  
**Santa Clara County Health Authority  
Governing Board**

Thursday, May 20, 2021, 3:00 PM – 5:00 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## MINUTES

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### Members Present

Bob Brownstein, Chair  
Dolores Alvarado  
Alma Burrell  
Dave Cameron  
Darrell Evora  
Kathleen King  
Liz Kniss  
Michele Lew  
Sue Murphy  
Ria Paul, MD  
Debra Porchia-Usher  
Sherri Sager  
Jolene Smith

### Staff Present

Christine Tomcala, Chief Executive Officer  
Neal Jarecki, Chief Financial Officer  
Laurie Nakahira, D.O., Chief Medical Officer  
Jonathan Tamayo, Chief Information Officer  
Chris Turner, Chief Operating Officer  
Ngoc Bui-Tong, VP, Strategies & Analytics  
Teresa Chapman, VP, Human Resources  
Barbara Granieri, Controller  
Lori Andersen, Director, Long Term Services & Supports  
Tyler Haskell, Director, Government Relations  
Johanna Liu, Director, Quality & Process Improvement  
Jessica Bautista, Manager, Community Based Case Management  
Emily Hennessy, Marketing & Communications Consultant  
Rita Zambrano, Executive Assistant

### Others Present

Maria Daane, Executive Director, Parents Helping Parents  
Elena Guzman, Deputy Director, Community Health Partnership  
Sarita Kohl, President & CEO, AACI  
Kayla Williams, Program Coordinator II, Community Health Partnership  
Devayani Kunjir, Epidemiologist, Community Health Partnership

### 1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 3:08 pm. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.



### 3. CalAIM Study Session

Tyler Haskell, Director, Government Relations; Johanna Liu, Director, Quality and Process Improvement; and Lori Andersen, Director, Long-Term Services and Supports provided an in-depth overview of California Advancing and Innovating Medi-Cal (CalAIM), a set of Medi-Cal reform proposals designed to address the Governors' top challenges.

*Debra Porchia-Usher joined the meeting at 3:35 pm.*

Discussion focused on transitioning Whole Person Care and the Health Homes Program to Enhanced Care Management (ECM) with In Lieu of Services (ILOS), effective January 1, 2022. Transition plans are due to DHCS July 2021.

There was additional discussion of mandatory NCQA accreditation for all plans and health plan delegates by January 2026, a required Population Health Management (PHM) program beginning January 2023, and the Cal Medi-Connect (CMC) transition to a D-SNP (Dual Eligible Special Needs Plan). It was noted that Regional Rates are also anticipated statewide after January 2024.

*Kathleen King left the meeting at 3:55 pm.*

### 4. Agrihood Proposal

Lori Andersen, Director, Long Term Services and Supports, presented an Innovation Fund request for a pilot program at Agrihood Senior Apartments. The request would commit \$2,420,000 to a five-year partnership with the County Office of Supportive Housing (OSH), Anthem Blue Cross, and Core Companies, the housing developer.

The project is estimated to be implemented in April 2024 and will provide permanent housing with services and supports for 44 SCFHP members who can transition from long term care (LTC) in nursing facilities, but who lack housing. The objective of this program is to enable these members to age in place with dignity and a higher quality of life, prevent institutionalization, and reduce other high cost utilization.

Discussion ensued and Board members voiced their support.

**It was moved, seconded, and** an expenditure from the Board Designated Innovation Fund in the amount of \$2,420,000 for the Agrihood Senior Apartment Pilot was **unanimously approved**, subject to noted contingencies.

**Motion:** Ms. Lew

**Second:** Ms. Smith

**Ayes:** Ms. Alvarado, Mr. Brownstein, Ms. Burrell, Mr. Cameron, Mr. Evora, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Smith

**Absent:** Ms. King

### 5. Adjournment

The meeting was adjourned at 4:57 pm.

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Susan G. Murphy, Secretary

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

Thursday, April 22, 2021, 11:30 AM – 1:30 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes

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### Members Present

Dolores Alvarado  
Bob Brownstein  
Dave Cameron  
Liz Kniss  
Sue Murphy

### Staff Present

Christine Tomcala, Chief Executive Officer  
Neal Jarecki, Chief Financial Officer  
Laurie Nakahira, DO, Chief Medical Officer  
Jonathan Tamayo, Chief Information Officer  
Chris Turner, Chief Operating Officer  
Ngoc Bui-Tong, VP, Strategies & Analytics  
Teresa Chapman, VP, Human Resources  
Laura Watkins, VP, Marketing & Enrollment  
Barbara Granieri, Controller  
Tyler Haskell, Director, Government Relations  
Khanh Pham, Director, Financial Reporting & Budgeting  
Rita Zambrano, Executive Assistant

### Others Present

Carlyn Obringer, Government & Community Engagement  
Manager, Blue Shield of California

### 1. Roll Call

Dolores Alvarado, Chair, called the meeting to order at 11:31 am. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.

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

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

- a. Approve minutes of the February 25, 2021 **Executive/Finance Committee** Meeting
- b. Approve **Claims Policies**
  - CL.04 Skilled Nursing Facility
  - CL.05 Long Term Care
  - CL.08 General Physician/Professional Services
  - CL.11 Ambulatory Surgery Center
  - CL.14 Processing of Radiology Claims
  - CL.15 Processing of Anesthesia Claims
  - CL.16 Processing of Drugs & Biologicals Claims

- CL.17 Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims
- CL.18 Processing of Home Health Claims
- CL.28 Other Health Coverage Cost Avoidance and Post-Payment Recovery

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

**Motion:** Ms. Kniss

**Second:** Ms. Murphy

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

#### 4. CEO Update

Christine Tomcala, Chief Executive Officer, presented the updated SCFHP COVID-19 Summary, noting SCFHP is holding vaccine clinics for the community at our Blanca Alvarado Community Resource Center in collaboration with the County. She presented data on the percentage of SCFHP members by age band who received at least one COVAX dose compared to the County, as well as a breakdown of the percentage of members who received a vaccine by ethnicity. She noted the groups with lower than average vaccine uptake include the Hispanic, African Ancestry, and American Indian communities. Ms. Tomcala further noted we inquire about vaccine hesitancy concerns when making outreach calls to members to assist with scheduling vaccine appointments. Discussion ensued regarding potential opportunities to assist members in overcoming vaccine hesitancy.

#### 5. Government Relations Update

Tyler Haskell, Director, Government Relations, provided an update on relevant state, federal and local government activity. He first gave an overview of the recently-enacted American Rescue Plan, specifically mentioning the inclusion of local government budget relief. He then gave an overview of the status of the state budget and state legislation that would impact the Plan. Mr. Haskell also discussed the President's new infrastructure plan and health care provisions it may contain, including sweeping reforms to prescription drug laws.

#### 6. Provider Payment Solution Vendor Selection

Chris Turner, Chief Operating Officer, provided an overview of the selection process for a Provider Payment Solution vendor. The highest scoring vendor responding to the RFP was PaySpan, and their pricing was comparable to the current vendor.

**It was moved, seconded and unanimously approved** to authorize the Chief Executive Officer to negotiate, execute, amend, and terminate a contract with Payspan based on RFP pricing.

**Motion:** Ms. Kniss

**Second:** Mr. Cameron

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

#### 7. Trizetto NetworX Pricer and Modeler

Jonathan Tamayo, Chief Information Officer, presented a proposal for the Cognizant NetworX claims pricing and modeling tool, designed to allow payers to compare and implement complex contract terms.

**It was moved, seconded and unanimously approved** to authorize the Chief Executive Officer to negotiate, execute, amend, and terminate a contract amendment with Cognizant at a cost of \$377,000 for the perpetual license fee and implementation, plus \$50,000 for annual maintenance.

**Motion:** Ms. Murphy

**Second:** Ms. Kniss

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

## 8. February 2021 Financial Statements

Neal Jarecki, Chief Financial Officer, presented the February 2021 financial statements, which reflected a current month net surplus of \$4.8 million (\$6.6 million favorable to budget) and a fiscal year-to-date net surplus of \$11.9 million (\$14.7 million favorable to budget). Enrollment increased by 2,088 members from the prior month to 274,988 members (2,720 members favorable to budget). The year-to-date membership growth due to COVID-19 has exceeded budget due to the extended duration of the pandemic versus budgeted enrollment and will be sustained for a longer period of time due to the continued public health emergency. Revenue reflected a favorable current month variance of \$19.5 million (17.5%) largely due to (1) additional capitation received due to the delayed carve-out of Medi-Cal pharmacy from managed care, and (2) unanticipated DHCS capitation payments for fiscal years 2014-2017. Medical Expense reflected an unfavorable current month variance of \$12.6 million (14.4%) largely due to (1) additional expenses due to the delayed carve-out of Medi-Cal pharmacy from managed care (offsetting the associated Pharmacy revenue), and (2) certain fee-for-service expenses in excess of budget, some of which are related to COVID. Administrative Expense reflected an unfavorable current month variance of \$417 thousand (7.8%) due largely to the timing of certain non-personnel expenses. The balance sheet reflected a Current Ratio of 1.23:1, versus the minimum required by DMHC of 1.00:1. Tangible Net Equity of \$220.6 million, which represented approximately two months of the Plan's total expenses, included unrestricted net assets of \$175 million. Year-to-date capital investments of \$3.7 million were made, predominately construction expenses of the Blanca Alvarado Community Resource Center.

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

**Motion:** Mr. Cameron

**Second:** Mr. Brownstein

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

## 9. Annual Investment Policy Review

Mr. Jarecki presented updates to the Investment Policy, as recommended following an annual review by Sperry Capital.

**It was moved, seconded, and** the updated Investment Policy FA.07 v3 was **unanimously approved.**

**Motion:** Mr. Cameron

**Second:** Ms. Murphy

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

*Dave Cameron and Liz Kniss left the meeting at 12:57 pm.*

## 10. Donations and Sponsorships Policy

Laura Watkins, VP, Marketing & Enrollment, presented the Donations and Sponsorships Policy, noting a change in the annual limit from \$150,000 to \$200,000.

**It was moved, seconded and** the updated Donations & Sponsorships Policy GO.04 v2 was **unanimously approved.**

**Motion:** Ms. Murphy

**Second:** Mr. Brownstein

**Ayes:** Ms. Alvarado, Mr. Brownstein, Ms. Murphy

**Absent:** Mr. Cameron, Ms. Kniss

## 11. Adjournment

The meeting was adjourned at 1:00 pm.

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Susan G. Murphy, Secretary

DRAFT

## POLICY

<b>Policy Title:</b>	<b>Skilled Nursing Facility</b>	<b>Policy No.:</b>	CL.04 v2
<b>Replaces Policy Title (if applicable):</b>	<b>Skilled Nursing Facility</b>	<b>Replaces Policy No. (if applicable):</b>	CL044
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding Skilled Nursing Facilities (SNF) in accordance with State and Federal regulatory requirements, and contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. Medi-Cal: For Medi-Cal SNF claims from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay at least ninety percent (90%) of all clean claims within thirty (30) calendar days, and ninety-nine (99%) within ninety (90) calendar days of the date of receipt of the claims.
- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) SNF Claims from contracted providers, SCFHP shall pay all claims within thirty (30) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding SNF from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days (sixty-two (62) calendar days) of the date of receipt.
- b. Cal Medi-Connect: For CMC claims regarding SNF from non-contracted providers, SCFHP shall pay all claims within thirty (30) calendar days of the date of receipt.

## POLICY

### B. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

### C. Date of Payment

The date of payment shall be the date of the check.

### D. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### E. Reimbursement Rates

#### 1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

#### 2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: In area Non-contracted providers will be paid for covered services at not less than 100% of Medicare FFS rates.
- c. CMC: Out of area non-contracted providers will be paid at Medicare Patient Driven Payment Model (PDPM) rates that are not less than the recognized rates under CMS Medicare.

## III. Responsibilities

Utilization Management (UM) is responsible for determining the member's appropriate level of care with the facility based on clinical information presented at the time of admission and ongoing review. In the event that services require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.

The Claims Department is responsible for ensuring applicable rates and interest payments are calculated accurately, applied correctly, and processed timely.



## POLICY

In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

### IV. References

Title 28, California Code of Regulations, Section 1300.71

Geographic Managed Care (GMC) Contract

California W&I Code § 14186.3 (c)(5)

Health and Safety Code (H&S) §§ 1371-1371.36

W&I Code § 14132.276 (b) and (c)

W&I Code § 14186.1 (c)(4)

Title 22 California Code of Regulations (CCR), § 72520

Title 22 (CCR) §§ 51535 and 51535.1

Medi-Cal SNF Provider Manual, Share of Cost

Medicare Claims Processing Manual Chapter 6 and 7

<http://www.cms.gov/Regulations-and-Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html>

Medicare Benefit Policy Manual Chapter 8

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>

**POLICY**

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original			8/26/2016
2	Revised	Executive/Finance	Recommend	4/22/2021

## POLICY

<b>Policy Title:</b>	<b>Long Term Care</b>	<b>Policy No.:</b>	CL.05 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	New
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding Long Term Care (LTC) facilities in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. Medi-Cal: For Medi-Cal LTC claims from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay at least ninety percent (90%) of all clean claims within thirty (30) calendar days, and ninety-nine (99%) within ninety (90) calendar days of the date of receipt.
- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) LTC claims from contracted providers, SCFHP shall pay all claims within thirty (30) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding SNF from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days (sixty-two (62) calendar days) of the date of receipt.
- b. Cal Medi-Connect: For CMC LTC claims from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

#### B. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

## POLICY

### C. Date of Payment

The date of payment shall be the date of the check.

### D. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### E. Reimbursement Rates

#### 1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

#### 2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers are paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers are paid for covered services at not less than 100% of the Medi-Cal FFS rates.

## III. Responsibilities

The Claims Department is responsible for ensuring applicable rates and interest payments are calculated accurately, applied correctly, and processed timely.

UM is responsible to determine the member's appropriate level of care with the facility based on clinical information presented at the time of admission and ongoing review. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.

In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## POLICY

### IV. References

Title 28, California Code of Regulations, Section 1300.71  
 W&I Code § 14186.3 (c)(5)  
 Health and Safety Code (H&S) §§ 1371-1371.36  
 W&I Code § 14132.276 (b) and (c)  
 W&I Code § 14186.1 (c)(4)  
 Title 22 California Code of Regulations (CCR), § 72520  
 Title 22 (CCR) §§ 51535 and 51535  
 Medi-Cal LTC Provider Manual, Share of Cost  
[www.medicare.gov](http://www.medicare.gov)  
 DHCS.ca.gov  
 CCR, Title 22, Section 51511 (a) (3)

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original			08/26/2016
V2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>General Physician/Professional Services</b>	<b>Policy No.:</b>	CL.08 v3
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding general physician or professional services in accordance with State and Federal regulatory requirements, and contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding general physician or professional services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding general physician or professional services from contracted providers, SCFHP shall pay all clean cleans within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding general physician or professional services from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims regarding general physician or professional services from non-contracted providers, SCFHP shall pay all clean cleans within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated

## POLICY

claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable professional rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.



## POLICY

### IV. References

Title 28, California Code of Regulations, Section 1300.71  
 GMC Contract  
 Medi-Cal Provider Manual, Share of Cost  
 Medicare Claims Processing Chapter 12

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/23/2016	N/A	N/A	N/A
2	Revised 02/19/2020	N/A	N/A	N/A
3	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Ambulatory Surgery Center (ASC)</b>	<b>Policy No.:</b>	CL.11 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding Ambulatory Surgery Center (ASC) services in accordance with State and Federal regulatory requirements, and contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding ASC services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) claims regarding ASC services from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding ASC services from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For CMC claims regarding ASC services from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated

## POLICY

claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable ASC rates and interest payments are calculated accurately, applied correctly, and processed timely
- C. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- D. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## POLICY

### IV. References

Title 28, California Code of Regulations, Section 1300.71

Title 22, California Code of Regulations, Sections 51509 and 51509.1

Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers

<http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads>

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/archive.html>

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/26/2016			
2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Processing of Radiology Claims</b>	<b>Policy No.:</b>	CL.14 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims related to radiology services in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding radiology services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding radiology services from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding radiology services from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims regarding radiology services from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first

## POLICY

delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable radiology rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

## POLICY

- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

### IV. References

Title 28, California Code of Regulations, Section 1300.71

[www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Radiology Services, Radiology Diagnostic and Radiology Nuclear Medicine and Medicare Chapter 13 – Radiology Services and Other Diagnostic Procedures -  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf>

Medi-Cal Provider Manual, Share of Cost

Medicare Claims Processing Manual Chapter 13 - Radiology Services and Other Diagnostic Procedures  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf>

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original			08/26/2016
2	Revised			04/08/2021



## POLICY

<b>Policy Title:</b>	<b>Processing of Anesthesia Claims</b>	<b>Policy No.:</b>	CL.15 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims related to anesthesia in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to anesthesia from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims related to anesthesia from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to anesthesia from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims related to anesthesia from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first

## POLICY

delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable anesthesia rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

**POLICY**

**IV. References**

Title 28, California Code of Regulations, Section 1300.71

[www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Anesthesia Services

Medicare Claims Processing Manual Chapter 12, Sections 50, 140.3.2, 140.4.2, 140.4.4 and 140.5  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf>

American Society of Anesthesia (ASA) [www.asahq.org](http://www.asahq.org)

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/26/2016			
2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Processing of Drugs and Biologicals Claims</b>	<b>Policy No.:</b>	CL.16 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	CL.16 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims related to drugs and biologicals in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to drugs and biologicals from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims related to drugs and biologicals from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to drugs and biologicals from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims related to drugs and biologicals from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

## POLICY

### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

### 4. Date of Payment

The date of payment shall be the date of the check.

### 5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

## B. Reimbursement Rates

### 1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

### 2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be reimbursed at 106% of the applicable Medicare Average Sales Price (ASP) rates.

## III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable radiology rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

**POLICY**

- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP’s Records Retention Policy.

**IV. References**

Title 28, California Code of Regulations, Section 1300.71

[www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Drugs and Biologicals Services and any related provider manual policies.

Medicare Claims Processing Manual Chapter 17 - Drugs and biologicals

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/26/2016	NA	NA	
2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims</b>	<b>Policy No.:</b>	CL.17 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	CL.17 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims related to Durable Medical Equipment (DME) in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding DME from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) claims regarding DME from contracted providers, SCFHP shall pay all clean cleans within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal claims regarding DME from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For CMC claims regarding DME from non-contracted providers, SCFHP shall pay all clean cleans within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first

## POLICY

delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable DME rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.



**POLICY**

**IV. References**

Title 28, California Code of Regulations, Section 1300.71

[www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – DME Provider Manual Services

Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics

**V. Approval/Revision History**

First Level Approval			Second Level Approval	
Arlene Bell Director, Claims			Neal Jarecki Chief Financial Officer	
Date			Date	
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/26/2016	NA	NA	
2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Processing of Home Health Claims</b>	<b>Policy No.:</b>	CL.18 v2
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	CL.18 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims related to home health (HH) in accordance with State and Federal regulatory requirements, and contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding home health services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding home health services from contracted providers, SCFHP shall pay all clean cleans within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding home health services from non-contracted providers, SCFHP shall pay ninety-five percent (95) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims regarding home health services from non-contracted providers, SCFHP shall pay all clean cleans within thirty (30) calendar days of the date of receipt.

##### 3. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated

## POLICY

claims processor, or to the Plan's capitated provider for that claim.

4. Date of Payment

The date of payment shall be the date of the check.

5. Clean Claim

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

B. Reimbursement Rates

1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations in the UM module of the system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable radiology rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

**POLICY**

**IV. References**

Title 28, California Code of Regulations, Section 1300.71

[www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) – Home Health Services

Medicare Claims Processing Manual Chapter 10 – Home Health

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original 08/26/2016	NA	NA	
2	Revised	Executive/Finance	Recommend	04/22/2021

## POLICY

<b>Policy Title:</b>	<b>Other Health Coverage Cost Avoidance and Post Payment Recovery</b>	<b>Policy No.:</b>	CL.28 v1
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> CMC	

### I. Purpose

To provide clarification and guidance to Santa Clara Family Health Plan (SCFHP) departments on cost avoidance and post-payment recovery requirements when a Medi-Cal member has other health coverage (OHC).

### II. Policy

- A. State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party. Medi-Cal members with OHC must utilize their OHC for covered services prior to utilizing their Medi-Cal benefits. Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the Medi-Cal program.
- B. SCFHP and its delegates utilize OHC information from the Department of Health Care Services' (DHCS) Medi-Cal Eligibility Record for processing claims, as well as reporting requirements.
- C. Pursuant to federal law, states must take all reasonable measures to determine the legal liability of third parties, and seek reimbursement for covered services for which the third party is liable. This requirement is referred to as post-payment recovery and extends to SCFHP. If SCFHP or its delegates paid a provider claim for which OHC was/is available at the time of service, SCFHP or the delegate engages in post-payment recovery for the reasonable value of the services from the liable third party.

### III. Responsibilities

- A. Information Technology (IT) is responsible for loading eligibility and OHC information into the claims system and submitting post payment recovery report.
- B. Claims is responsible for denying claims without explanation of benefits (EOB) from OHC carrier for Medi-Cal members with OHC.
- C. Finance is responsible for post payment recovery of paid claims for Medi-Cal members with OHC, for reporting, and repayment to DHCS of any recovery received on or after the 13<sup>th</sup> month of original claim payment.

**POLICY**

D. Enrollment and Eligibility is responsible for verifying eligibility and notifying the state of OHC updates.

**IV. References**

APL 21-002 - Cost Avoidance and Post-Payment Recovery for Other Health Coverage.

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original	Executive/Finance	Recommend	4/22/2021



**Santa Clara Family  
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# Provider Payment Solution Vendor Selection

April 16, 2021

# Provider Payment Solution


- SCFHP utilizes a vendor to process provider payments and associated notifications
- In order to improve provider satisfaction it was determined that a new, more responsive vendor solution was needed for:
  - Processing payments to providers (electronic and paper);
  - Issuing provider payment notification (835, eRA, paper RAs)
  - Monitoring payments (reporting and analytics)
  - Improving service to providers and increasing adoption of electronic payments & notifications



# Project Deliverables and Milestones

- Obtain cross-functional feedback from internal stakeholders
- Develop & distribute RFP
- Receive & review proposals
- Participate in live candidate demonstrations
- Group discussions on proposal and demonstrations
- Obtain network match for each solution
- Conduct reference calls
- Complete vendor scorecard

# Vendor Selection Process

January 4, 2021	RFP – Request for Proposal
January 20, 2021	Proposals received from 4 vendors
February 11 - March 9, 2021	Candidate demonstrations
March 5 - March 26, 2021	Candidate reference calls
March 29, 2021	Scorecards submitted by internal stakeholders
March 30, 2021	Scorecards reviewed & recommendation developed
 April 15, 2021	Vendor decision: PaySpan
May - June 2021	Negotiate contract & begin implementation

# Scorecard

Scoring 1-3 Score x Weight = Final rating					
	Weight (1-3)	Change Healthcare	Payspan	Zelis	Notes
Implementation Cost	1				
Implementation Length of Time	2				
Provider Support Model (Availability, scope of support)	3				
Solution Utilized by MC/CMC/MA Plans	2				
Funding Mechanism/Model	3				
Platform (single platform, portal)	2				
Reporting & Analytics	3				
Ease of Integration w/ Existing Products	2				
Provider Electronic Adoption Rate	1				
<b>Total</b>		0	0	0	
Additional Considerations/Factors					
Existing Working Relationship					
Quality of Working Relationship					
References					
<b>Total</b>		0	0	0	
<b>Final Score</b>		0	0	0	

# Recommended Solution

- **Payspan** scored the highest with stakeholder group.
- Rationale:
  - Solid strategy for provider support and increasing adoption of electronic processes
  - High match rate with SCFHP providers
    - 93% of our providers are in Payspan's network
    - 94% receiving electronic payment
  - Preferred funding mechanism
  - Robust reporting capabilities
  - Single system platform model & ease of use of provider portal
    - Other candidates had 2 platforms for their solution
  - Positive references
  - Understanding of SCFHP's business (existing clients include Medi-Cal and CMC plans)
  - Supports business requirements in terms of flexibility and timeliness of execution

# Cost Analysis

Based on pricing as presented in RFP responses, Payspan meets SCFHP's requirements and offers pricing comparable with our current vendor

- Current spend is ~\$111,000 per year (varies based on volume)
- Paper checks/RA
  - Proposal is comparable to current vendor
- Electronic payments/eRA
  - Proposal is comparable to current vendor
  - Increased adoption will reduce overall costs to SCFHP
- Provider Support
  - No charge for outreach, enrollment & training of providers
  - Provider portal use will reduce calls to SCFHP
  - Improvements in the RA/eRA will increase provider satisfaction, reduce calls to SCFHP
- One-time implementation fee
  - Waived with 4-year agreement

# Provider Payment Solution

## Possible Action

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with Payspan based on RFP pricing.



**Santa Clara Family  
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Trizetto NetworX Pricer and Modeler

April 22, 2021

# What is NetworX?

- NetworX Pricer and NetworX Modeler is part of the Cognizant line of Trizetto products designed to allow payers to implement more complex contract terms, as well as provide a way to support quick and accurate reimbursement comparisons.

# Why NetworX?

- SCFHP currently uses pricing options embedded within QNXT.
- As our contractual agreements with providers and facilities have evolved, and become more complex, it was determined that an integrated solution was needed to:
  - Handle more intricate pricing methods
  - Improve auto-adjudication
  - Improve accuracy of payments
  - Address pain points that are manually corrected



# Trizetto NetworX Pricer and Modeler

**Cost: \$277,000 (One time Perpetual License fee)/ \$50,000 (Annual Maintenance Fees)**

- Only product that integrates with QNXT
- Expands the amount of configurable payment methodologies (from 25 to 350)
  - Allows greater flexibility and options when negotiating provider contract agreements
  - Allows for automation of items that are currently manually handled in QNXT today resulting in higher rate of auto-adjudication, efficiency, and accuracy
- Ability to quickly conduct more robust testing of contract changes
- Ability to easily move contract setup between Test environment and Production environment, reducing implementation time and manual setup errors
- Allows Contracting/Finance to view and compare financial impact of various pricing scenarios
- Produces standard reports of provider contract setup and claims payment

BUDGETED – FY20-21		
Item	Finance	IT
Perpetual License	\$277,000	
Annual Maintenance		\$50,000
Implementation	\$100,000	

TOTAL CLAIMS AFFECTED	TOTAL TIME SAVINGS - Claims	TOTAL DOLLAR SAVINGS - Claims
54,000	850 hrs	\$49,000
TOTAL CLAIMS AFFECTED	TOTAL TIME SAVINGS - Config	TOTAL DOLLAR SAVINGS - Config
	200 hrs	\$12,000

# Trizetto NetworX Pricer and Modeler

## Possible Action:

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract amendment with Cognizant at a cost of \$377,000 for the perpetual license fee and implementation, plus \$50,000 for annual maintenance



Santa Clara Family  
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Unaudited Financial Statements  
For The Eight Months Ended February 28, 2021

# Agenda

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# Financial Highlights



	MTD		YTD	
Revenue	\$110 M		\$836 M	
Medical Expense (MLR)	\$100 M	90.7%	\$779 M	93.2%
Administrative Expense (% Rev)	\$5.7 M	5.2%	\$44.3 M	5.3%
Other Income/(Expense)	\$354K		(\$387K)	
<b>Net Surplus (Net Loss)</b>	<b>\$4.8 M</b>		<b>\$11.9 M</b>	
Cash and Investments			\$362 M	
Receivables			\$651 M	
Total Current Assets			\$1,022 M	
Current Liabilities			\$834 M	
Current Ratio			1.23	
Tangible Net Equity			\$221 M	
% of DMHC Requirement			<b>641.9%</b>	

# Financial Highlights

<b>Net Surplus (Net Loss)</b>	<ul style="list-style-type: none"> <li>▶ Month: Surplus of \$4.8M is \$6.6M or 373.3% favorable to budget of \$1.8M loss.</li> <li>▶ YTD: Surplus of \$11.9M is \$14.7M or 539.7% favorable to budget of \$2.7M loss.</li> </ul>
<b>Enrollment</b>	<ul style="list-style-type: none"> <li>▶ Month: Membership was 274,988 (2,720 or 1.0% higher than budget of 272,268).</li> <li>▶ YTD: Member Months YTD was 2,133,922 (23,276 or 1.1% lower than budget of 2,157,198).</li> </ul>
<b>Revenue</b>	<ul style="list-style-type: none"> <li>▶ Month: \$110.3M (\$19.5M or 21.5% favorable to budget of \$90.8M).</li> <li>▶ YTD: \$836.1M (\$53.4M or 6.8% favorable to budget of \$782.7M).</li> </ul>
<b>Medical Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$100.1M (\$12.6M or 14.4% unfavorable to budget of \$87.5M).</li> <li>▶ YTD: \$779.4M (\$36.6M or 4.9% unfavorable to budget of \$742.8M).</li> </ul>
<b>Administrative Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$5.7M (\$417K or 7.8% unfavorable to budget of \$5.3M).</li> <li>▶ YTD: \$44.3M (\$273K or 0.6% favorable to budget of \$44.6M).</li> </ul>
<b>Tangible Net Equity</b>	<ul style="list-style-type: none"> <li>▶ TNE was \$220.6M (represents approximately two months of total expenses).</li> </ul>
<b>Capital Expenditures</b>	<ul style="list-style-type: none"> <li>▶ YTD Capital Investments of \$3.7M vs. \$6.9M annual budget, primarily Community Resource Center.</li> </ul>



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Detail Analyses

# Enrollment

- Total enrollment of 274,988 members is 2,720 or 1.0% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 21,113 members or 8.3%.
- Medi-Cal enrollment has been increasing since January 2020, largely COVID enrollment (beginning in March 2020 annual eligibility redeterminations were suspended).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 8.8%, Medi-Cal Dual enrollment has increased 3.7%, and CMC enrollment has grown 10.1% also due largely to the suspension of disenrollments.

	For the Month February 2021				For Eight Months Ending February 28, 2021				Δ	
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	FY20 vs. FY21
Medi-Cal	265,095	262,974	2,121	0.8%	2,057,430	2,083,866	(26,436)	(1.3%)	1,886,396	9.1%
Cal Medi-Connect	9,893	9,294	599	6.4%	76,492	73,332	3,160	4.3%	66,241	15.5%
<b>Total</b>	<b>274,988</b>	<b>272,268</b>	<b>2,720</b>	<b>1.0%</b>	<b>2,133,922</b>	<b>2,157,198</b>	<b>(23,276)</b>	<b>(1.1%)</b>	<b>1,952,637</b>	<b>9.3%</b>

## Santa Clara Family Health Plan Enrollment By Network February 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	33,180	13%	9,893	100%	43,073	16%
SCVHHS <sup>1</sup> , Safety Net Clinics, FQHC <sup>2</sup> Clinics	132,968	50%	-	0%	132,968	48%
Palo Alto Medical Foundation	7,143	3%	-	0%	7,143	3%
Physicians Medical Group	45,466	17%	-	0%	45,466	17%
Premier Care	15,781	6%	-	0%	15,781	6%
Kaiser	30,557	12%	-	0%	30,557	11%
<b>Total</b>	<b>265,095</b>	<b>100%</b>	<b>9,893</b>	<b>100%</b>	<b>274,988</b>	<b>100%</b>
Enrollment at June 30, 2020	244,888		8,987		253,875	
Net Δ from Beginning of FY21	8.3%		10.1%		8.3%	

<sup>1</sup> SCVHHS = Santa Clara Valley Health & Hospital System

<sup>2</sup> FQHC = Federally Qualified Health Center



# Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD FEBRUARY-2021

		2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	FYTD var	%
<b>NON DUAL</b>	Adult (over 19)	23,604	23,873	24,051	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	5,008	19.0%
	Child (under 19)	92,248	92,843	93,374	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	3,204	3.3%
	Aged - Medi-Cal Only	10,831	10,753	10,801	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	244	2.2%
	Disabled - Medi-Cal Only	10,854	10,882	10,851	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	-75	(0.7%)
	Adult Expansion	68,372	69,272	70,458	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	10,924	14.7%
	BCCTP	11	11	11	11	11	11	11	11	11	11	11	10	10	-1	(9.1%)
	Long Term Care	373	367	380	398	405	402	406	407	409	389	393	388	380	-25	(6.2%)
	<b>Total Non-Duals</b>	<b>206,293</b>	<b>208,001</b>	<b>209,926</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>19,279</b>	<b>8.8%</b>

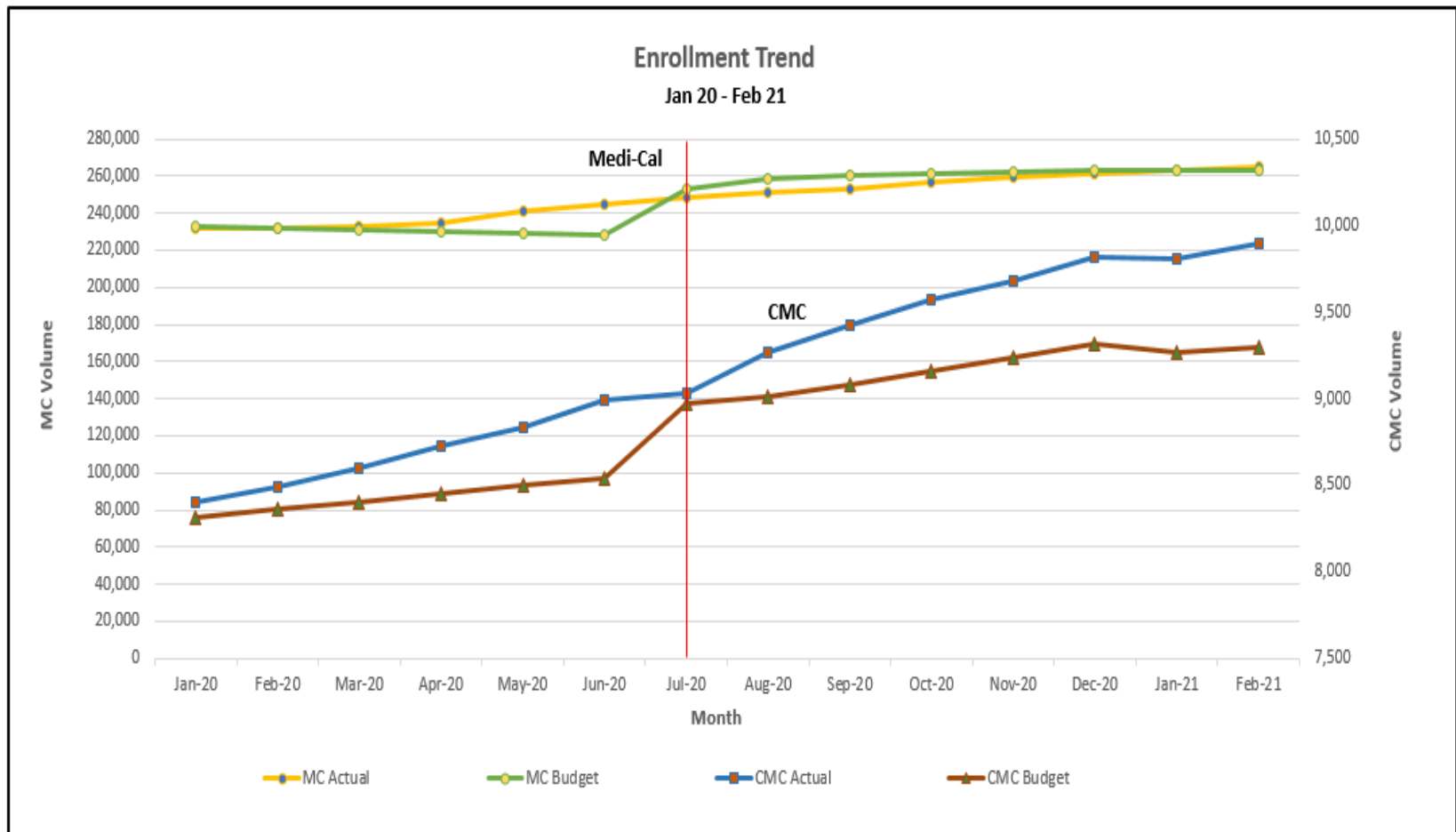
<b>DUAL</b>	Adult (21 Over)	328	320	311	320	321	327	320	337	354	353	353	352	355	34	10.6%
	SPD (21 Over)	23,540	23,541	23,443	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	647	2.8%
	Adult Expansion	130	136	134	190	241	261	289	358	410	498	537	590	662	421	174.7%
	Long Term Care	1,257	1,231	1,235	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	-174	(13.9%)
	<b>Total Duals</b>	<b>25,255</b>	<b>25,228</b>	<b>25,123</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>928</b>	<b>3.7%</b>

<b>Total Medi-Cal</b>	<b>231,548</b>	<b>233,229</b>	<b>235,049</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>20,207</b>	<b>8.3%</b>
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<b>CMC</b>	CMC Non-Long Term Care	8,261	8,388	8,511	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	931	10.6%
	CMC - Long Term Care	225	213	214	212	212	215	211	216	210	209	207	193	187	-25	(11.8%)
	<b>Total CMC</b>	<b>8,486</b>	<b>8,601</b>	<b>8,725</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>906</b>	<b>10.1%</b>

<b>Total Enrollment</b>	<b>240,034</b>	<b>241,830</b>	<b>243,774</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>21,113</b>	<b>8.3%</b>
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# Enrollment Trend

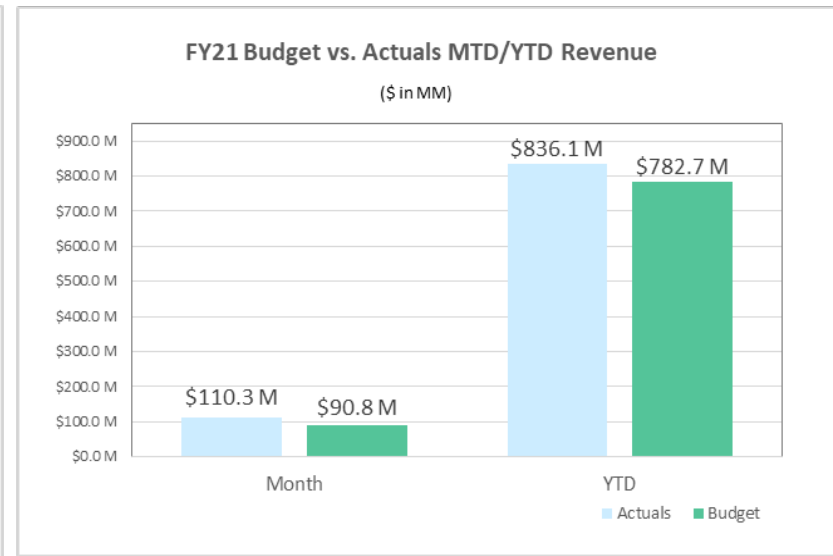
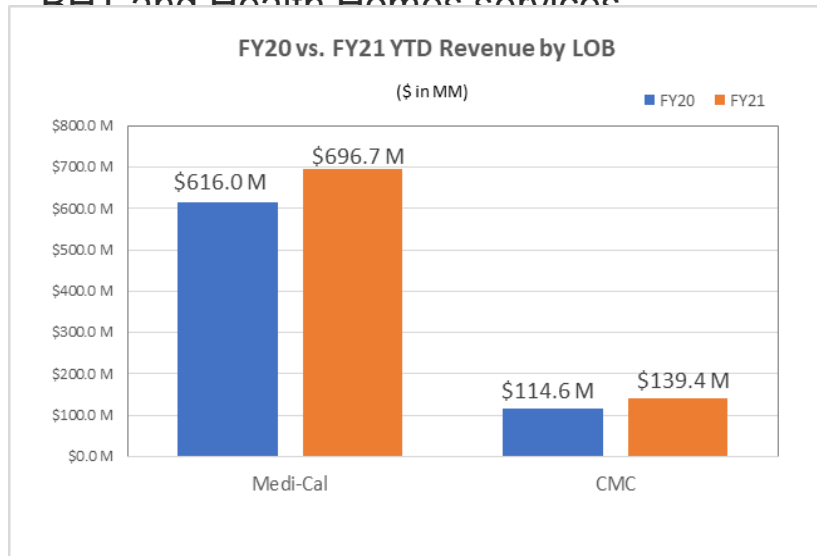


- Budgeted enrollment, represented by the green & red lines, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the gold & blue lines, has grown steadily.

# Revenue

Current month revenue of \$110.3M is \$19.5M or 21.5% favorable to budget of \$90.8M. The current month variance was primarily due to the following:

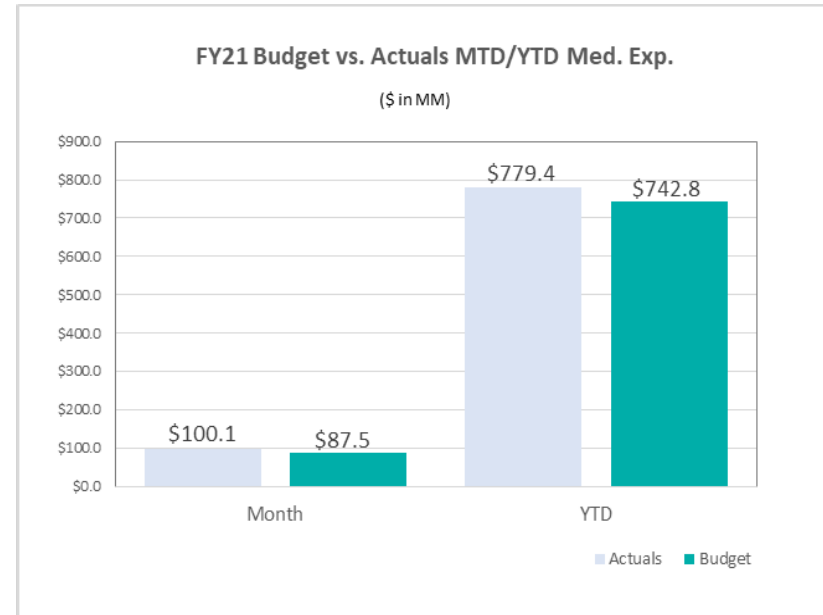
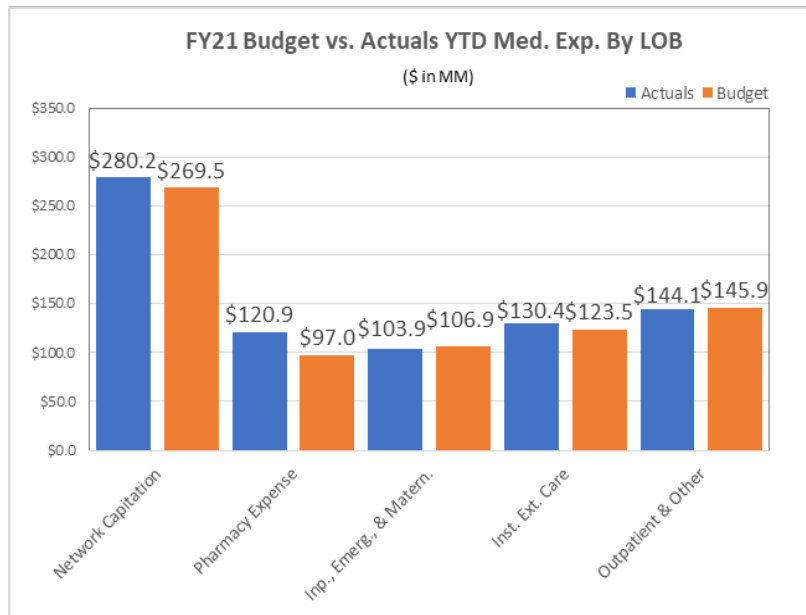
- MCAL Non-Dual revenue is \$15.7M net favorable to budget primarily due to the Rx carve-out suspension (with associated medical expense offset) coupled with FY14 – FY17 retro rates payment, certain CY21 rates higher than budgeted and favorable enrollment variances in certain categories of aid.
- CMC revenue is \$2.1M favorable to budget due to CY15 – CY17 retro rates payment and favorable enrollment to budget.
- MCAL Dual MLTSS revenue is \$1.3M favorable to budget due to higher CY20 rates and higher enrollment than budgeted.
- MCAL Supplemental Kick revenue is \$403K favorable to budget due to increase utilization in BHT and Health Homes services.



# Medical Expense

Current month medical expense of \$100.1M is \$12.6M or 14.4% unfavorable to budget of \$87.5M. The current month variance was due largely to:

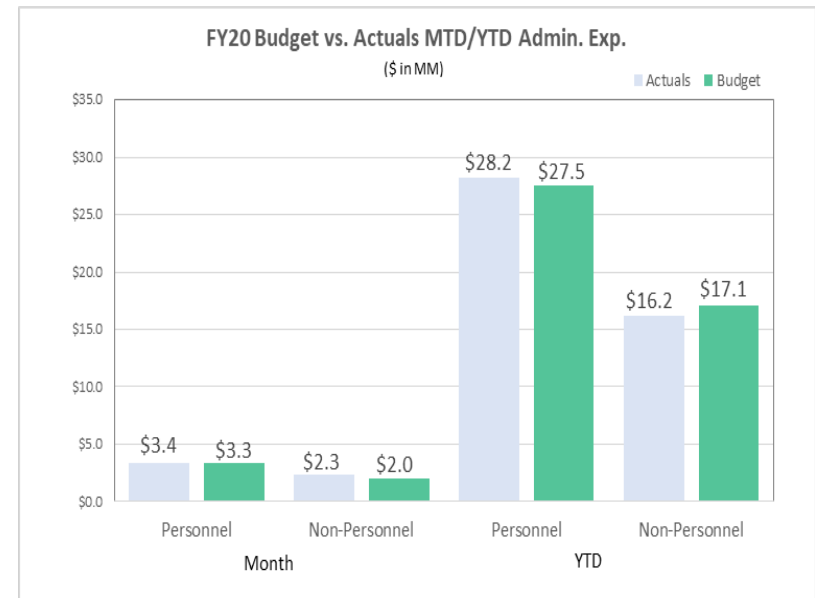
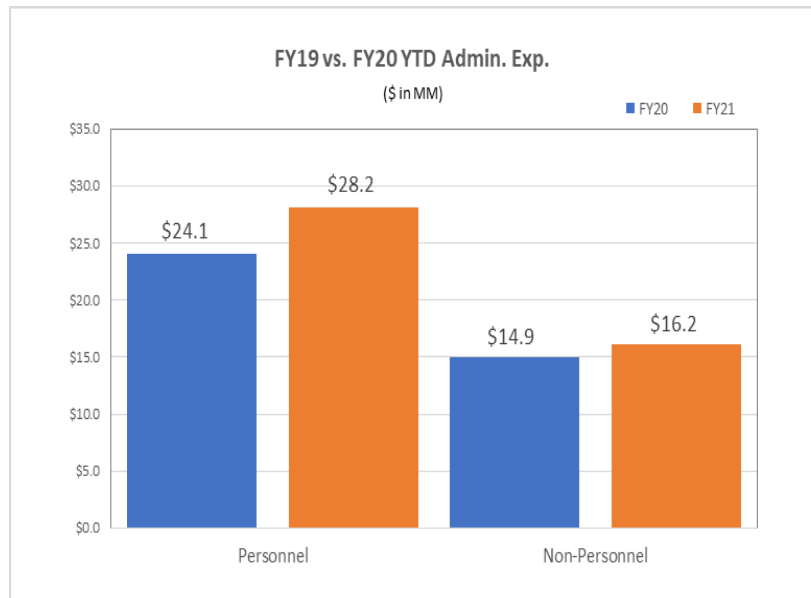
- Pharmacy expenses were \$10.8M or 297% unfavorable to budget due to postponement of the pharmacy carve-out from managed care (offset with favorable revenue variance).
- Fee-For-Service expenses reflects a \$2.0M or 4.3% favorable variance due to an increase trend of LTC enrollment decreases (largely deaths) which resulted in lower enrollment and lower utilization of Long-Term-Care facilities and Professional services.
- Supplemental kick payments are \$207K unfavorable to budget due to an increase in BHT utilization (offsetting unfavorable revenue variance).



# Administrative Expense

Current month expense of \$5.7M is \$417K or 7.8% unfavorable to budget of \$5.3M. The current month variances were primarily due to the following:

- Personnel expenses were \$57K or 1.7% unfavorable to budget due to savings on salary and benefits from lower headcount than budget, offset by increased CalPERS retirement expense.
- Non-Personnel expenses were \$360K or 18.2% unfavorable to budget due to timing of budgeted spending in professional & contract services for translations, claim recovery fee (offset with favorable claim refunds), and quality improvement consulting.



# Balance Sheet

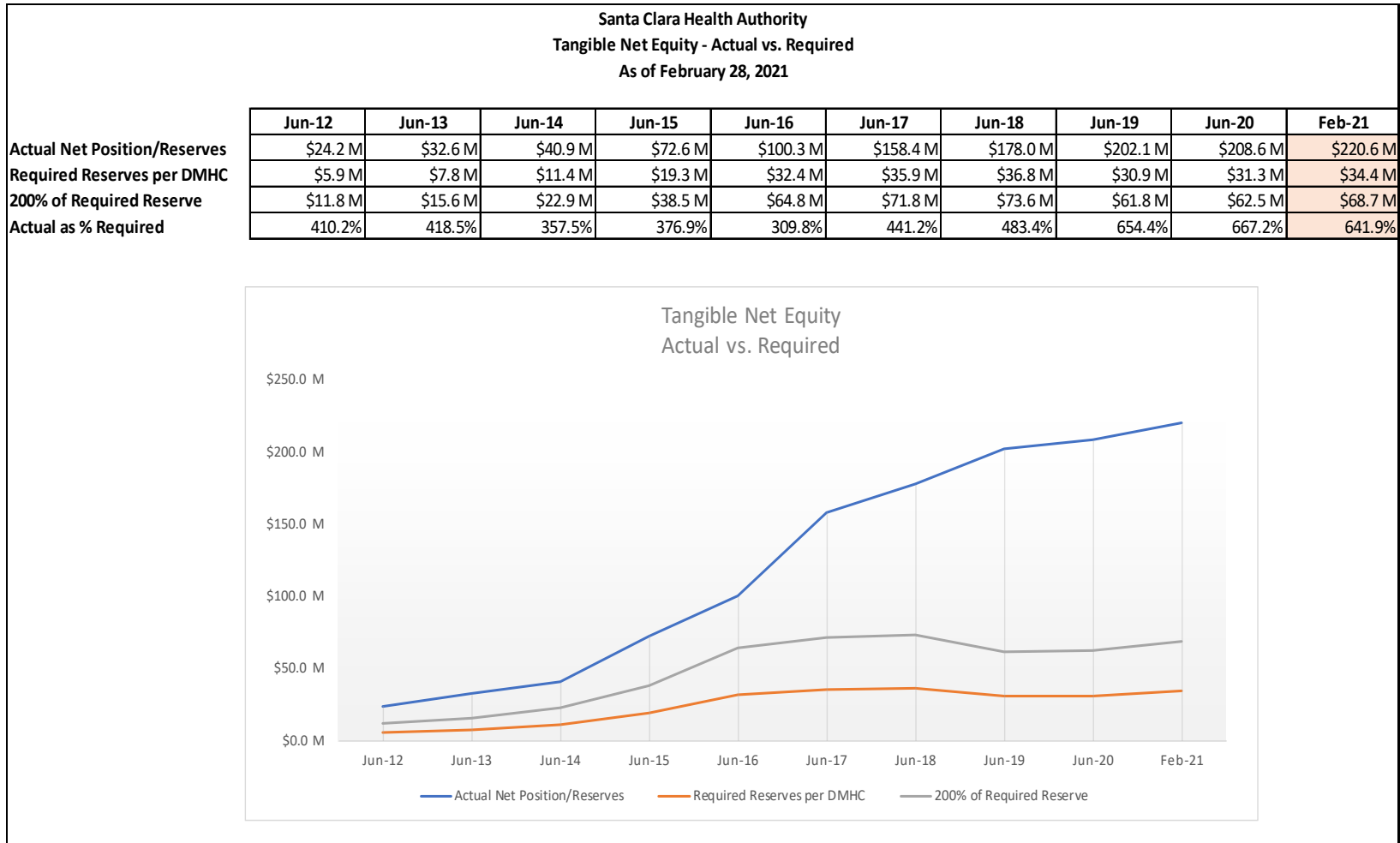
- Current assets totaled \$1.02B compared to current liabilities of \$833.9M, yielding a current ratio (Current Assets/Current Liabilities) of 1.23:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by \$28.0M compared to the cash balance as of year-end June 30, 2020 due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
<b>Short-Term Investments</b>				
County of Santa Clara Comingled Pool	\$157,013,467	0.92%	\$216,271	\$1,021,175
Wells Fargo Investments	\$193,847,673	0.12%	\$10,113	\$217,576
	<u>\$350,861,139</u>		<u>\$226,384</u>	<u>\$1,238,751</u>
<b>Cash &amp; Equivalents</b>				
Bank of the West Money Market	\$327,408	0.10%	\$272	\$12,425
Wells Fargo Bank Accounts	\$10,386,096	0.01%	\$394	\$4,575
	<u>\$10,713,504</u>		<u>\$666</u>	<u>\$17,000</u>
<b>Assets Pledged to DMHC</b>				
Restricted Cash	\$425,000	0.42%	\$79	\$1,105
<b>Petty Cash</b>				
	\$500	0.00%	\$0	\$0
<b>Month-End Balance</b>	<u><u>\$362,000,143</u></u>		<u><u>\$227,128</u></u>	<u><u>\$1,256,857</u></u>

- County of Santa Clara Comingled Pool funds have longer-term investments currently with a higher yield than WFB investments.
- Overall cash and investment yield is lower than budget (0.46% actual vs. 1.4% budgeted).

# Tangible Net Equity

- TNE was \$220.6M - representing approximately two months of the Plan's total expenses.



# Reserves Analysis

SCFHP RESERVES ANALYSIS FEBRUARY 2021			
Financial Reserve Target #1: Tangible Net Equity			
	Approved	Expended	Balance
<b>Unrestricted Net Assets</b>			<b>\$175,060,910 *</b>
Board Designated Funds (Note 1):			
Special Project Funding for CBOs	\$4,000,000	\$662,727	\$3,337,274
Innovation & COVID-19 Fund	\$16,000,000	\$2,169,999	\$13,830,001
Subtotal	\$20,000,000	\$2,832,726	\$17,167,275
Net Book Value of Fixed Assets			\$27,937,112
Restricted Under Knox-Keene Agreement			\$425,000
<b>Total Tangible Net Equity (TNE)</b>			<b>\$220,590,296</b>
Current Required TNE			\$34,366,177
TNE %			641.9%
<b>SCFHP Target TNE Range:</b>			
350% of Required TNE (Low)			\$120,281,619
500% of Required TNE (High)			\$171,830,884
<b>Total TNE Above/(Below) SCFHP Low Target</b>			<b>\$100,308,678</b>
<b>Total TNE Above/(Below) High Target</b>			<b>\$48,759,412</b>
Financial Reserve Target #2: Liquidity			
Cash & Investments			\$362,000,143
Less Pass-Through Liabilities:			
Hospital Directed Payments			(124,956,903)
MCO Tax Payable to State of CA			(18,230,783)
Whole Person Care / Prop 56			(49,144,350)
Other Pass-Through Liabilities (Note 2)			(53,090,907)
<b>Total Pass-Through Liabilities</b>			<b>(245,422,943)</b>
Net Cash Available to SCFHP			<u>116,577,200</u>
SCFHP Target Liquidity (Note 3)			
45 Days of Total Operating Expense			(139,235,856)
60 Days of Total Operating Expense			(185,647,807)
Liquidity Above/(Below) SCFHP Low Target			<u>(22,658,655)</u>
Liquidity Above/(Below) High Target			<u>-\$69,070,607</u>

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

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

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

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



# Capital Expenditures

- Majority of the capital variances are Community Resource Center, hardware, software, and building improvements due to timing of certain projects.

<b>Expenditure</b>	<b>YTD Actual</b>	<b>Annual Budget</b>
Community Resource Center	\$2,841,527	\$3,507,100
Hardware	\$246,700	\$1,282,500
Software	\$131,703	\$1,194,374
Building Improvements	\$464,328	\$866,500
Furniture & Equipment	\$0	\$28,000
<b>TOTAL</b>	<b>\$3,684,258</b>	<b>\$6,878,474</b>



Santa Clara Family  
Health Plan™

Financial Statements

# Income Statement



## Santa Clara County Health Authority INCOME STATEMENT For Eight Months Ending February 28, 2021

	Feb-2021	% of	Feb-2021	% of	Current Month Variance		YTD Feb-2021	% of	YTD Feb-2021	% of	YTD Variance	
	Actuals	Rev	Budget	Rev	\$	%	Actuals	Rev	Budget	Rev	\$	%
<b>REVENUES</b>												
MEDI-CAL	\$ 91,745,688	83.2%	\$ 74,346,540	81.9%	\$ 17,399,148	23.4%	\$ 696,703,188	83.3%	\$ 653,636,591	83.5%	\$ 43,066,597	6.6%
CMC MEDI-CAL	4,559,153	4.1%	2,886,384	3.2%	1,672,770	58.0%	30,531,681	3.7%	23,444,843	3.0%	7,086,838	30.2%
CMC MEDICARE	14,012,113	12.7%	13,573,701	14.9%	438,411	3.2%	108,861,065	13.0%	105,614,996	13.5%	3,246,069	3.1%
TOTAL CMC	18,571,266	16.8%	16,460,085	18.1%	2,111,181	12.8%	139,392,746	16.7%	129,059,839	16.5%	10,332,907	8.0%
<b>TOTAL REVENUE</b>	<b>\$ 110,316,953</b>	<b>100.0%</b>	<b>\$ 90,806,624</b>	<b>100.0%</b>	<b>\$ 19,510,329</b>	<b>21.5%</b>	<b>\$ 836,095,934</b>	<b>100.0%</b>	<b>\$ 782,696,430</b>	<b>100.0%</b>	<b>\$ 53,399,504</b>	<b>6.8%</b>
<b>MEDICAL EXPENSES</b>												
MEDI-CAL	\$ 82,892,853	75.1%	\$ 72,084,125	79.4%	\$ (10,808,729)	-15.0%	\$ 654,329,269	78.3%	\$ 620,735,829	79.3%	\$ (33,593,441)	-5.4%
CMC MEDI-CAL	3,425,893	3.1%	3,004,794	3.3%	(421,099)	-14.0%	24,275,603	2.9%	24,112,850	3.1%	(162,752)	-0.7%
CMC MEDICARE	13,783,872	12.5%	12,417,499	13.7%	(1,366,373)	-11.0%	100,800,542	12.1%	97,932,203	12.5%	(2,868,339)	-2.9%
TOTAL CMC	17,209,765	15.6%	15,422,293	17.0%	(1,787,473)	-11.6%	125,076,144	15.0%	122,045,053	15.6%	(3,031,091)	-2.5%
HEALTHY KIDS	0	0.0%	0	0.0%	0	0.0%	7,303	0.0%	0	0.0%	(7,303)	0.0%
<b>TOTAL MEDICAL EXPENSES</b>	<b>\$ 100,102,618</b>	<b>90.7%</b>	<b>\$ 87,506,417</b>	<b>96.4%</b>	<b>\$ (12,596,201)</b>	<b>-14.4%</b>	<b>\$ 779,412,717</b>	<b>93.2%</b>	<b>\$ 742,780,882</b>	<b>94.9%</b>	<b>\$ (36,631,835)</b>	<b>-4.9%</b>
<b>MEDICAL OPERATING MARGIN</b>	<b>\$ 10,214,335</b>	<b>9.3%</b>	<b>\$ 3,300,207</b>	<b>3.6%</b>	<b>\$ 6,914,128</b>	<b>209.5%</b>	<b>\$ 56,683,217</b>	<b>6.8%</b>	<b>\$ 39,915,548</b>	<b>5.1%</b>	<b>\$ 16,767,669</b>	<b>42.0%</b>
<b>ADMINISTRATIVE EXPENSE</b>												
SALARIES AND BENEFITS	\$ 3,393,169	3.1%	\$ 3,336,586	3.7%	\$ (56,583)	-1.7%	\$ 28,180,283	3.4%	\$ 27,512,996	3.5%	\$ (667,288)	-2.4%
RENTS AND UTILITIES	43,684	0.0%	43,275	0.0%	(409)	-0.9%	322,115	0.0%	293,285	0.0%	(28,830)	-9.8%
PRINTING AND ADVERTISING	13,177	0.0%	77,429	0.1%	64,253	83.0%	165,521	0.0%	590,658	0.1%	425,137	72.0%
INFORMATION SYSTEMS	204,774	0.2%	351,656	0.4%	146,882	41.8%	2,126,664	0.3%	2,717,244	0.3%	590,580	21.7%
PROF FEES/CONSULTING/TEMP STAFFING	1,463,756	1.3%	868,417	1.0%	(595,339)	-68.6%	7,786,758	0.9%	7,692,307	1.0%	(94,451)	-1.2%
DEPRECIATION/INSURANCE/EQUIPMENT	403,818	0.4%	384,396	0.4%	(19,422)	-5.1%	2,834,531	0.3%	2,870,063	0.4%	35,531	1.2%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	41,266	0.0%	66,006	0.1%	24,741	37.5%	573,579	0.1%	519,685	0.1%	(53,893)	-10.4%
MEETINGS/TRAVEL/DUES	70,853	0.1%	110,304	0.1%	39,452	35.8%	630,542	0.1%	882,228	0.1%	251,686	28.5%
OTHER	99,545	0.1%	79,417	0.1%	(20,128)	-25.3%	1,726,801	0.2%	1,541,186	0.2%	(185,615)	-12.0%
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<b>\$ 5,734,042</b>	<b>5.2%</b>	<b>\$ 5,317,487</b>	<b>5.9%</b>	<b>\$ (416,555)</b>	<b>-7.8%</b>	<b>\$ 44,346,793</b>	<b>5.3%</b>	<b>\$ 44,619,652</b>	<b>5.7%</b>	<b>\$ 272,858</b>	<b>0.6%</b>
<b>OPERATING SURPLUS (LOSS)</b>	<b>\$ 4,480,294</b>	<b>4.1%</b>	<b>\$ (2,017,279)</b>	<b>-2.2%</b>	<b>\$ 6,497,573</b>	<b>322.1%</b>	<b>\$ 12,336,424</b>	<b>1.5%</b>	<b>\$ (4,704,104)</b>	<b>-0.6%</b>	<b>\$ 17,040,528</b>	<b>362.2%</b>
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	\$ 65,750	0.1%	\$ 60,000	0.1%	\$ (5,750)	-9.6%	\$ 654,221	0.1%	\$ 480,000	0.1%	\$ (174,221)	-36.3%
GASB 68 - UNFUNDED PENSION LIABILITY	(156,500)	-0.1%	75,000	0.1%	231,500	308.7%	1,915,458	0.2%	600,000	0.1%	(1,315,458)	-219.2%
<b>NON-OPERATING EXPENSES</b>	<b>\$ (90,750)</b>	<b>-0.1%</b>	<b>\$ 135,000</b>	<b>0.1%</b>	<b>\$ 225,750</b>	<b>167.2%</b>	<b>\$ 2,569,679</b>	<b>0.3%</b>	<b>\$ 1,080,000</b>	<b>0.1%</b>	<b>\$ (1,489,679)</b>	<b>-137.9%</b>
INTEREST & INVESTMENT INCOME	\$ 227,128	0.2%	\$ 350,000	0.4%	\$ (122,872)	-35.1%	\$ 1,256,857	0.2%	\$ 2,800,000	0.4%	\$ (1,543,143)	-55.1%
OTHER INCOME	35,828	0.0%	33,668	0.0%	2,159	6.4%	925,908	0.1%	266,255	0.0%	659,653	247.8%
<b>NON-OPERATING INCOME</b>	<b>\$ 262,956</b>	<b>0.2%</b>	<b>\$ 383,668</b>	<b>0.4%</b>	<b>\$ (120,712)</b>	<b>-31.5%</b>	<b>\$ 2,182,765</b>	<b>0.3%</b>	<b>\$ 3,066,255</b>	<b>0.4%</b>	<b>\$ (883,490)</b>	<b>-28.8%</b>
<b>NET NON-OPERATING ACTIVITIES</b>	<b>\$ 353,706</b>	<b>0.3%</b>	<b>\$ 248,668</b>	<b>0.3%</b>	<b>\$ 105,038</b>	<b>42.2%</b>	<b>\$ (386,914)</b>	<b>0.0%</b>	<b>\$ 1,986,255</b>	<b>0.3%</b>	<b>\$ (2,373,169)</b>	<b>-119.5%</b>
<b>NET SURPLUS (LOSS)</b>	<b>\$ 4,834,000</b>	<b>4.4%</b>	<b>\$ (1,768,611)</b>	<b>-1.9%</b>	<b>\$ 6,602,611</b>	<b>373.3%</b>	<b>\$ 11,949,509</b>	<b>1.4%</b>	<b>\$ (2,717,849)</b>	<b>-0.3%</b>	<b>\$ 14,667,358</b>	<b>539.7%</b>

# Balance Sheet



**SANTA CLARA COUNTY HEALTH AUTHORITY**  
As of February 28, 2021

	Feb-2021	Jan-2021	Dec-2020	Feb-2020
<b>Assets</b>				
<b>Current Assets</b>				
Cash and Investments	362,000,143	384,167,611	335,480,779	331,155,934
Receivables	650,794,128	502,763,948	561,944,558	538,827,087
Prepaid Expenses and Other Current Assets	8,901,299	10,789,770	10,139,670	10,910,433
<b>Total Current Assets</b>	<b>1,021,695,570</b>	<b>897,721,329</b>	<b>907,565,007</b>	<b>880,893,455</b>
<b>Long Term Assets</b>				
Property and Equipment	51,070,144	50,645,446	50,627,203	46,056,161
Accumulated Depreciation	(23,133,032)	(22,794,622)	(22,461,569)	(19,711,463)
Total Long Term Assets	27,937,112	27,850,825	28,165,634	26,344,698
<b>Total Assets</b>	<b>1,049,632,682</b>	<b>925,572,153</b>	<b>935,730,641</b>	<b>907,238,153</b>
<b>Deferred Outflow of Resources</b>	<b>8,402,260</b>	<b>8,402,260</b>	<b>8,402,260</b>	<b>9,237,609</b>
<b>Total Assets &amp; Deferred Outflows</b>	<b>1,058,034,942</b>	<b>933,974,413</b>	<b>944,132,901</b>	<b>916,475,762</b>
<b>Liabilities and Net Assets:</b>				
<b>Current Liabilities</b>				
Trade Payables	8,087,827	6,472,762	8,192,320	6,954,520
Deferred Rent	48,585	48,414	48,243	0
Employee Benefits	3,002,306	2,948,693	2,858,642	1,995,511
Retirement Obligation per GASB 75	2,768,118	2,702,368	2,618,301	3,168,673
Deferred Revenue - Medicare	0	0	0	10,629,601
Whole Person Care / Prop 56	49,144,350	47,108,193	44,179,230	33,656,494
Payable to Hospitals (SB90)	20,688	37,715,808	37,699,413	0
Payable to Hospitals (SB208)	124,936,215	203,428	832,942	0
Pass-Throughs Payable	330,470	26,787	26,787	28,935,668
Due to Santa Clara County Valley Health Plan and Kaiser	29,466,215	22,286,701	22,553,954	37,115,900
MCO Tax Payable - State Board of Equalization	18,230,783	9,115,391	27,346,174	16,205,140
Due to DHCS	52,760,437	45,976,921	45,596,872	41,503,407
Liability for In Home Support Services (IHSS)	419,268,582	419,268,582	419,268,582	416,092,527
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	117,508,759	112,316,256	107,840,726	102,342,543
<b>Total Current Liabilities</b>	<b>833,867,361</b>	<b>714,484,332</b>	<b>727,356,210</b>	<b>706,894,007</b>
<b>Non-Current Liabilities</b>				
Net Pension Liability GASB 68	1,915,458	2,071,957.68	1,704,912	571,940
<b>Total Non-Current Liabilities</b>	<b>1,915,458</b>	<b>2,071,957.68</b>	<b>1,704,912</b>	<b>571,940</b>
<b>Total Liabilities</b>	<b>835,782,819</b>	<b>716,556,289</b>	<b>729,061,122</b>	<b>707,465,947</b>
<b>Deferred Inflow of Resources</b>	<b>1,661,827</b>	<b>1,661,827</b>	<b>1,661,827</b>	<b>2,994,548</b>
<b>Net Assets</b>				
Board Designated Fund: Special Project Funding for CBOs	3,337,274	3,377,274	3,419,274	3,840,000
Board Designated Fund: Innovation & COVID-19 Fund	13,830,001	13,830,001	13,830,001	16,000,000
Invested in Capital Assets (NBV)	27,937,112	27,850,825	28,165,634	26,344,698
Restricted under Knox-Keene agreement	425,000	530,350	305,350	305,350
Unrestricted Net Equity	163,111,401	163,052,338	162,920,529	155,635,705
Current YTD Income (Loss)	11,949,509	7,115,510	4,769,165	3,889,514
<b>Total Net Assets / Reserves</b>	<b>220,590,296</b>	<b>215,756,297</b>	<b>213,409,952</b>	<b>206,015,267</b>
<b>Total Liabilities, Deferred Inflows and Net Assets</b>	<b>1,058,034,942</b>	<b>933,974,413</b>	<b>944,132,901</b>	<b>916,475,762</b>

# Cash Flow Statement



	<u>Feb-2021</u>	<u>Year-to-date</u>
Cash Flows from Operating Activities		
Premiums Received	(21,814,319)	962,239,806
Medical Expenses Paid	(87,730,602)	(754,487,968)
Administrative Expenses Paid	87,539,195	(178,209,672)
<b>Net Cash from Operating Activities</b>	<b>(22,005,726)</b>	<b>29,542,167</b>
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(424,697)	(3,684,258)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	262,956	2,182,765
<b>Net Increase/(Decrease) in Cash &amp; Cash Equivalents</b>	<b>(22,167,468)</b>	<b>28,040,674</b>
Cash & Investments (Beginning)	384,167,611	333,959,470
Cash & Investments (Ending)	<b>362,000,143</b>	<b>362,000,143</b>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	4,571,044	9,766,745
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	338,410	2,396,233
Changes in Operating Assets/Liabilities		
Premiums Receivable	(148,030,180)	160,212,588
Prepays & Other Assets	1,888,471	962,400
Accounts Payable & Accrued Liabilities	91,112,106	(136,567,290)
State Payable	15,898,907	(34,068,716)
IGT, HQAF & Other Provider Payables	7,179,514	(5,478,860)
Net Pension Liability	(156,500)	1,915,458
Medical Cost Reserves & PDR	5,192,503	30,403,609
<b>Total Adjustments</b>	<b>(26,576,770)</b>	<b>19,775,422</b>
<b>Net Cash from Operating Activities</b>	<b>(22,005,726)</b>	<b>29,542,167</b>

# Statement of Operations by Line of Business - YTD



**Santa Clara County Health Authority**  
**Statement of Operations**  
**By Line of Business (Including Allocated Expenses)**  
**For Eight Months Ending February 28, 2021**

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
<b>P&amp;L (ALLOCATED BASIS)</b>					
REVENUE	\$696,703,188	\$30,531,681	\$108,861,065	\$139,392,746	<b>\$836,095,934</b>
<b>MEDICAL EXPENSE</b> (MLR)	\$654,329,269 93.9%	\$24,275,603 79.5%	\$100,800,542 92.6%	\$125,076,144 89.7%	<b>\$779,412,717</b> 93.2%
<b>GROSS MARGIN</b>	\$42,373,919	\$6,256,078	\$8,060,524	\$14,316,602	<b>\$56,683,217</b>
<b>ADMINISTRATIVE EXPENSE</b> (% of Revenue Allocation)	\$36,953,358	\$1,619,410	\$5,774,025	\$7,393,435	<b>\$44,346,793</b>
<b>OPERATING INCOME/(LOSS)</b> (% of Revenue Allocation)	\$5,420,561	\$4,636,668	\$2,286,498	\$6,923,166	<b>\$12,336,424</b>
<b>OTHER INCOME/(EXPENSE)</b> (% of Revenue Allocation)	(\$322,408)	(\$14,129)	(\$50,377)	(\$64,506)	<b>(\$386,914)</b>
<b>NET INCOME/(LOSS)</b>	\$5,098,152	\$4,622,539	\$2,236,121	\$6,858,661	<b>\$11,949,509</b>
<b>PMPM (ALLOCATED BASIS)</b>					
REVENUE	\$338.63	\$399.15	\$1,423.17	\$1,822.32	<b>\$391.81</b>
MEDICAL EXPENSES	\$318.03	\$317.36	\$1,317.79	\$1,635.15	<b>\$365.25</b>
GROSS MARGIN	\$20.60	\$81.79	\$105.38	\$187.16	<b>\$26.56</b>
ADMINISTRATIVE EXPENSES	\$17.96	\$21.17	\$75.49	\$96.66	<b>\$20.78</b>
OPERATING INCOME/(LOSS)	\$2.63	\$60.62	\$29.89	\$90.51	<b>\$5.78</b>
OTHER INCOME/(EXPENSE)	(\$0.16)	(\$0.18)	(\$0.66)	(\$0.84)	<b>(\$0.18)</b>
NET INCOME/(LOSS)	\$2.48	\$60.43	\$29.23	\$89.67	<b>\$5.60</b>
<b>ALLOCATION BASIS:</b>					
MEMBER MONTHS - YTD	2,057,430	76,492	76,492	76,492	2,133,922
REVENUE BY LOB	83.3%	3.7%	13.0%	16.7%	100.0%



Santa Clara Family  
Health Plan™

Appendix

# Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD MARCH-2021

		2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	FYTD var	%
<b>NON DUAL</b>	Adult (over 19)	23,873	24,051	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	5,412	20.6%
	Child (under 19)	92,843	93,374	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	3,384	3.5%
	Aged - Medi-Cal Only	10,753	10,801	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	11,459	252	2.2%
	Disabled - Medi-Cal Only	10,882	10,851	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	10,811	-111	(1.0%)
	Adult Expansion	69,272	70,458	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	12,124	16.3%
	BCCTP	11	11	11	11	11	11	11	11	11	11	10	10	11	0	0.0%
	Long Term Care	367	380	398	405	402	406	407	409	389	393	388	380	373	-32	(7.9%)
	<b>Total Non-Duals</b>	<b>208,001</b>	<b>209,926</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>240,599</b>	<b>21,029</b>	<b>9.6%</b>

<b>DUAL</b>	Adult (21 Over)	320	311	320	321	327	320	337	354	353	353	352	355	361	40	12.5%
	SPD (21 Over)	23,541	23,443	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	698	3.0%
	Adult Expansion	136	134	190	241	261	289	358	410	498	537	590	662	742	501	207.9%
	Long Term Care	1,231	1,235	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	-194	(15.5%)
	<b>Total Duals</b>	<b>25,228</b>	<b>25,123</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>26,363</b>	<b>1,045</b>	<b>4.1%</b>

<b>Total Medi-Cal</b>	<b>233,229</b>	<b>235,049</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>	<b>22,074</b>	<b>9.0%</b>
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<b>CMC</b>	CMC Non-Long Term Care	8,388	8,511	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	921	10.5%
	CMC - Long Term Care	213	214	212	212	215	211	216	210	209	207	193	187	184	-28	(13.2%)
	<b>Total CMC</b>	<b>8,601</b>	<b>8,725</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>	<b>893</b>	<b>9.9%</b>

<b>Total Enrollment</b>	<b>241,830</b>	<b>243,774</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>276,842</b>	<b>22,967</b>	<b>9.0%</b>
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## POLICY

<b>Policy Title:</b>	<b>Investment Policy</b>	<b>Policy No.:</b>	<b>FA.07</b>
<b>Replaces Policy Title (if applicable):</b>	NA	<b>Replaces Policy No. (if applicable):</b>	NA
<b>Issuing Department:</b>	Finance	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> CMC	

### I. PURPOSE

This investment policy sets for the investment guidelines and structure for the investment of short-term operating funds not required for the immediate needs on and after April 22, 2021 of the Santa Clara Family Health Plan (SCFHP or the Plan) which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

Investments may only be made as authorized by this Annual Investment Policy. SCFHP is required to invest its funds in accordance with the California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox-Keene Act of 1975 as well as the prudent investment standard:

The Prudent Investor Standard: When investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of SCFHP, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code Section 53600.3).

### II. OBJECTIVES

- i. **Safety:** the primary objective of this policy is the preservation of principal; avoiding capital losses by minimizing credit risk and interest rate or market risk.
- ii. **Liquidity:** maintain sufficient liquidity to meet the operating requirements for six months.
- iii. **Yield:** achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
- iv. **Diversification:** provide diversification of the portfolio securities to avoid incurring unreasonable market and credit risks.

## POLICY

### III. INVESTMENT STRATEGY

The Plan will adhere to the investment goal of holding investments to maturity. From time to time, the portfolio may go out of alignment. The Chief Financial Officer may choose to rebalance the portfolio earlier to bring it back into compliance if the portfolio will not suffer any losses for selling the investment prior to maturity.

### IV. ETHICS AND CONFLICTS OF INTEREST

SCFHP's officers, employees and Governing Board members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. SCFHP's officers and employees involved in the investment process are not permitted to have any material financial interests in financial interests in financial institutions, including state or federal credit unions, that conduct business with SCFHP, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of SCFHP's investments.

### V. DELEGATION OF AUTHORITY

#### A. County of Santa Clara Commingled Investment Pool

The Governing Board is responsible for the management and oversight of SCFHP's investment program. The Board has directed that available excess funds not required for immediate operational cash flow purposes be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

- (1) All of the evidence of indebtedness of the County, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.
- (2) The County has cash or cash equivalents in an amount equal to fifty million dollars or more, based on its audited financial statements for the immediately preceding fiscal year.
- (3) The day-to-day managing, reporting, and oversight of the investment contractual obligations between the County and SCFHP shall be the responsibility of SCFHP's Chief Financial Officer.

## POLICY

### B. Depository (Financial) Institutions

All SCFHP money shall be deposited in financial institutions that meet the requirements as set forth in Section 53635.2 and authorized by the Board. The financial institution shall have received an overall rating of not less than “satisfactory” in its most recent evaluation by its appropriate federal financial supervisory agency. In addition, the depository financial institution shall maintain a rating of its senior long-term debt obligations, deposit rating or claims-paying ability rating, or is guaranteed by an entity whose obligations are rated not lower than “AA- by S&P, AA- by Fitch or “Aa3” by Moody’s or its equivalent from another nationally recognized rating agency.

(1) All depository institutions shall provide SCFHP with notification of any downgrades in long-term ratings or any unsatisfactory rating by their appropriate federal financial supervisory agency within 10 days of such downgrade.

(2) Any downgrade in ratings of a financial institution holding SCFHP funds, shall be provided to the Board by the Chief Financial Officer.

(3) The day-to-day managing, reporting, and oversight of the depository and investment contractual obligations for SCFHP shall be the responsibility of SCFHP’s Chief Financial Officer.

(4) The Board of Directors may renew the delegation of authority to enter into depository and investment relationships annually.

(5) Funds not required to compensate for transaction costs shall be invested in and earn a market rate of return in the depository institution’s highest rated money market mutual fund as permitted by the California Government Code, Section 53600 et seq.

### C. Portfolio Investment Manager

The Governing Board may grant authority to a qualified investment manager to direct investments of excess funds in accordance with the AIP and be subject to periodic review for compliance to the AIP. The qualified investment manager must meet all requirements established by federal and California law. Any Board-approved changes in Permitted Investments and the AIP shall be communicated to the investment manager upon approval.

### D. Exceptions to this Policy

The Governing Board may grant express written authority to make a one-time investment not permitted by this Policy however, the investment must be permitted by the CA Government code. The Board of Directors may also make amendments to the AIP at any quarterly meeting as needed.

## VI. AUTHORIZED INVESTMENTS

A. Authorized Investment Types: SCFHP shall invest only in instruments as permitted by the CA Government Code, subject to the limitations of this AIP.



## POLICY

1. Permitted investments in the managed portfolio shall be considered short-term operating funds and are subject to a maximum stated term of four hundred fifty (450) days.

2. The Governing Board may designate a reserve fund for excess funds not required for operational cash flow for which permitted investments are subject to a maximum term of five years pursuant to the Code.

INVESTMENT TYPE	MAXIMUM REMAINING MATURITY	MAXIMUM SPECIFIED % OF PORTFOLIO	MINIMUM QUALITY REQUIREMENTS
U.S. Treasury Obligations	5 years	None	None. May invest in securities that could result in zero or negative interest accrual if held to maturity, in the event of a period of negative market interest rates.
U.S. Agency Obligations	5 years	None	None
State Obligations: CA and Others	5 years	None	None for CA; AA or better for other States
CA Local Agency Obligations	5 years	None	AA rated
Commercial Paper: Non-Pooled Funds (minimum \$100,000,000 of investments)	270 days or less	40% of Plan's investible funds	Highest letter and number rating by an NRSRO <sup>1,5</sup>
Placement Service Certificates of Deposit	2 years	\$250,000 per deposit per institution	FDIC insured at all times
Repurchase Agreements	1 year	None	U.S. Treasury and Agency Obligations
Medium-term Notes	5 years or less	30% (with not more than 10 % in any one institution)	"A" rating category or better
Mutual Funds and Money Market Mutual Funds	N/A	20% (no more than 10% invested in any one mutual fund; limitation does not apply to money market mutual funds)	Multiple <sup>2</sup>
Collateralized Bank Deposits	5 years	None	If investments require collateral, collateral must be placed in institution not affiliated with the issuer of the obligation.

## POLICY

Mortgage Pass-through and Asset Backed Securities	5 years or less	20%	“AA” rating category or its equivalent or better <sup>4</sup>
County Pooled Investment Funds- Santa Clara County Pool	N/A	None	A or better
Joint Powers Authority Pool (CAMP, CalTrust)	N/A	None	Multiple <sup>3</sup>
Local Agency Investment Fund (LAIF)	N/A	None	None
Supranational Obligations	5 years or less	30%	“AA” rating or better
<u>Public Bank Obligations</u>	<u>5 years</u>	<u>None</u>	<u>Section 57600 (b)</u> <sup>6</sup>

*1* Issuing corporation must be organized and operating within the U.S., have assets in excess of \$500 million, and debt other than commercial paper must be in a rating category of “A” or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated “A-1” or higher, or the equivalent, by a nationally recognized statistical rating agency (NSRO).

*2* A money market mutual fund must receive the highest ranking by not less than two nationally recognized rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years’ experience investment in money market instruments with assets under management in excess of \$500 million.

*3* A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of \$500 million, and has at least five years’ experience investment in instruments authorized by Section 53601, subdivisions (a) to (o).

*4* Any investments in asset-backed securities (mortgage pass-through securities, collateralized mortgage obligations, mortgage-backed or other pay-through bonds, equipment lease-backed certificates, consumer receivable pass-through certificates, or consumer receivable-backed bonds) are required to have a maximum remaining maturity of five years or less. While the Legislature removed the requirement that the securities’ issuer be rated “A” or its equivalent or better for the issuer’s debts in accordance with a nationally recognized statistical rating organization (NRSRO), the Plan retains this requirement.

<sup>3</sup>In 2021, Section 53601 (h) amended to allow local agencies that have one hundred million dollars or more of investment assets under management to invest no more than 40% of their moneys in eligible commercial paper. Further amendment to Section 53601 limits local agencies to invest no more than 10% of their total investment assets in commercial paper and medium- term notes of any single issuer.

<sup>6</sup>Public Bank means a corporation organized under the Nonprofit Mutual benefit corporation Law for the purpose of engaging in the commercial banking business or industrial banking business that is wholly owned by a local agency, local agencies or a joint powers authority that is composed only of local agencies. A local agency may invest in commercial paper, debt securities, or other obligations of a public bank.

## POLICY

B. Prohibited Investment Types: CA Government Code Section 53601.6 prohibits local agencies from investing in inverse floaters, range notes, or mortgage-derived, interest-only strips, and any security which could result in zero interest accrual if held to maturity. In addition, the Plan does not authorize investment in the following:

- i. Bankers' Acceptances
- ii. Commercial Paper: Pooled Funds (pertains only to Managed Portfolio)
- iii. Negotiable Certificates of Deposit
- iv. Non-negotiable Certificates of Deposit
- v. Reverse Repurchase Agreements and Securities Lending Agreements
- vi. Voluntary Investment Program Fund

## VII. REPORTING REQUIREMENTS

The following documents and reports will be periodically provided to support the investment procedures, oversight and reporting requirements:

- A. County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits
- B. County of Santa Clara Treasury Investment Policy
- C. County of Santa Clara Treasury Quarterly Report
- D. SAP Balance and Interest Earnings Report of SCFHP Invested Funds
- E. Depository Institution – daily transaction and monthly activity report
- F. Managed Portfolio - Month-end and quarter-end portfolio performance summary, income, ending balance sheet, trading activity, transaction detail and portfolio diversification report. The listing must include issuer names, dates of maturity, par amounts, dollar amount, market values as of month-end and comparable published index as to diversification and duration that most closely tracks the performance of the portfolio.
- G. Investment Oversight Quarterly Report – provides independent review of all invested funds for tracking of AIP, diversification requirements and performance review. Minimum reporting requirements includes a listing of the types of investment, issuer names, dates of maturity, par amounts, dollar amount, market values, descriptions of the programs under the management of contracted parties, a statement of compliance with the investment policy, and a statement of the ability to meet cash flow needs for six months. Any irregularities shall be noted and included in the report.



**POLICY**

**VIII. REVIEW OF INVESTMENT POLICY**

At least annually and more frequently as needed, the Governing Board will review this investment policy at a regular meeting of the Board. Any recommended changes to the Policy, including modifications to current investment strategy, oversight procedures including internal controls will be first be brought to the Executive/Finance Committee by the CFO for review and approval prior to presentation to the Board. The Executive Committee and Board of Directors will be supported in this work by the CFO, investment advisors and legal counsel for financial and legal issues, respectively.

Any modifications to this Investment Policy, including withdrawal from the County of Santa Clara Commingled Investment Pool, will be made in accordance with California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox Keene Act of 1975 as well as the prudent investment standard.

**IX. Approval/Revision History**

First Level Approval		Second Level Approval		
Barbara Granieri, Controller <b>April 14, 2021</b>		Neal Jarecki Chief Financial Officer <b>April 14, 2021</b>		
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	Exec/Finance	Approved 04/26/18	Approved 06/28/18
V1	Original (no changes)	Exec/Finance	Approved 05/01/19	Approved 06/27/19
V2	Revised	Exec/Finance	Approved 04/23/20	Approved 06/25/20
<b>V3</b>	<b>Revised</b>	<b>Exec/Finance</b>	<b>04/22/21</b>	

## POLICY

<b>Policy Title:</b>	<b>Investment Policy</b>	<b>Policy No.:</b>	<b>FA.07</b>
<b>Replaces Policy Title (if applicable):</b>	NA	<b>Replaces Policy No. (if applicable):</b>	NA
<b>Issuing Department:</b>	Finance	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> CMC	

### I. PURPOSE

This investment policy (~~AIP~~) sets for the investment guidelines and structure for the investment of short-term operating funds not required for the immediate needs on and after April ~~2322~~, 2020~~1~~ of the Santa Clara Family Health Plan (SCFHP or the Plan) which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

Investments may only be made as authorized by this Annual Investment Policy. SCFHP is required to invest its funds in accordance with the California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox-Keene Act of 1975 as well as the prudent investment standard:

The Prudent Investor Standard: When investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of SCFHP, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code Section 53600.3).

### II. OBJECTIVES

- i. **Safety:** the primary objective of this policy is the preservation of principal; avoiding capital losses by minimizing credit risk and interest rate or market risk.
- ii. **Liquidity:** maintain sufficient liquidity to meet the operating requirements for six months.
- iii. **Yield:** achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
- iv. **Diversification:** provide diversification of the portfolio securities to avoid incurring unreasonable market and credit risks.



## POLICY

### III. INVESTMENT STRATEGY

The Plan will adhere to the investment goal of holding investments to maturity. From time to time, the portfolio may go out of alignment. The Chief Financial Officer may choose to rebalance the portfolio earlier to bring it back into compliance if the portfolio will not suffer any losses for selling the investment prior to maturity.

### IV. ETHICS AND CONFLICTS OF INTEREST

SCFHP's officers, employees and Governing Board members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. SCFHP's officers and employees involved in the investment process are not permitted to have any material financial interests in financial interests in financial institutions, including state or federal credit unions, that conduct business with SCFHP, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of SCFHP's investments.

### V. DELEGATION OF AUTHORITY

#### A. County of Santa Clara Commingled Investment Pool

The Governing Board ~~of Directors of the SCFHP~~ is responsible for the management and oversight of SCFHP's investment program. The Board has directed that available excess funds not required for immediate operational cash flow purposes be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

- (1) All of the evidence of indebtedness of the County, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.
- (2) The County has cash or cash equivalents in an amount equal to fifty million dollars or more, based on its audited financial statements for the immediately preceding fiscal year.
- (3) The day-to-day managing, reporting, and oversight of the investment contractual obligations between the County and SCFHP shall be the responsibility of SCFHP's Chief Financial Officer.

## POLICY

### B. Depository (Financial) Institutions

All SCFHP money shall be deposited in financial institutions that meet the requirements as set forth in Section 53635.2 and authorized by the Board. The financial institution shall have received an overall rating of not less than “satisfactory” in its most recent evaluation by its appropriate federal financial supervisory agency. In addition, the depository financial institution shall maintain a rating of its senior long-term debt obligations, deposit rating or claims-paying ability rating, or is guaranteed by an entity whose obligations are rated not lower than “AA- by S&P, AA- by Fitch or “Aa3” by Moody’s or its equivalent from another nationally recognized rating agency.

(1) All depository institutions shall provide SCFHP with notification of any downgrades in long-term ratings or any unsatisfactory rating by their appropriate federal financial supervisory agency within 10 days of such downgrade.

(2) Any downgrade in ratings of a financial institution holding SCFHP funds, shall be provided to the Board by the Chief Financial Officer.

(3) The day-to-day managing, reporting, and oversight of the depository and investment contractual obligations for SCFHP shall be the responsibility of SCFHP’s Chief Financial Officer.

(4) The Board of Directors may renew the delegation of authority to enter into depository and investment relationships annually.

(5) Funds not required to compensate for transaction costs shall be invested in and earn a market rate of return in the depository institution’s highest rated money market mutual fund as permitted by the California Government Code, Section 53600 et seq.

### C. Portfolio Investment Manager

The Governing Board ~~of Directors~~ may grant authority to a qualified investment manager to direct investments of excess funds in accordance with the AIP and be subject to periodic review for compliance to the AIP. The qualified investment manager must meet all requirements established by federal and California law. Any Board-approved changes in Permitted Investments and the AIP shall be communicated to the investment manager upon approval.

### D. Exceptions to this Policy

The Governing Board ~~of Directors~~ may grant express written authority to make a one-time investment not permitted by this Policy however, the investment must be permitted by the CA Government code. The Board of Directors may also make amendments to the AIP at any quarterly meeting as needed.

## VI. AUTHORIZED INVESTMENTS

A. Authorized Investment Types: SCFHP shall invest only in instruments as permitted by the CA Government Code, subject to the limitations of this AIP.



## POLICY

1. Permitted investments in the managed portfolio shall be considered short-term operating funds and are subject to a maximum stated term of four hundred fifty (450) days.

2. The Governing Board may designate a reserve fund for excess funds not required for operational cash flow for which permitted investments are subject to a maximum state-term of five years pursuant to the Code.

INVESTMENT TYPE	MAXIMUM REMAINING MATURITY	MAXIMUM SPECIFIED % OF PORTFOLIO	MINIMUM QUALITY REQUIREMENTS
U.S. Treasury Obligations	5 years	None	None. <u>May invest in securities that could result in zero or negative interest accrual if held to maturity, in the event of a period of negative market interest rates.</u>
U.S. Agency Obligations	5 years	None	None
State Obligations: CA and Others	5 years	None	None for CA; AA or better for other States
CA Local Agency Obligations	5 years	None	AA rated
Commercial Paper: Non-Pooled Funds <u>(minimum \$100,000,000 of investments)</u>	270 days or less	<del>25</del> 40% of Plan's investible funds	Highest letter and number rating by an NRSRO <sup>1,5</sup>
Placement Service Certificates of Deposit	2 years	\$250,000 per deposit per institution	FDIC insured at all times
Repurchase Agreements	1 year	None	U.S. Treasury and Agency Obligations
Medium-term Notes	5 years or less	30% (with not more than 10 % in any one institution)	"A" rating category or better
Mutual Funds and Money Market Mutual Funds	N/A	20% (no more than 10% invested in any one mutual fund; limitation does not apply to money market mutual funds)	Multiple <sup>2</sup>
Collateralized Bank Deposits	5 years	None	If investments require collateral, collateral must be placed in institution not affiliated with the issuer of the obligation.

## POLICY

Mortgage Pass-through and Asset Backed Securities	5 years or less	20%	“AA” rating category or its equivalent or better <sup>4</sup>
County Pooled Investment Funds- Santa Clara County Pool	N/A	None	A or better
Joint Powers Authority Pool (CAMP, CalTrust)	N/A	None	Multiple <sup>3</sup>
Local Agency Investment Fund (LAIF)	N/A	None	None
Supranational Obligations	5 years or less	30%	“AA” rating or better
<u>Public Bank Obligations</u>	<u>5 years</u>	<u>None</u>	<u>Section 57600 (b)</u> <sup>6</sup>

*1* Issuing corporation must be organized and operating within the U.S., have assets in excess of \$500 million, and debt other than commercial paper must be in a rating category of “A” or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated “A-1” or higher, or the equivalent, by a nationally recognized statistical rating agency (NSRO).

*2A* money market mutual fund must receive the highest ranking by not less than two nationally recognized rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years’ experience investment in money market instruments with assets under management in excess of \$500 million.

*3A* joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of \$500 million, and has at least five years’ experience investment in instruments authorized by Section 53601, subdivisions (a) to (o).

*4* Any investments in asset-backed securities (mortgage pass-through securities, collateralized mortgage obligations, mortgage-backed or other pay-through bonds, equipment lease-backed certificates, consumer receivable pass-through certificates, or consumer receivable-backed bonds) are required to have a maximum remaining maturity of five years or less. While the Legislature removed the requirement that the securities’ issuer be rated “A” or its equivalent or better for the issuer’s debts in accordance with a nationally recognized statistical rating organization (NRSRO), the Plan retains this requirement.

<sup>5</sup>In 2021, Section 53601 (h) amended to allow local agencies that have one hundred million dollars or more of investment assets under management to invest no more than 40% of their moneys in eligible commercial paper. Further amendment to Section 53601 limits local agencies to invest no more than 10% of their total investment assets in commercial paper and medium- term notes of any single issuer.

<sup>6</sup>Public Bank means a corporation organized under the Nonprofit Mutual benefit corporation Law for the purpose of engaging in the commercial banking business or industrial banking business that is wholly owned by a local agency, local agencies or a joint powers authority that is composed only of local agencies. A local agency may invest in commercial paper, debt securities, or other obligations of a public bank.

## POLICY

B. Prohibited Investment Types: CA Government Code Section 53601.6 prohibits local agencies from investing in inverse floaters, range notes, or mortgage-derived, interest-only strips, and any security which could result in zero interest accrual if held to maturity. In addition, the Plan does not authorize investment in the following:

- i. Bankers' Acceptances
- ii. Commercial Paper: Pooled Funds (pertains only to Managed Portfolio)
- iii. Negotiable Certificates of Deposit
- iv. Non-negotiable Certificates of Deposit
- v. Reverse Repurchase Agreements and Securities Lending Agreements
- vi. Voluntary Investment Program Fund

## VII. REPORTING REQUIREMENTS

The following documents and reports will be periodically provided to support the investment procedures, oversight and reporting requirements:

- A. County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits
- B. County of Santa Clara Treasury Investment Policy
- C. County of Santa Clara Treasury Quarterly Report
- D. SAP Balance and Interest Earnings Report of SCFHP Invested Funds
- E. Depository Institution – daily transaction and monthly activity report
- F. Managed Portfolio - Month-end and quarter-end portfolio performance summary, income, ending balance sheet, trading activity, transaction detail and portfolio diversification report. The listing must include issuer names, dates of maturity, par amounts, dollar amount, market values as of month-end and comparable published index as to diversification and duration that most closely tracks the performance of the portfolio.
- G. Investment Oversight Quarterly Report – provides independent review of all invested funds for tracking of AIP, diversification requirements and performance review. Minimum reporting requirements includes a listing of the types of investment, issuer names, dates of maturity, par amounts, dollar amount, market values, descriptions of the programs under the management of contracted parties, a statement of compliance with the investment policy, and a statement of the ability to meet cash flow needs for six months. Any irregularities shall be noted and included in the report.



## POLICY

### VIII. REVIEW OF INVESTMENT POLICY

At least annually and more frequently as needed, the Governing Board will review this investment policy at a regular meeting of the Board. Any recommended changes to the Policy, including modifications to current investment strategy, oversight procedures including internal controls will be first be brought to the Executive/Finance-Committee by the CFO for review and approval prior to presentation to the Board. The Executive Committee and Board of Directors will be supported in this work by the CFO, investment advisors and ~~the SCFHP Vice President/General Counsel~~ legal counsel for financial and legal issues, respectively.

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### IX. Approval/Revision History

First Level Approval		Second Level Approval		
Barbara Granieri, Controller <u>April 14, 2021</u>		Neal Jarecki Chief Financial Officer <u>April 14, 2021</u>		
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	Exec/Finance	Approved 04/26/18	Approved 06/28/18
V1	Original (no changes)	Exec/Finance	Approved 05/01/19	Approved 06/27/19
V2	Revised	Exec/Finance	Approved 04/23/20	Approved 06/25/20
<u>V3</u>	<u>Revised</u>	<u>Exec/Finance</u>	<u>04/22/21</u>	

## POLICY

<b>Policy Title:</b>	<b>Donations and Sponsorships</b>	<b>Policy No.:</b>	GO.04 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Governance & Org Structure	<b>Policy Review Frequency:</b>	Periodically as warranted
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

To establish criteria for Santa Clara Family Health Plan (SCFHP) to make a donation or sponsorship using SCFHP funds.

### II. Policy

SCFHP makes donations and sponsorships in support of SCFHP’s mission to improve the well-being of our members by addressing their health and social needs in a culturally competent manner, and partnering with providers and organizations in our shared commitment to the health of our community, and to support the broader Santa Clara County safety net. SCFHP recognizes that health is impacted by many factors. It is SCFHP’s policy to support community organizations and public agencies that provide safety net services that help to directly or indirectly strengthen community health and/or the health of county residents.

Any donations or sponsorships must meet the following criteria:

- A. The organization requesting funding is a non-profit, not-for-profit, or public agency providing safety net services to residents of Santa Clara County; and
- B. The donation or sponsorship will not be used to support political causes, candidates, organizations, campaigns, ballot measures, or religious organizations for religious purposes; and
- C. The donation or sponsorship will not personally financially benefit any Santa Clara County Health Authority official or employee.

SCFHP’s Chief Executive Officer has authority to approve donations and sponsorships not to exceed \$5,000 to a single organization in any given fiscal year, up to a total limit for all donations and sponsorships of \$200,000 in any given fiscal year. Exceptions to these limits require approval by the Executive/Finance Committee.

**III. Approval/Revision History**

First Level Approval		Third Level Approval		
Laura Watkins VP, Marketing & Enrollment		Christine M. Tomcala CEO		
April 16, 2021		April 16, 2021		
Version Number	Original/ Reviewed/ Revised	Reviewing Committee (if applicable)	Committee Action/Date (Recommended or Approved)	Board Action/Date (Approved or Ratified)
-	Board Resolution			Approved November 4, 2010
-	Board Resolution			Approved April 28, 2016
<b>v1</b>	Original	Executive/Finance Committee	Approved May 28, 2020	Ratified June 25, 2020
<b>v2</b>	Revised	Executive/Finance Committee		



## POLICY

<b>Policy Title:</b>	<b>Donations and Sponsorships</b>	<b>Policy No.:</b>	GO.04 v <del>21</del>
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Governance & Org Structure	<b>Policy Review Frequency:</b>	Periodically as warranted
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Laura Watkins VP, Marketing & Enrollment		Christine M. Tomcala CEO		
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-	Board Resolution			Approved November 4, 2010
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<b><u>v2</u></b>	<b><u>Revised</u></b>	<b><u>Executive/Finance Committee</u></b>		

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

Thursday, May 27, 2021, 11:30 AM – 1:30 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes

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### **Members Present**

Bob Brownstein  
Dolores Alvarado  
Dave Cameron  
Liz Kniss  
Sue Murphy

### **Staff Present**

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

### **1. Roll Call**

Dolores Alvarado, Chair, called the meeting to order at 11:36 am. Roll Call was taken and a quorum was established.

Ms. Alvarado asked the Committee and staff to take a moment of silence to honor those in the community who were severely impacted by the VTA shooting tragedy.

### **2. Public Comment**

There were no public comments.

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

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

#### **a. Approve minutes of the April 22, 2021 Executive/Finance Committee Meeting**

#### **b. Approve Claims Policies**

- CL.06 Inpatient Admission
- CL.10 Provider Dispute Resolution
- CL.12 Coordination of Benefits and Medicare-Medi-Cal Crossover Claims
- CL.19 Processing of Rehabilitation Therapies Claims
- CL.20 Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims
- CL.23 Overpayment Recovery
- CL.24 Timely Processing of Non-Clean Claims

- CL.25 Direct Member Reimbursement
- CL.26 Claim Development of Non-Clean Non-Contracted Medicare Claims
- CL.27 Non-Medical Transportation Services

c. Approve **Finance Policies**

- FA.01 Finance-General
- FA.02 Cash & Cash Receipts
- FA.03 Cash Disbursements
- FA.04 Accounts Receivable & Revenue
- FA.05 Payroll & Employee Expenses
- FA.06 Fixed Assets & Depreciation Expense
- FA.07 Investments
- FA.08 Treasury & Debt
- FA.09 Financial Close & Reporting
- FA.10 Medical Expense & Incurred-But-Not Paid (IBNR)
- FA.11 Healthcare Economics

d. Approve **Quarterly Investment Compliance Report**

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

**Motion:** Ms. Kniss

**Second:** Mr. Brownstein

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

#### 4. CEO Update

Christine Tomcala, Chief Executive Officer, presented the updated SCFHP COVID-19 Summary, noting 6,333 members have tested positive, 1,781 were hospitalized, and 191 are deceased. In addition, she presented data on the percentage of SCFHP members by age band who received at least one COVAX dose compared to the county, and a breakdown of the percentage of members who received a vaccine by ethnicity. It was noted that the Hispanic, African Ancestry, and American Indian communities had lower COVAX percentages than the 47% Plan average for members age twelve and up. Ms. Tomcala further reported that 841 individuals had been vaccinated at the Blanca Alvarado Community Resource Center (CRC), and noted we started offering a gift card incentive to encourage people to get vaccinated. She also reported staff are actively conducting robocalls and direct outreach to encourage individuals to get their vaccine and to provide assistance with scheduling appointments and transportation. Discussion ensued regarding potential opportunities to assist members in overcoming vaccine hesitancy.

Ms. Tomcala noted a tentative plan to reopen the office after Labor Day. She also reported that the Plan participated with Supervisor Ellenberg in a press conference supporting her proposal on Black Infant Health, which the Board of Supervisors subsequently approved.

#### 5. Government Relations Update

Tyler Haskell, Director of Government Relations, provided an update on federal and state issues affecting the Plan and related advocacy actions. He discussed the infrastructure legislation being debated in Congress, which could contain provisions relating to telehealth and prescription drug pricing. Mr. Haskell also gave an update on the State budget, which was recently modified to include significant enhancements to the Medi-Cal program. Finally, Mr. Haskell discussed other, non-budget legislation relating to CalAIM, COVID-related provider payments, and a statewide health information exchange.

#### 6. March 2021 Financial Statements

Neal Jarecki, Chief Financial Officer, presented the March 2021 financial statements, which reflected a current month net surplus of \$4.5 million (\$7.0 million favorable to budget) and a fiscal year-to-date net surplus of \$16.4 million (\$21.6 million favorable to budget). Enrollment increased by 1,854 members from the prior month to 276,842 members (4,683 members favorable to budget). The year-to-date membership growth due to COVID-19

has exceeded budget due to the extended duration of the pandemic and will be sustained for a longer period of time due to the continued public health emergency. Revenue reflected a favorable current month variance of \$16.9 million (18.6%) largely due to (1) additional capitation received due to the delayed carve-out of Medi-Cal pharmacy from managed care, and (2) increased enrollment due to the suspension of disenrollment's, and (3) higher capitation rates than budgeted. Medical Expense reflected an unfavorable current month variance of \$11.0 million (12.54%) largely due to (1) additional expenses due to the delayed carve-out of Medi-Cal pharmacy from managed care (offsetting the associated increased pharmacy revenue), (2) lower than planned FFS utilization reflected in reductions in incurred-but-not-reported (IBNP) reserves, (3) lower than planned Long Term Care (LTC) enrollment and utilization, and (4) retroactive adjustments to capitation expense. Administrative Expense reflected a favorable current month variance of \$1.1 million (19.3%) due largely to the one-time release of an accrual. The balance sheet reflected a Current Ratio of 1.23:1, versus the minimum required by DMHC of 1.00:1. Tangible Net Equity of \$225.1million, which represented approximately two months of the Plan's total expenses, included unrestricted net assets of \$180 million. Year-to-date capital investments of \$3.8 million were made, predominately construction expenses of the Blanca Alvarado Community Resource Center.

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

**Motion:** Mr. Cameron

**Second:** Ms. Kniss

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

## 7. COVID-19 Funding Request

Ms. Tomcala presented a funding request for \$100,000 from the YMCA of Silicon Valley to support their Expanded Summer Nutrition Program for Children and Families in the lowest-income neighborhoods. The program would coordinate the distribution of approximately 155,880 meals and snacks to children, and they partner with Second Harvest Food Bank to provide meals for adults in those families.

**It was moved, seconded and** the YMCA funding request for \$100,000 to support the Expanded Summer Nutrition Program was **unanimously approved**.

**Motion:** Ms. Murphy

**Second:** Ms. Kniss

**Ayes:** Ms. Alvarado, Mr. Brownstein, Mr. Cameron, Ms. Kniss, Ms. Murphy

## 8. Adjourn to Closed Session

a. **Contract Rates** (Welfare and Institutions Code Section 14087.38(n)):

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

## 9. Report from Closed Session

Ms. Alvarado reported the Executive/Finance Committee met in Closed Session to discuss plan partner rates.

## 10. Adjournment

The meeting was adjourned at 1:15 pm.

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Susan G. Murphy, Secretary

## POLICY

<b>Policy Title:</b>	<b>Inpatient Admission</b>	<b>Policy No.:</b>	CL.06 v4
<b>Replaces Policy Title (if applicable):</b>	Inpatient Admission	<b>Replaces Policy No. (if applicable):</b>	CL.06 v3
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding inpatient admission in accordance with State and Federal regulatory requirements.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. Medi-Cal: For Medi-Cal inpatient admission claims, from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay:
  - At least ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) inpatient admission claims from contracted providers, SCFHP shall pay all claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal inpatient admission claims from non-contracted providers, SCFHP shall pay:
  - At least ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. Cal Medi-Connect: For CMC inpatient admission claims from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

## POLICY

### B. Availability and Accessibility

SCFHP shall ensure the availability of, and accessibility to, emergency health care services including ambulance services, twenty-four hours-a-day and seven days-a-week.

SCFHP or its delegated groups are financially responsible for emergency services and urgently needed services:

- Regardless of whether services are obtained within or outside the plan's authorized service area and/or network (if applicable);
- Regardless of whether there is prior authorization for the services;
- If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis.

### C. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

### D. Date of Payment

The date of payment shall be the date of the check or other form of payment.

### E. Clean Claim

A claim is considered to be clean when it is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### F. Reimbursement Rates

#### 1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

#### 2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be reimbursed in accordance with the All Patient Refined – Diagnosis Related Groups (APR-DRG) schedule.
- b. CMC: Non-contracted providers will be reimbursed at rates in accordance with the Medicare Severity – Diagnosis Related Group (MS-DRG) schedule.

## POLICY

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations within the appropriate system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable inpatient rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.

### IV. References

Title 28, California Code of Regulations, Section and 1300.67.2(c) and 1300.71, 1300.71.4(b)(d)  
California W&I Code, Section 14105.28 and 14166 (b)(1)(A)(ii) – APR DRG Payment Methodology  
CA Health and Safety Code section 1371.4(a)(b)  
Medicare Claims Processing Manual, Chapter 3, Inpatient Hospital  
Medicare Managed Care Manual, Chapter 4 section 20.3  
Acute Inpatient PPS  
<http://www.cms.gov/AcuteInpatientPPS/>



**POLICY**

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 8/26/2016	N/A		N/A
2	Revised – 11/16/2018	N/A		N/A
3	Revised - 2/19/2020	N/A		N/A
4	Revised	Executive/Finance	Recommend 05/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Provider Dispute Resolution</b>	<b>Policy No.:</b>	CL.10 v3
<b>Replaces Policy Title (if applicable):</b>	Provider Dispute Resolution	<b>Replaces Policy No. (if applicable):</b>	CL.10 v2
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To establish a Provider Dispute Resolution (PDR) process for providers to dispute claim determinations which ensures timely acknowledgement and processing of PDRs in accordance with State and Federal regulatory requirements, and contractual obligations.

### II. Policy

- A. All PDRs shall be processed in accordance with State and Federal regulatory requirements, as well as Department of Health Care Services (DHCS) contractual requirements.
- B. Medi-Cal – In order for a provider dispute to be counted as timely and compliant, provider disputes from both contracted and non-contracted providers must be processed within:
  1. Medi-Cal – forty-five (45) working days or sixty-two (62) calendar days after receipt date.
- C. Cal Medi-Connect (CMC) – In order for a provider dispute to be counted as timely and compliant, provider disputes must be processed within:
  1. Contracted Providers –sixty (60) calendar after receipt date.
- D. Each provider dispute must be acknowledged within two (2) working days of the date of receipt if received electronically and within fifteen (15) working days if received via paper.
- E. Capitated subcontractors will be required to adhere to the same statutory, regulatory and contractual requirements governing the timely processing of first level PDRs as the Santa Clara Family Health Plan (SCFHP). SCFHP’s annual audit of its capitated subcontractors will ensure that these requirements are being followed.
- F. SCFHP will receive and process second level PDRs when a provider is not satisfied with the first level determination related to provider disputes from subcontractors.

## POLICY

### III. Responsibilities

- A. SCFHP designates the Chief Financial Officer as the principal officer to be responsible for the maintenance of the provider dispute resolution mechanism, for the review of its operations, and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care.
- B. The PDR staff is responsible for ensuring that the inventory of PDRs is in compliance with timelines for acknowledgement, resolution, and payment in accordance with State and Federal regulatory requirements, and contractual obligations.
- C. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- D. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

### IV. References

California Health and Safety Code Section 1371

Industry Collaboration Effort Time Limits and Measurements - Assembly Bill - AB 1455

Title 22, California Code of Regulations, Section 53622

Title 28, California Code of Regulations

Section 1300.71.38

Section 1300.71.38 (a) (10-11)

Section 1300.71.38 (d) (1-3)

Section 1300.71.38 (g)

Section 1300.85.1

Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Section 80.2.2

CFR 422. 422.100 - General requirements

U.S. Public Laws 111 – 148 Section 6506 (d)

**POLICY**

**V. Approval/Revision/History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 8/26/2016	N/A	N/A	N/A
2	Revised – 9/6/2019	N/A	N/A	N/A
3	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Coordination of Benefits and Medicare_Medi-Cal Crossover Claims</b>	<b>Policy No.:</b>	CL.12 v2
<b>Replaces Policy Title (if applicable):</b>	Coordination of Benefits and Medicare_Medi-Cal Crossover Claims	<b>Replaces Policy No. (if applicable):</b>	CL.12 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> CMC	

### I. Purpose

To determine coordination of benefits and ensure proper adjudication of claims for members with multiple forms of healthcare insurance coverage.

### II. Policy

#### A. Timeframes

##### 1. Contracted and Non-Contracted Providers

- a. Medi-Cal: For Medi-Cal claims related to Coordination of Benefits (COB) and Medicare Medi-Cal Crossover claims, Santa Clara Family Health Plan (SCFHP) will pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.

B. Coordination of benefits (COB) will apply when a member has multiple forms of healthcare insurance coverage.

C. SCFHP will first identify who is the primary payer for services and process the coordination of benefits accordingly.

#### D. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

#### E. Date of Payment

The date of payment shall be the date of the check.

## POLICY

### F. Clean Claim

A claim is considered to be clean when it is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### III. Responsibilities

- A. It is the responsibility of all departments to be aware of potential “other payer” status when processing authorization requests, claims, member inquiries, and enrollment.
- B. The Eligibility Department is responsible for conducting review of all eligibility files to determine any known COB possibilities.
- C. The Finance Department is responsible for reviewing the Medicare Monthly Membership Report to identify those members with MSP designation.
- D. Claims and Finance Recovery staff are responsible for identifying potential COB situations.
- E. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- F. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP’s Records Retention Policy.

### IV. References

Medi-Cal – Other Health Coverage (OHC) and Medicare/Medi-Cal Claims – [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

Medicare Managed Care Manual - Chapter 4 - Benefits and Beneficiary Protections

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326>

**POLICY**

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 08/26/2016	N/A	N/A	N/A
2	Revised	Executive/Finance	Recommend 5/27/2021	N/A

Approved

## POLICY

<b>Policy Title:</b>	<b>Processing of Rehabilitation Therapies Claims</b>	<b>Policy No.:</b>	CL.19 v2
<b>Replaces Policy Title (if applicable):</b>	Processing of Rehabilitation Therapies Claims	<b>Replaces Policy No. (if applicable):</b>	CL.19 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding outpatient rehabilitation therapy, such as physical therapy (PT), occupational therapy (OT), and speech therapy (ST) in accordance with State and Federal regulatory requirements and contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding rehabilitation therapy services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding rehabilitation therapy services from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding rehabilitation therapy services from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For CMC claims regarding rehabilitation therapy services from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

#### B. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first



## **POLICY**

delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

### **C. Date of Payment**

The date of payment shall be the date of the check.

### **D. Clean Claim**

A claim is considered to be a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### **E. Reimbursement Rates**

#### **1. Contracted Providers**

Contracted Providers shall be paid in accordance with their applicable contract.

#### **2. Non-Contracted Providers**

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.
- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

## **III. Responsibilities**

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations within the appropriate system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable PT, OT, ST rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## POLICY

### IV. References

Title 28, California Code of Regulations, Section 1300.71

[www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Rehabilitation Therapy PT, OT, ST Services and any related provider manual policies.

Medicare Claims Processing Manual Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services –  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf>

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original	Original 8/26/2016	N/A	N/A
2	Revised	Executive/Finance	Recommend / 5-27-2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims</b>	<b>Policy No.:</b>	CL.20 v4
<b>Replaces Policy Title (if applicable):</b>	Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims	<b>Replaces Policy No. (if applicable):</b>	CL.20 v3
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately process claims regarding behavioral health in accordance with State and Federal regulatory requirements, as well as contractual obligations.

### II. Policy

#### A. Timeframes

##### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to inpatient psychiatric facility admissions, claims are carved out to Santa Clara County Behavioral Health Department. Outpatient claims from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) inpatient psychiatric facility admission claims and outpatient claims from contracted providers, SCFHP shall pay all claims within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims related to inpatient psychiatric facility admissions, claims are carved out to Santa Clara County Behavioral Health Department. Outpatient claims from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.

## POLICY

- b. Cal Medi-Connect: For Cal Medi-Connect (CMC) inpatient psychiatric facility admission claims and outpatient claims from non-contracted providers, SCFHP shall pay all claims within thirty (30) calendar days of the date of receipt.

### B. Availability and Accessibility

SCFHP shall ensure the availability of, and accessibility to, emergency health care services including ambulance services, twenty-four hours-a-day and seven days-a-week.

SCFHP or its delegated groups are financially responsible for emergency services and urgently needed services:

- Regardless of whether services are obtained within or outside the plan's authorized service area and/or network (if applicable);
- Regardless of whether there is prior authorization for the services;
- If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis.

### C. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

### D. Date of Payment

The date of payment shall be the date of the check.

### E. Clean Claim

A claim is considered to be clean when it is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### F. Reimbursement Rates

#### 1. Contracted Providers

Contracted Providers shall be paid in accordance with their applicable contract.

#### 2. Non-Contracted Providers

- a. Medi-Cal: Non-contracted providers will be paid for covered services at not less than 100% of the Medi-Cal FFS rates.

## POLICY

- b. CMC: Non-contracted providers will be paid for covered services at not less than 100% of the applicable Medicare FFS rates.

### III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations within the appropriate system for Medi-Cal and CMC members.
- B. The Claims Department is responsible for ensuring applicable rates and interest payments are calculated accurately, applied correctly, and processed timely.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

### IV. References

Title 28, California Code of Regulations, Sections, 1300.67.2(c), 1300.71 and 1300.71.4(b)(d)

California W&I Code, Section 14105.28 and 14166 (b)(1)(A)(ii) – APR DRG Payment Methodology

CA Health and Safety Code section 1371.4(a)(b) and 1374.72(g)(2),

California W&I Code, Section 5150

Inpatient and Outpatient Mental Health Services provider manual policies - [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov)  
Medi-Cal Psychological and Psychiatry Services Provider Manual Policy

Medicare Chapter 1 – General Billing Requirement  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

Medicare Chapter 3 – Inpatient Hospital Billing  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf>

**POLICY**

Inpatient Psychiatric Facility PPS  
<https://www.cms.gov/InpatientPsychFacilPPS>

**V. Approval/Revision History**

First Level Approval			Second Level Approval	
Arlene Bell Director, Claims			Neal Jarecki Chief Financial Officer	
Date			Date	
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 8/26/2016	N/A	N/A	N/A
2	Revised – 11/16/2018	N/A	N/A	N/A
3	Revised – 2/19/2020	N/A	N/A	N/A
4	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Overpayment Recovery</b>	<b>Policy No.:</b>	CL.23 v2
<b>Replaces Policy Title (if applicable):</b>	Overpayment Recovery	<b>Replaces Policy No. (if applicable):</b>	CL.23 v1
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To establish the policy for requesting provider refunds and receiving voluntary refunds from a provider related to overpayment of claims and to outline the plan's recovery process of overpaid claims through the refund request letter.

### II. Policy

It is the policy of the Santa Clara Family Health Plan (SCFHP) to recover overpayments on claims paid to contracted and non-contracted providers.

#### A. Cal Medi-Connect (CMC):

As required by Medicare, SCFHP complies with the requirements pertaining to accurate and timely overpayment recovery. Overpayments are Medicare payments a provider or beneficiary has received in excess of amounts due and payable under the statute and regulations. Once a determination of overpayment has been made, the amount owed is a debt owed to the U.S. government.

1. Timeframe: SCFHP will send a written request for reimbursement to provider within 4 years of the Date of Payment on the overpaid claim. The 4 year time limit will not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

#### B. Medi-Cal

It is the policy of SCFHP to adhere to requirements specified in Sections 1300.71 and 1300.71.38, California Code of Regulations Title 28, Claims Settlement Practices and Dispute Resolution Mechanism, when processing overpayments.

1. Timeframe: SCFHP will send a written request for reimbursement to provider within 365 days of the Date of Payment on the overpaid claim. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

## POLICY

In the event that SCFHP is not permitted to retain some or all of the recoveries of overpayments, then SCFHP will pay recoveries of overpayments to DHCS as appropriate.

- C. SCFHP claims in conjunction with compliance promptly reports all overpayments identified or recovered that are deemed to be potential fraud, waste or abuse.
- D. SCFHP Claims and Finance Management annually report to DHCS their recoveries of overpayments.

### III. Responsibilities

- A. The Claims Refund Recovery Specialist is responsible to generate refund requests to providers as identified by the various areas within SCFHP, along with research and resolve voluntary refunds received by a provider.
- B. The Claims Department is responsible to ensure all overpayment recoveries are calculated accurately, applied correctly, and processed timely.
- C. The Finance Department is responsible for reconciling transactions that impact SCFHP's financial statements.
- D. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- E. The Claims Department will retain copies of all overpayment and recovery cases in accordance with SCFHP's Records Retention Policy.

### IV. References

#### CMC:

- Medicare Financial Management Manual, Chapter 3 – Overpayments
- Medicare Financial Management, Chapter 4 – Debt Collection Manual
- Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements
- Medicare Claims Processing Manual, Chapter 28 – Coordination with Medigap, Medicaid and other Commentary Insurers

#### Medi-Cal:

- 1300.71, California Code of Regulations Title 28, AB1455 - Claims Settlement Practices and Dispute Resolution Mechanism
- Title 28 CCR section 1300.71(d)(3)(4)(5)(6)
- 42 CFR 438.608(d)(2)(3).



**POLICY**

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 5/12/2017	N/A	N/A	N/A
2	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Timely Processing of Non-Clean Claims</b>	<b>Policy No.:</b>	CL.24 v1
<b>Replaces Policy Title (if applicable):</b>	Timely Processing of Non-Clean Claims	<b>Replaces Policy No. (if applicable):</b>	CL.24 v2
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To accurately and timely process non-clean claims in accordance with State and Federal regulatory requirements, as well as contractual obligations.

### II. Policy

SCFHP shall conduct required outreach to providers to obtain information necessary to make appropriate claim decisions.

#### A. Timeframes

##### 1. Contracted Providers

- a. Cal Medi-Connect: For Cal Medi-Connect (CMC) non-clean claims from contracted providers will pay or deny within sixty (60) calendar days of the date of receipt.

##### 2. Non-Contracted Providers

- b. Cal Medi-Connect: For CMC non-clean claims from non-contracted providers, SCFHP will pay or deny all non-clean cleans within sixty (60) calendar days of the date of receipt.

#### B. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor.

#### C. Date of Payment

The date of payment shall be the date of the check.

## POLICY

### D. Clean Claim

A claim is considered a clean claim when a claim is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### E. Non-Clean Claim

A claim missing key data, such as procedure, diagnosis, or provider information that prohibits the claim from being processed.

## III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations within the appropriate system for CMC members.
- B. The Claims Department is responsible to adhere to Medicare non-clean claims guidelines on an on-going basis.
- C. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- D. The Claims Department is responsible for ensuring applicable Medicare reimbursement rates and interest payments are calculated accurately, applied correctly, and processed timely.
- E. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, all information that is required to be kept confidential, shall be kept confidential.
- F. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## IV. References

42 C.F.R. § 422.520(a)(3); Medicare Managed Care Manual Chapter 11 – Section 100.2 & Chapter 13 – Section 40.1

42 C.F.R. § 422.566; and IOM Pub. 100-16,

Medicare Managed Care Manual, Chapter 4, Section 110.4



**POLICY**

Medicare Managed Care Chapter 13, Section 40.1

[Chapter 13 - Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans \(HCPPs\), \(collectively referred to as Medicare Health Plans\) \(PDF\)](#)

Medicare Managed Care Manual, Chapter 13, Sections 70.7.1 and 70.7.2

Policy CL.26 Claim Development of Non Clean Non Contracted Medicare Claims

**V. Approval/Revision History**

First Level Approval		Second Level Approval	
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer	
Date		Date	

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 3/22/2019	N/A	N/A	N/A
2	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Direct Member Reimbursement</b>	<b>Policy No.:</b>	CL.25 v3
<b>Replaces Policy Title (if applicable):</b>	Direct Member Reimbursement	<b>Replaces Policy No. (if applicable):</b>	CL.25 v2
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To identify the process of handling requests for direct member reimbursement (DMR) to reimburse members for out-of-pocket charges paid for covered services rendered.

#### Policy

DMRs are defined as a request for payment to a beneficiary, including approvals, denials, partial approvals, reconsiderations and non-contract provider claim reconsiderations submitted by beneficiaries.

Santa Clara Family Health Plan (SCFHP) will pay or deny DMRs within 60 calendar days from the date all of the required information is received.

SCFHP members may be reimbursed for out-of-pocket charges that are approved and authorized, if required, and if the acceptable documentation is received for all lines of business.

SCFHP members have within 90 days from date of service for Medi-Cal LOB and within 180 days from date of service for CMC to submit request for reimbursement.

### II. Responsibilities

Customer Service Department initiates the call log and provides Claims the pertinent information and receipts for proof of payment from the member.

Utilization Management (UM) is responsible for determining the medical necessity of services. In the event that services require prior authorization, UM will enter authorizations within the appropriate system for Medi-Cal and CMC members.

The Claims Department is responsible for determining if services are covered benefits and appropriate documentation has been provided.



## POLICY

The Claims Department is responsible for ensuring applicable program reimbursement rates are calculated accurately and that claims are processed timely.

The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.

In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, all information that is required to be kept confidential, shall be kept confidential.

The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP’s Records Retention Policy.

### III. References

42 C.F.R. § 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1  
 SCFHP Member Handbook – Evidence of Coverage (EOC)

### IV. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims	Neal Jarecki Chief Financial Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 3/21/2018	N/A	N/A	N/A
2	Revised – 3/22/2019	N/A	N/A	N/A
3	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Claim Development of Non-Clean Non-Contracted Medicare Claims</b>	<b>Policy No.:</b>	CL.26 v2
<b>Replaces Policy Title (if applicable):</b>	Claim Development of Non-Clean Non-Contracted Medicare Claims	<b>Replaces Policy No. (if applicable):</b>	CL.26 v1
<b>Issuing Department:</b>	Claims	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To define the manner in which Santa Clara Family Health Plan (SCFHP) will handle development of Non-Clean Non-Contracted Cal Medi-Connect (CMC) Claims and to accurately process claims in accordance with State and Federal regulatory requirements, as well as contractual obligations.

### II. Policy

SCFHP will develop non-clean claims and process within 60 calendar days of receipt.

SCFHP will conduct required outreach to providers to obtain information necessary to make appropriate decisions for claims processing.

SCFHP will obtain any necessary clinical decisions or retro-authorizations for unauthorized claims from non-contracted CMC providers in order to determine the medical necessity and appropriateness of claims.

#### A. Timeframes

##### 1. Non-Contracted Providers

- a. Cal Medi-Connect: For CMC non-clean claims from non-contracted providers, SCFHP will pay or deny them within sixty (60) calendar days of the date of receipt.

#### B. Date of Receipt

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

#### C. Date of Payment

The date of payment shall be the date of the check.

## POLICY

### D. Clean Claim

A claim is considered to be clean when it is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### E. Non-Clean Claim

A claim missing key data, such as procedure, diagnosis, or provider information that prohibits the claim from being processed.

### F. Claim Development

Requesting the claims information from the non-contracted providers.

## III. Responsibilities

- A. Utilization Management (UM) is responsible for determining the medical necessity of services. In the event of services that require prior authorization, UM is to enter authorizations within the appropriate system for CMC members.
- B. The Claims Department is responsible to adhere to Medicare non-clean claims guidelines on an on-going basis.
- C. The Claims Department is responsible for ensuring applicable Medicare reimbursement rates and interest payments are calculated accurately, applied correctly, and processed timely.
- D. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- E. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, all information that is required to be kept confidential, shall be kept confidential.
- F. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## IV. References

42 C.F.R. § 422.520(a)(3); Medicare Managed Care Manual Chapter 11 – Section 100.2

42 C.F.R. § 422.566; and IOM Pub. 100-16

Medicare Managed Care Manual, Chapter 4, Section 110.4

Medicare Managed Care Chapter 13 – Beneficiary, Grievances, Organization Determinations and Appeals, Section 40.1 and 50.1



**POLICY**

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 05/11/2018	N/A	N/A	N/A
2	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	<b>Non-Medical Transportation Services</b>	<b>Policy No.:</b>	CL.27 v2
<b>Replaces Policy Title (if applicable):</b>	Non-Medical Transportation Services	<b>Replaces Policy No. (if applicable):</b>	CL.27 v1
<b>Issuing Department:</b>	Claims	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

To establish the policy for payment of Non-Medical Transportation services in accordance with State and Federal regulatory requirements.

### II. Policy

A. Non-Medical Transportation (NMT) is payable at contracted rates or not less than the Medi-Cal FFS rate for non-contracted providers. No authorization is required for this service.

1. Indian Health Care Providers (IHCP) that provide NMT services follow the same requirements as other contracted or non-contracted providers, as applicable.
  - a. An Indian Health Care Provider (IHCP) is a health care program operated by the Indian Health Services (IHS), an Indian Tribe, a Tribal Organization, or an Urban Indian Organization as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).
  - b. IHCPs are not required to be contracted with MCPs in order to be reimbursed for services provided to American Indians.

B. Timeframes

#### 1. Contracted Providers

- a. **Medi-Cal:** For Medi-Cal claims regarding Non-Medical Transportation services from contracted providers, Santa Clara Family Health Plan (SCFHP) shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding Non-Medical Transportation services from contracted providers, SCFHP shall pay all clean claims within sixty (60) calendar days of the date of receipt.

## **POLICY**

### **2. Non-Contracted Providers**

- a. **Medi-Cal:** For Medi-Cal claims regarding Non-Medical Transportation services from non-contracted providers, SCFHP shall pay ninety-five percent (95%) of all clean claims within forty-five (45) working days of the date of receipt.
- b. **Cal Medi-Connect:** For Cal Medi-Connect (CMC) claims regarding Non-Medical Transportation services from non-contracted providers, SCFHP shall pay all clean claims within thirty (30) calendar days of the date of receipt.

#### **C. Date of Receipt**

The date of receipt shall be the working day when a claim, by physical or electronic means, is first delivered to either the Plan's specified claims payment office, post office box, or designated claims processor, or to the Plan's capitated provider for that claim.

#### **D. Date of Payment**

The date of payment shall be the date of the check.

#### **E. Clean Claim**

A claim is considered to be clean when it is complete and accurate with a claim form that includes all provider and member information, as well as medical records, additional information, or documents needed from the member or provider to enable SCFHP to process the claim.

### **III. Responsibilities**

- A. The Claims department is responsible for timely processing NMT claims, ensuring that all applicable rates and interest payments are calculated accurately and applied correctly.
- B. The Claims Department is responsible for running daily claims pend reports to monitor and track timely processing compliance for all claims.
- C. Customer Service will coordinate NMT services.
- D. Provider Network Management will coordinate contracting, as applicable, provide education regarding requirements and benefits for NMT providers.
- E. In accordance with SCFHP Confidentiality Policy, and all applicable State and Federal laws, any and all information that is required to be kept confidential, shall be kept confidential.
- F. The Claims Department will retain copies of all interest and penalty payments in accordance with SCFHP's Records Retention Policy.

## POLICY

### IV. References

APL 17-010  
 W&I Code, Section 14132(ad)(1); Section 14132(ad)(2)(A)(i)  
 PPL No. 18-019  
 PPL No. 20-005  
 25 U.S. Code § 1603  
 42 CFR 438.14(b)(2)

### V. Approval/Revision History

First Level Approval		Second Level Approval		
Arlene Bell Director, Claims		Neal Jarecki Chief Financial Officer		
Date 7/22/2020		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original – 7/22/2020	N/A	N/A	N/A
2	Revised	Executive/Finance	Recommend 5/27/2021	N/A

## POLICY

<b>Policy Title:</b>	Finance - General	<b>Policy No.:</b>	FA.01 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs the general financial policies and procedures used by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures to ensure that the Plan's assets are protected, properly recorded, and periodically reconciled.

This policy will ensure that the Finance department has sufficient procedures governing the general Finance areas not otherwise addressed through specific procedures for a specific area (e.g., Cash Receipts).

This policy will be supported by specific detailed procedures on:

- a. Finance definitions,
- b. Asset access controls
- c. Budgeting & forecasting
- d. Member months
- e. Audit preparation
- f. Financial systems access,
- g. Accounting calendar development
- h. Commercial insurance
- i. Administrative expense allocations
- j. Any future procedures of a general financial nature as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

**POLICY**

**IV. References**

None

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Barbara Granieri, Controller		Neal Jarecki, CFO		
5/3/21		Date		
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Cash & Cash Receipts	<b>Policy No.:</b>	FA.02 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Periodically As Warranted
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all Cash and Cash Receipts received by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing cash and cash receipts to ensure that the Plan's assets are protected, properly recorded, and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Cash receipts
- Incoming wire transfers
- Bank accounts
- Bank statement reconciliations
- Incoming Finance mail
- Petty cash
- Any future cash receipts procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval		Third Level Approval		
Barbara Granieri, Controller		Neal Jarecki, CFO		
5/3/21				
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19



## POLICY

<b>Policy Title:</b>	Cash Disbursements	<b>Policy No.:</b>	FA.03 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls, policies and procedures governing all disbursement of funds, and ensure that the Plan's assets are protected, properly recorded, and routinely reconciled.

### II. Policy

The Chief Executive Officer (CEO) and Executive Management Team are charged with the authority and responsibility for maximizing the purchasing value of the Plan's funds as follows:

- a. Acquiring services, supplies and equipment for all department in an economical, consistent, expeditious, and reasonable manner.
- b. Analyzing bids, awarding contracts, and assuring vendor performance through effective contract administration.
- c. Identifying qualified vendors and maintaining good vendor relationships.
- d. Educating and training employees and vendors on this policy and associated procedures.

Unless specifically exempted, no expenditure of funds should occur without a contract, statement of work (SOW), or check request approved by the CEO (or, for urgent purchases and/or in the CEO's absence, an Executive Management designee). Exceptions include:

- a. Contracts with healthcare providers involved in the delivery of healthcare services (which are governed by specific procedures of the Provider Network Management department).
- b. Personnel (which are governed by specific procedures of the Human Resources department).
- c. Items under \$1,000, which are subject to approval after purchase.
- d. Urgent purchases, as designated by the CEO or CFO. Emergency purchases require CEO or CFO advance approval. Should an emergency occur in the absence of the CEO and CFO, another Executive may approve the purchase and subsequently the purchase will be approved by the CFO.

## POLICY

- e. Telephone and utilities expenses, which are recurring in nature and require initial approval by the Facilities department and CFO.
- f. Brokered insurance and reinsurance, following a competitive bidding process, which require CFO review and approval.
- g. Postage, delivery and shipping charges, which require approval after purchase.
- h. Janitorial or facilities services, which require approval after purchase.
- i. Purchases made via credit card or purchasing card, which require subsequent approval.

All contracts in excess of \$250,000 require the review and approval of the Governing Board or the Executive/Finance Committee.

This policy is supported by detailed procedures on such topics as:

- a. Procurement
- b. Contracting
- c. Payment processing
- d. Authorization of administrative and capital expenditures
- e. Company credit & purchasing cards
- f. Accounts payable vendor maintenance
- g. Company accounts with outside vendors
- h. Prepaid expense
- i. Stale checks & escheatment
- j. Provider refunds
- k. Any future cash disbursement procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller	Neal Jarecki, CFO
5/3/21	
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	NA	NA	Approved 12/13/18

## POLICY

<b>Policy Title:</b>	Accounts Receivable and Revenue	<b>Policy No.:</b>	FA.04 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all accounts receivables and revenue recorded by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing accounts receivables and revenues to ensure that the Plan's assets are protected, properly recorded and periodically reconciled.

This policy will be supported by specific detailed procedures:

- Capitation
- Premiums accounts receivable/revenue
- Supplemental (kick) accounts receivable/revenue
- Healthy Kids' member accounts receivable/revenue
- Pass-through accounts receivable/revenue
- Any future accounts receivable/revenue procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller	Neal Jarecki, CFO
5/3/21	
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Payroll & Employee Expenses	<b>Policy No.:</b>	FA.05 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all payroll and employee expenses recorded by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing payroll and employee expenses to ensure that the Plan's assets are protected, properly recorded and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Payroll & employee benefits processing
- Reimbursed business expenses
- Employee gift cards
- Any future payroll and/or employee expense procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller	Neal Jarecki, CFO
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Fixed Assets & Depreciation Expense	<b>Policy No.:</b>	FA.06 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all fixed asset and depreciation transactions recorded by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing fixed asset transactions to ensure that the Plan's assets are protected, properly recorded and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Capital asset acquisitions
- Depreciation & amortization expense
- Disposition of fixed asset
- Any future fixed asset procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.



**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller	Neal Jarecki, CFO
<b>5/3/21</b>	
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Procedure Title:</b>	Investments	<b>Procedure No.:</b>	FA.07 v3
<b>Replaces Procedure Title (if applicable):</b>		<b>Replaces Procedure No. (if applicable):</b>	
<b>Issuing Department:</b>	Finance	<b>Procedure Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. PURPOSE

This investment policy sets for the investment guidelines and structure for the investment of short-term operating funds not required for the immediate needs on and after April 22, 2021 of the Santa Clara Family Health Plan (SCFHP or the Plan) which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

Investments may only be made as authorized by this Annual Investment Policy. SCFHP is required to invest its funds in accordance with the California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox-Keene Act of 1975 as well as the prudent investment standard:

The Prudent Investor Standard: When investing, reinvesting, purchasing, acquiring, exchanging, selling or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of SCFHP, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code Section 53600.3).

### II. OBJECTIVES

- i. **Safety:** the primary objective of this policy is the preservation of principal; avoiding capital losses by minimizing credit risk and interest rate or market risk.
- ii. **Liquidity:** maintain sufficient liquidity to meet the operating requirements for six months.
- iii. **Yield:** achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
- iv. **Diversification:** provide diversification of the portfolio securities to avoid incurring unreasonable market and credit risks.

## POLICY

### III. INVESTMENT STRATEGY

The Plan will adhere to the investment goal of holding investments to maturity. From time to time, the portfolio may go out of alignment. The Chief Financial Officer may choose to rebalance the portfolio earlier to bring it back into compliance if the portfolio will not suffer any losses for selling the investment prior to maturity.

### IV. ETHICS AND CONFLICTS OF INTEREST

SCFHP's officers, employees and Governing Board members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. SCFHP's officers and employees involved in the investment process are not permitted to have any material financial interests in financial interests in financial institutions, including state or federal credit unions, that conduct business with SCFHP, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of SCFHP's investments.

### V. DELEGATION OF AUTHORITY

#### A. County of Santa Clara Commingled Investment Pool

The Governing Board is responsible for the management and oversight of SCFHP's investment program. The Board has directed that available excess funds not required for immediate operational cash flow purposes be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

- (1) All of the evidence of indebtedness of the County, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.
- (2) The County has cash or cash equivalents in an amount equal to fifty million dollars or more, based on its audited financial statements for the immediately preceding fiscal year.
- (3) The day-to-day managing, reporting, and oversight of the investment contractual obligations between the County and SCFHP shall be the responsibility of SCFHP's Chief Financial Officer.

## POLICY

### B. Depository (Financial) Institutions

All SCFHP money shall be deposited in financial institutions that meet the requirements as set forth in Section 53635.2 and authorized by the Board. The financial institution shall have received an overall rating of not less than “satisfactory” in its most recent evaluation by its appropriate federal financial supervisory agency. In addition, the depository financial institution shall maintain a rating of its senior long-term debt obligations, deposit rating or claims-paying ability rating, or is guaranteed by an entity whose obligations are rated not lower than “AA- by S&P, AA- by Fitch or “Aa3” by Moody’s or its equivalent from another nationally recognized rating agency.

(1) All depository institutions shall provide SCFHP with notification of any downgrades in long-term ratings or any unsatisfactory rating by their appropriate federal financial supervisory agency within 10 days of such downgrade.

(2) Any downgrade in ratings of a financial institution holding SCFHP funds, shall be provided to the Board by the Chief Financial Officer.

(3) The day-to-day managing, reporting, and oversight of the depository and investment contractual obligations for SCFHP shall be the responsibility of SCFHP’s Chief Financial Officer.

(4) The Board of Directors may renew the delegation of authority to enter into depository and investment relationships annually.

(5) Funds not required to compensate for transaction costs shall be invested in and earn a market rate of return in the depository institution’s highest rated money market mutual fund as permitted by the California Government Code, Section 53600 et seq.

### C. Portfolio Investment Manager

The Governing Board may grant authority to a qualified investment manager to direct investments of excess funds in accordance with the AIP and be subject to periodic review for compliance to the AIP. The qualified investment manager must meet all requirements established by federal and California law. Any Board-approved changes in Permitted Investments and the AIP shall be communicated to the investment manager upon approval.

### D. Exceptions to this Policy

The Governing Board may grant express written authority to make a one-time investment not permitted by this Policy however, the investment must be permitted by the CA Government code. The Board of Directors may also make amendments to the AIP at any quarterly meeting as needed.

## VI. AUTHORIZED INVESTMENTS



## POLICY

- A. Authorized Investment Types: SCFHP shall invest only in instruments as permitted by the CA Government Code, subject to the limitations of this AIP.
1. Permitted investments in the managed portfolio shall be considered short-term operating funds and are subject to a maximum stated term of four hundred fifty (450) days.
  2. The Governing Board may designate a reserve fund for excess funds not required for operational cash flow for which permitted investments are subject to a maximum term of five years pursuant to the Code.

INVESTMENT TYPE	MAXIMUM REMAINING MATURITY	MAXIMUM SPECIFIED % OF PORTFOLIO	MINIMUM QUALITY REQUIREMENTS
U.S. Treasury Obligations	5 years	None	None. May invest in securities that could result in zero or negative interest accrual if held to maturity, in the event of a period of negative market interest rates.
U.S. Agency Obligations	5 years	None	None
State Obligations: CA and Others	5 years	None	None for CA; AA or better for other States
CA Local Agency Obligations	5 years	None	AA rated
Commercial Paper: Non-Pooled Funds (minimum \$100,000,000 of investments)	270 days or less	40% of Plan's investible funds	Highest letter and number rating by an NRSRO <sup>1,5</sup>
Placement Service Certificates of Deposit	2 years	\$250,000 per deposit per institution	FDIC insured at all times
Repurchase Agreements	1 year	None	U.S. Treasury and Agency Obligations
Medium-term Notes	5 years or less	30% (with not more than 10 % in any one institution)	"A" rating category or better
Mutual Funds and Money Market Mutual Funds	N/A	20% (no more than 10% invested in any one mutual fund; limitation does not apply to	Multiple <sup>2</sup>

## POLICY

		money market mutual funds)	
Collateralized Bank Deposits	5 years	None	If investments require collateral, collateral must be placed in institution not affiliated with the issuer of the obligation.
Mortgage Pass-through and Asset Backed Securities	5 years or less	20%	“AA” rating category or its equivalent or better <sup>4</sup>
County Pooled Investment Funds- Santa Clara County Pool	N/A	None	A or better
Joint Powers Authority Pool (CAMP, CalTrust)	N/A	None	Multiple <sup>3</sup>
Local Agency Investment Fund (LAIF)	N/A	None	None
Supranational Obligations	5 years or less	30%	“AA” rating or better
<u>Public Bank Obligations</u>	<u>5 years</u>	<u>None</u>	<u>Section 57600 (b) <sup>6</sup></u>

*1 Issuing corporation must be organized and operating within the U.S., have assets in excess of \$500 million, and debt other than commercial paper must be in a rating category of “A” or its equivalent or higher by a nationally recognized statistical rating organization, or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, have program wide credit enhancements, and have commercial paper that is rated “A-1” or higher, or the equivalent, by a nationally recognized statistical rating agency (NSRO).*

*2 A money market mutual fund must receive the highest ranking by not less than two nationally recognized rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years’ experience investment in money market instruments with assets under management in excess of \$500 million.*

*3 A joint powers authority pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of \$500 million, and has at least five years’ experience investment in instruments authorized by Section 53601, subdivisions (a) to (o).*

*4 Any investments in asset-backed securities (mortgage pass-through securities, collateralized mortgage obligations, mortgage-backed or other pay-through bonds, equipment lease-backed certificates, consumer receivable pass-through certificates, or consumer receivable-backed bonds) are required to have a maximum remaining maturity of five years or less. While the Legislature removed the requirement that the securities’ issuer be rated “A” or its equivalent or better for the issuer’s debts in accordance with a nationally recognized statistical rating organization (NRSRO), the Plan retains this requirement.*

*5 In 2021, Section 53601 (h) amended to allow local agencies that have one hundred million dollars or more of investment assets under management to invest no more than 40% of their moneys in eligible commercial paper. Further amendment to Section 53601 limits local agencies to invest no more than 10% of their total investment assets in commercial paper and medium- term notes of any single issuer.*

## POLICY

*<sup>6</sup> Public Bank means a corporation organized under the Nonprofit Mutual benefit corporation Law for the purpose of engaging in the commercial banking business or industrial banking business that is wholly owned by a local agency, local agencies or a joint powers authority that is composed only of local agencies. A local agency may invest in commercial paper, debt securities, or other obligations of a public bank.*

- B. Prohibited Investment Types: CA Government Code Section 53601.6 prohibits local agencies from investing in inverse floaters, range notes, or mortgage-derived, interest-only strips, and any security which could result in zero interest accrual if held to maturity. In addition, the Plan does not authorize investment in the following:
- i. Bankers' Acceptances
  - ii. Commercial Paper: Pooled Funds (pertains only to Managed Portfolio)
  - iii. Negotiable Certificates of Deposit
  - iv. Non-negotiable Certificates of Deposit
  - v. Reverse Repurchase Agreements and Securities Lending Agreements
  - vi. Voluntary Investment Program Fund

## VII. REPORTING REQUIREMENTS

The following documents and reports will be periodically provided to support the investment procedures, oversight and reporting requirements:

- A. County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits
- B. County of Santa Clara Treasury Investment Policy
- C. County of Santa Clara Treasury Quarterly Report
- D. SAP Balance and Interest Earnings Report of SCFHP Invested Funds
- E. Depository Institution – daily transaction and monthly activity report
- F. Managed Portfolio - Month-end and quarter-end portfolio performance summary, income, ending balance sheet, trading activity, transaction detail and portfolio diversification report. The listing must include issuer names, dates of maturity, par amounts, dollar amount, market values as of month-end and comparable published index as to diversification and duration that most closely tracks the performance of the portfolio.
- G. Investment Oversight Quarterly Report – provides independent review of all invested funds for tracking of AIP, diversification requirements and performance review. Minimum reporting requirements includes a listing of the types of investment, issuer names, dates of maturity, par amounts, dollar amount, market values, descriptions of the programs under the management of contracted parties, a statement of compliance with the investment policy, and a statement of the ability to meet cash flow needs for six months. Any irregularities shall be noted and included in the report.



## POLICY

### VIII. REVIEW OF INVESTMENT POLICY

At least annually and more frequently as needed, the Governing Board will review this investment policy at a regular meeting of the Board. Any recommended changes to the Policy, including modifications to current investment strategy, oversight procedures including internal controls will be first be brought to the Executive/Finance Committee by the CFO for review and approval prior to presentation to the Board. The Executive Committee and Board of Directors will be supported in this work by the CFO, investment advisors and legal counsel for financial and legal issues, respectively.

Any modifications to this Investment Policy, including withdrawal from the County of Santa Clara Commingled Investment Pool, will be made in accordance with California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox Keene Act of 1975 as well as the prudent investment standard.

### IX. Approval/Revision History

First Level Approval		Third Level Approval		
Barbara Granieri, Controller 5/3/21		Neal Jarecki, CFO		
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	Executive/Finance Committee	Approved 04/26/18	Approved 06/28/18
V2	Reviewed	Executive/Finance Committee	Reviewed (no changes) 05/01/19	Approved 6/27/19



## POLICY

<b>Policy Title:</b>	Treasury & Debt	<b>Policy No.:</b>	FA.08 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all treasury and debt transactions recorded by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing treasury and debt to ensure that the Plan's assets are protected, properly recorded and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Treasury management
- Debt
- Any future treasury or debt procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller	Neal Jarecki, CFO
5/3/21	
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Financial Close & Reporting	<b>Policy No.:</b>	FA.09 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs the financial closing and reporting processes used by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team, and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing financial close and reporting to ensure that the Plan's assets are protected, properly recorded, and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Month-end close & reconciliation process
- Journal entries
- Internal financial reporting
- External & regulatory financial reporting
- Monitoring of capitated providers' financial solvency
- Tangible net equity (TNE)
- Managed care organization (MCO) taxes
- Month-end close analysis
- Any future financial close and reporting procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

**POLICY**

None.

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller <b>5/3/21</b>	Neal Jarecki, CFO
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Medical Expense & Incurred-But-Not Paid (IBNP)	<b>Policy No.:</b>	FA.10 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all medical expense and IBNP transactions recorded by SCFHP.

### II. Policy

SCFHP's Governing Board, Executive Management Team and generally-accepted accounting principles (GAAP) require that the Finance department implement and maintain proper controls and procedures governing medical expense recordation and IBNP to ensure that the Plan's assets are protected, properly recorded, and periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Fee-for-service (FFS) provider payments
- Pharmacy expense
- Pharmacy rebates
- IBNP calculations (claims incurred-but-not-paid)
- Reinsurance expense
- Reinsurance recoveries
- Any future medical expense and IBNP procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Barbara Granieri, Controller <b>5/3/21</b>	Neal Jarecki, CFO
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19

## POLICY

<b>Policy Title:</b>	Healthcare Economics	<b>Policy No.:</b>	FA.11 v2
<b>Replaces Policy Title (if applicable):</b>	N/A	<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Finance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

This policy governs all key functions performed by the Healthcare Economics team.

### II. Policy

SCFHP's Governing Board and Executive Management Team require that the Healthcare Economics team implement and maintain proper controls and procedures governing certain key tasks to ensure that the Plan's assets are protected, transactions are properly recorded, and records are periodically reconciled.

This policy will be supported by specific detailed procedures on:

- Target claims audits
- Monthly calculation and payment of capitation to delegates
- Medicare prescription drug event (PDE) reporting
- Any future Healthcare Economics procedures as needed.

### III. Responsibilities

The Chief Financial Officer has overall responsibility for this policy. The Director of Healthcare Economics has responsibility for implementation, periodic updates, and oversight of the staff's adherence to this policy and all related procedures.

### IV. References

None.

**POLICY**

**V. Approval/Revision History**

First Level Approval	Third Level Approval
Ngoc Bui-Tong, VP, Strategies and Analytics	Neal Jarecki, CFO
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	Executive/Finance Committee	Approved 05/01/19	Approved 06/27/19



**Santa Clara Family Health Plan  
Quarterly Investment Compliance Report  
for the Quarter Ended March 31, 2021**

## **1. OVERVIEW**

The California Government Code (the Code), Section 53646, which governs Santa Clara Family Health Plan's (the Plan's) investments, states that the Chief Financial Officer may render a quarterly report on the status of investment portfolio and excess cash to its Governing Board.

This quarterly report contains a listing of investments, fund balances, activity, and return on investments made by the Plan. Quarterly reports also reflect the current positions and past performance of a portfolio of investments for the period of time under consideration.

This quarterly report also includes 1) a statement of compliance with the investment policy or an explanation for non-compliance; and 2) a statement of SCFHP's ability to meet its expenditure requirements for the next six months (and an explanation of why sufficient money would not be available, if that were the case).

The Plan's investments and excess cash accounts currently include:

1. County of Santa Clara Comingled Investment Pool (County Pool)
2. Wells Fargo Investment Management Portfolio (Portfolio)
3. Wells Fargo Stagecoach Money Market Fund (Sweep)

## **2. COMPLIANCE WITH ANNUAL INVESTMENT POLICY**

Based upon our independent compliance review of the quarterly investment reports prepared for the County Pool, and Portfolio investments and the Sweep account, all investments were in compliance with the Santa Clara Family Health Plan's 2021 Annual Investment Policy adopted April 22, 2021. Investments made by Wells Fargo Asset Management are made in keeping with the Annual Investment Policy and the California Government Code.

As required by the Code, the quarter end listing of the portfolio holdings is attached to this report.



### 3. PORTFOLIO SUMMARY

As of March 31, 2021, the market values of the investments of the SCFHP in the County Pool, the Wells' managed portfolio and the Wells' Stagecoach Money Market Fund (Sweep Account) are as follows:

County Commingled Investment Pool (County Pool)	Wells Fargo Asset Management Portfolio (Portfolio)	Wells Fargo Stagecoach Money Market Fund (Sweep Account)	Total
\$157,013,467	\$331,005,299	\$39,058,250	\$527,077,016

### 4. SIX MONTH CASH SUFFICIENCY

The Plan's CFO confirmed to Sperry Capital that as of the quarter ending March 31, 2021, the Plan has sufficient cash on-hand plus projected revenues to meet its operating expenditure requirements for at least the next six months.

### 5. DIVERSIFICATION COMPLIANCE

As of March 31, 2021, the investment composition of the Wells Portfolio and Sweep accounts is compliant with the SCFHP Annual Investment Policy 2021.

The published Quarterly Investment Report as of March 31, 2021 for the Commingled Investment Pool indicates compliance with the County Treasurer's Investment Policy and Diversification parameters. There is no maximum percentage requirement for investment in the Commingled Investment Pool.

**6. ACTUAL VS. DIVERSIFICATION REQUIREMENTS**

Investment Type	Maximum Maturity	Maximum Specified % of Portfolio	Minimum Quality Requirements	Portfolio As of 12-31-2020	Compliance
Wells Stagecoach MMF	N/A	20%	**	39,058,250	Yes
Wells Govt MMF	N/A	20%	**	2,804,298	Yes
Commingled Investment Pool	N/A	None	None	157,013,467	Yes
U.S. Treasury Obligations	450 days	None	None	95,760,613	Yes
U.S. Agency Obligations	450 days	None	None	142,962,422	Yes
Commercial Paper (Non-Pooled Funds)	270 days	40% of the Plan's investible funds	Highest letter & number rating by a national rating agency	39,450,001	Yes
CA Local Agency Obligations	450 days	None	None	7,978,808	Yes
Medium-Term Notes	450 days	30% (with not more than 20% in any 1 institution)	"A" rating or better	35,680,542	Yes
Supranationals	450 days	30%	"AA" rating or better	11,005,166	Yes
Cash		None		-4,636,551	Yes

\*\*A money market mutual fund must receive the highest ranking by not less than two nationally recognized statistical rating organizations or retain an investment advisor registered with the SEC or exempt from registration and who has not less than five years' experience investing in money market instruments with assets under management in excess of \$500 million.

**7. PERFORMANCE**

For the quarter ended March 31, 2021.

**Wells Fargo Asset Managed Portfolio**

Annualized Yield = 0.00%\* (0.00% = quarter-end; net of fees)

Primary Benchmark: ICE BofA Merrill Lynch 3-Month T-Bill: 0.03%

Average Duration: 0.178 years\*

Average Effective Maturity: 0.199 years\*

\*provided by Wells Fargo Asset Management

**Santa Clara County Commingled Investment Pool**

Annualized Yield = .88%

Weighted average life = 1.64 years (597 days)

Benchmark: LAIF = 0.41%; weighted average life = 0.55 years (202 days)

Benchmark: 2-year T-Note = 0.13% (730 days)

**Stagecoach Sweep Account (Wells Money Market Mutual Fund)**

Annualized Yield = 0.01%

Benchmark: Fidelity Class 1 (FIGXX) MMF = 0.03%



**ATTACHMENT**

Portfolio listing of the Wells Fargo Asset Managed Portfolio as of March 31, 2021

**Sperry Capital Inc. Disclaimer:** *Sperry Capital provides this Investment Summary Report for the sole use by the Santa Clara Family Health Plan and is not intended for distribution other than to members of the Board and Financial Committees of the Santa Clara Family Health Plan. This report is based on information prepared and distributed by and market valuations provided by Wells Fargo Asset Management and the Santa Clara County Treasurer's Pool, for those funds held by those entities respectively. Sperry Capital does not provide investment advice or profess an opinion as to asset allocation, appropriateness of investment or recommend alternative investment strategies. Sources for the material contained herein are deemed reliable but cannot be guaranteed.*



# Portfolio Holdings

US Dollar  
As of 31 March 2021

WC-Santa Clara Family HealthPI  
Account: XXXX5000  
Investment Strategy: Short Duration Fixed Income  
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS  
FARGO

Asset  
Management

## Cash

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
CCYUSD Cash	0.05 0.05	0.00 AAA	03/31/2021 03/31/2021	0.05	1.0000 0.00	0.00 0.00	0.05 0.05
CCYUSD Payable	-4,636,565.14 -4,636,565.14	0.00 AAA	03/31/2021 03/31/2021	-4,636,565.14	1.0000 0.00	0.00 0.00	-4,636,565.14 -4,636,565.14
CCYUSD Receivable	13.62 13.62	0.00 AAA	03/31/2021 03/31/2021	13.62	1.0000 0.00	0.00 0.00	13.62 13.62
<b>CCYUSD ---</b>	<b>-4,636,551.47 -4,636,551.47</b>	<b>0.00 AAA</b>	<b>03/31/2021 03/31/2021</b>	<b>-4,636,551.47</b>	<b>1.0000 0.00</b>	<b>0.00 0.00</b>	<b>-4,636,551.47 -4,636,551.47</b>

## MMFund

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
94975P405 WELLSFARGO:GOVT MM I	2,804,298.48 2,804,298.48	0.01 AAA	03/31/2021 03/31/2021	2,804,298.48	1.0000 0.01	0.00 0.00	2,804,298.48 2,804,298.48
<b>94975P405 WELLSFARGO:GOVT MM I</b>	<b>2,804,298.48 2,804,298.48</b>	<b>0.01 AAA</b>	<b>03/31/2021 03/31/2021</b>	<b>2,804,298.48</b>	<b>1.0000 0.01</b>	<b>0.00 0.00</b>	<b>2,804,298.48 2,804,298.48</b>

## Fixed Income

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
06051GEM7 BANK OF AMERICA CORP	2,715,000.00 2,715,000.00	5.70 A	01/24/2022 01/24/2022	2,834,980.22	104.3471 0.34	28,801.63 -1,956.46	2,833,023.77 2,861,825.39
06406FAB9 BANK OF NEW YORK MELLON CORP	1,500,000.00 1,500,000.00	2.05 A+	05/03/2021 05/03/2021	1,500,155.32	100.0000 0.81	12,641.67 -155.32	1,500,000.00 1,512,641.67
06406RAA5 BANK OF NEW YORK MELLON CORP	1,550,000.00 1,550,000.00	2.60 A+	02/07/2022 01/07/2022	1,578,210.00	101.7949 0.25	6,492.78 -389.05	1,577,820.95 1,584,313.73
14913Q2W8 CATERPILLAR FINANCIAL SERVICES CORP	1,102,000.00 1,102,000.00	2.65 A	05/17/2021 05/17/2021	1,105,382.24	100.2917 0.35	10,870.01 -167.70	1,105,214.53 1,116,084.54
14913Q3D9 CATERPILLAR FINANCIAL SERVICES CORP	2,000,000.00 2,000,000.00	0.40 A	11/12/2021 11/12/2021	2,002,626.53	100.0998 0.42	1,069.01 -630.53	2,001,996.00 2,003,065.01
808513AW5 CHARLES SCHWAB CORP	2,000,000.00 2,000,000.00	3.25 A	05/21/2021 04/21/2021	2,003,305.88	100.2068 1.70	23,472.22 830.12	2,004,136.00 2,027,608.22
22550L2A8 CREDIT SUISSE AG (NEW YORK BRANCH)	2,100,000.00 2,100,000.00	2.10 A+	11/12/2021 11/12/2021	2,123,403.33	101.0421 0.40	17,027.50 -1,519.23	2,121,884.10 2,138,911.60
30231GAJ1 EXXON MOBIL CORP	2,500,000.00 2,500,000.00	2.40 AA-	03/06/2022 01/06/2022	2,541,761.79	101.6509 0.23	4,161.46 -489.29	2,541,272.50 2,545,433.96
30229AU23 Exxon Mobil Corporation	600,000.00 600,000.00	0.00 A-1+	07/02/2021 07/02/2021	599,846.66	99.9788 0.08	0.00 26.24	599,872.90 599,872.90

The information contained in this report represents estimated trade date investment calculations. Certain calculations may not be available for all time periods. Please refer to your custody statement for official portfolio holdings and transactions. Note that certain accounting methods may cause differences between this investment report and your custody statement.

# Portfolio Holdings

US Dollar  
As of 31 March 2021

WC-Santa Clara Family HealthPI  
Account: XXXX5000  
Investment Strategy: Short Duration Fixed Income  
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS  
FARGO

Asset  
Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
30229AW13 Exxon Mobil Corporation	250,000.00 250,000.00	0.00 A-1+	09/01/2021 09/01/2021	249,840.62	99.9517 0.11	0.00 38.53	249,879.15 249,879.15
313313DU9 FEDERAL FARM CREDIT BANKS FUNDING CORP	1,000,000.00 1,000,000.00	0.00 A-1+	04/01/2021 04/01/2021	1,000,000.00	100.0000 0.00	0.00 0.00	1,000,000.00 1,000,000.00
313313NF1 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00 2,000,000.00	0.00 A-1+	10/21/2021 10/21/2021	1,998,533.48	99.9774 0.04	0.00 1,014.52	1,999,548.00 1,999,548.00
313313NP9 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00 2,000,000.00	0.00 A-1+	10/29/2021 10/29/2021	1,998,827.64	99.9766 0.07	0.00 704.36	1,999,532.00 1,999,532.00
313313KW7 FEDERAL FARM CREDIT BANKS FUNDING CORP	2,000,000.00 2,000,000.00	0.00 A-1+	08/25/2021 08/25/2021	1,999,269.93	99.9878 0.03	0.00 486.07	1,999,756.00 1,999,756.00
313313LK2 FEDERAL FARM CREDIT BANKS FUNDING CORP	7,000,000.00 7,000,000.00	0.00 A-1+	09/07/2021 09/07/2021	6,998,233.25	99.9823 0.04	0.00 527.75	6,998,761.00 6,998,761.00
313313JU3 FEDERAL FARM CREDIT BANKS FUNDING CORP	1,250,000.00 1,250,000.00	0.00 A-1+	07/30/2021 07/30/2021	1,249,791.66	99.9900 0.03	0.00 83.34	1,249,875.00 1,249,875.00
313313RK6 FEDERAL FARM CREDIT BANKS FUNDING CORP	3,000,000.00 3,000,000.00	0.00 A-1+	01/05/2022 01/05/2022	2,998,605.00	99.9612 0.05	0.00 231.00	2,998,836.00 2,998,836.00
313378CR0 FEDERAL HOME LOAN BANKS	2,000,000.00 2,000,000.00	2.25 AAA	03/11/2022 03/11/2022	2,040,652.73	102.0257 0.10	2,500.00 -138.73	2,040,514.00 2,043,014.00
3130AF5B9 FEDERAL HOME LOAN BANKS	5,000,000.00 5,000,000.00	3.00 AAA	10/12/2021 10/12/2021	5,075,749.05	101.5616 0.06	70,416.67 2,330.95	5,078,080.00 5,148,496.67
313385EA0 FEDERAL HOME LOAN BANKS	40,000,000.00 40,000,000.00	0.00 A-1+	04/07/2021 04/07/2021	39,999,933.33	100.0000 0.00	0.00 66.67	40,000,000.00 40,000,000.00
313385DZ6 FEDERAL HOME LOAN BANKS	9,400,000.00 9,400,000.00	0.00 A-1+	04/06/2021 04/06/2021	9,399,889.02	100.0000 0.00	0.00 110.98	9,400,000.00 9,400,000.00
313385DY9 FEDERAL HOME LOAN BANKS	3,210,000.00 3,210,000.00	0.00 A-1+	04/05/2021 04/05/2021	3,209,998.22	100.0000 0.00	0.00 1.78	3,210,000.00 3,210,000.00
313385FM3 FEDERAL HOME LOAN BANKS	30,000,000.00 30,000,000.00	0.00 A-1+	05/12/2021 05/12/2021	29,998,974.98	99.9989 0.01	0.00 695.02	29,999,670.00 29,999,670.00
313385EH5 FEDERAL HOME LOAN BANKS	10,935,000.00 10,935,000.00	0.00 A-1+	04/14/2021 04/14/2021	10,934,987.48	100.0000 0.00	0.00 12.52	10,935,000.00 10,935,000.00
313385EG7 FEDERAL HOME LOAN BANKS	10,731,000.00 10,731,000.00	0.00 A-1+	04/13/2021 04/13/2021	10,730,953.46	100.0000 0.00	0.00 46.54	10,731,000.00 10,731,000.00
313385FG6 FEDERAL HOME LOAN BANKS	7,000,000.00 7,000,000.00	0.00 A-1+	05/07/2021 05/07/2021	6,999,790.00	99.9990 0.01	0.00 140.00	6,999,930.00 6,999,930.00
313385FS0 FEDERAL HOME LOAN BANKS	1,250,000.00 1,250,000.00	0.00 A-1+	05/17/2021 05/17/2021	1,249,936.11	99.9987 0.01	0.00 47.64	1,249,983.75 1,249,983.75
313385MC7 FEDERAL HOME LOAN BANKS	5,000,000.00 5,000,000.00	0.00 A-1+	09/24/2021 09/24/2021	4,998,973.34	99.9804 0.04	0.00 46.66	4,999,020.00 4,999,020.00
38346LS72 Gotham Funding Corporation	1,500,000.00 1,500,000.00	0.00 A-1	05/07/2021 05/07/2021	1,499,850.00	99.9862 0.13	0.00 -56.58	1,499,793.42 1,499,793.42
38346LS31 Gotham Funding Corporation	2,500,000.00 2,500,000.00	0.00 A-1	05/03/2021 05/03/2021	2,499,711.11	99.9885 0.13	0.00 0.14	2,499,711.25 2,499,711.25
38346LTP1 Gotham Funding Corporation	2,000,000.00 2,000,000.00	0.00 A-1	06/23/2021 06/23/2021	1,999,354.44	99.9627 0.16	0.00 -101.10	1,999,253.34 1,999,253.34

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# Portfolio Holdings

US Dollar

As of 31 March 2021

WC-Santa Clara Family HealthPI

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS  
FARGO

Asset  
Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
45950VNE2 INTERNATIONAL FINANCE CORP	11,000,000.00 11,000,000.00	0.24 AAA	08/23/2021 08/23/2021	11,006,571.99	100.0410 1.13	655.54 -2,061.99	11,004,510.00 11,005,165.54
24422EUK3 JOHN DEERE CAPITAL CORP	1,000,000.00 1,000,000.00	3.13 A	09/10/2021 09/10/2021	1,013,070.00	101.2583 0.27	1,822.92 -487.00	1,012,583.00 1,014,405.92
24422EUV9 JOHN DEERE CAPITAL CORP	2,500,000.00 2,500,000.00	2.30 A	06/07/2021 06/07/2021	2,509,421.82	100.3830 0.21	18,208.33 153.18	2,509,575.00 2,527,783.33
46625HJD3 JPMORGAN CHASE & CO	2,000,000.00 2,000,000.00	4.50 A	01/24/2022 01/24/2022	2,069,598.77	103.4191 0.29	16,750.00 -1,216.77	2,068,382.00 2,085,132.00
4820P2SK2 Jupiter Securitization Company LLC	3,000,000.00 3,000,000.00	0.00 A-1+	05/19/2021 05/19/2021	2,999,280.00	99.9805 0.14	0.00 136.08	2,999,416.08 2,999,416.08
4820P2U78 Jupiter Securitization Company LLC	3,000,000.00 3,000,000.00	0.00 A-1+	07/07/2021 07/07/2021	2,998,706.66	99.9562 0.16	0.00 -21.50	2,998,685.16 2,998,685.16
4820P2SLO Jupiter Securitization Company LLC	300,000.00 300,000.00	0.00 A-1+	05/20/2021 05/20/2021	299,959.17	99.9801 0.14	0.00 -18.75	299,940.42 299,940.42
50000DSA5 Koch Industries, Inc.	3,000,000.00 3,000,000.00	0.00 A-1+	05/10/2021 05/10/2021	2,999,707.50	99.9873 0.11	0.00 -87.51	2,999,619.99 2,999,619.99
542424WH5 LONG BEACH CALIF HBR REV	1,500,000.00 1,500,000.00	4.00 AA	07/15/2021 07/15/2021	1,513,196.32	101.0830 0.14	12,666.67 3,048.68	1,516,245.00 1,528,911.67
5445872P2 LOS ANGELES CALIF MUN IMPT CORP LEASE REV	1,385,000.00 1,385,000.00	0.27 AA-	11/01/2021 11/01/2021	1,385,000.00	100.0060 0.26	279.42 83.10	1,385,083.10 1,385,362.52
67983TRD0 Old Line Funding, LLC	5,000,000.00 5,000,000.00	0.00 A-1+	04/13/2021 04/13/2021	4,999,716.67	99.9966 0.09	0.00 111.78	4,999,828.45 4,999,828.45
69371RN44 PACCAR FINANCIAL CORP	1,100,000.00 1,100,000.00	1.65 A+	08/11/2021 08/11/2021	1,105,887.74	100.4631 0.36	2,520.83 -793.64	1,105,094.10 1,107,614.93
69371RP26 PACCAR FINANCIAL CORP	125,000.00 125,000.00	3.10 A+	05/10/2021 05/10/2021	125,404.01	100.2730 0.56	1,517.71 -62.76	125,341.25 126,858.96
69371RP75 PACCAR FINANCIAL CORP	900,000.00 900,000.00	2.85 A+	03/01/2022 03/01/2022	922,133.83	102.4405 0.18	2,137.50 -169.33	921,964.50 924,102.00
713448BY3 PEPSICO INC	1,000,000.00 1,000,000.00	2.75 A+	03/05/2022 03/05/2022	1,023,780.00	102.3393 0.22	1,986.11 -387.00	1,023,393.00 1,025,379.11
69353RFB9 PNC BANK NA	2,000,000.00 2,000,000.00	2.63 A	02/17/2022 01/17/2022	2,038,816.39	101.8641 0.27	6,416.67 -1,534.39	2,037,282.00 2,043,698.67
752147HE1 RANCHO SANTIAGO CALIF CMNTY COLLEGE DIST	550,000.00 550,000.00	0.23 AA	09/01/2021 09/01/2021	550,000.00	100.0230 0.18	107.71 126.50	550,126.50 550,234.21
797356CB6 SAN DIEGO CALIF UNI SCH DIST	1,000,000.00 1,000,000.00	0.10 AA	07/01/2021 07/01/2021	1,000,000.00	100.0030 0.09	75.00 30.00	1,000,030.00 1,000,105.00
82707BDH9 SILICON VY CLEAN WTR CALIF WASTEWTR REV	2,000,000.00 2,000,000.00	0.18 AA	08/01/2021 08/01/2021	2,000,000.00	100.0050 0.16	147.50 100.00	2,000,100.00 2,000,247.50
857477AV5 STATE STREET CORP	2,000,000.00 2,000,000.00	1.95 A+	05/19/2021 05/19/2021	2,004,384.81	100.2096 0.37	14,300.00 -192.81	2,004,192.00 2,018,492.00
88602TSL8 Thunder Bay Funding, LLC	5,000,000.00 5,000,000.00	0.00 A-1+	05/20/2021 05/20/2021	4,998,775.00	99.9829 0.12	0.00 370.85	4,999,145.85 4,999,145.85

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# Portfolio Holdings

US Dollar  
As of 31 March 2021

WC-Santa Clara Family HealthPI  
Account: XXXX5000  
Investment Strategy: Short Duration Fixed Income  
Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index

WELLS  
FARGO

Asset  
Management

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
88602TVG5 Thunder Bay Funding, LLC	3,810,000.00 3,810,000.00	0.00 A-1+	08/16/2021 08/16/2021	3,807,825.13	99.9356 0.17	0.00 -278.77	3,807,546.36 3,807,546.36
89236TFX8 TOYOTA MOTOR CREDIT CORP	1,000,000.00 1,000,000.00	2.65 A+	04/12/2022 04/12/2022	1,025,037.39	102.4128 0.30	12,440.28 -909.39	1,024,128.00 1,036,568.28
89236TGS8 TOYOTA MOTOR CREDIT CORP	2,250,000.00 2,250,000.00	0.32 A+	08/13/2021 08/13/2021	2,250,834.57	100.0388 0.20	876.56 38.43	2,250,873.00 2,251,749.56
89233GTP1 Toyota Motor Credit Corporation	3,000,000.00 3,000,000.00	0.00 A-1+	06/23/2021 06/23/2021	2,999,239.17	99.9655 0.15	0.00 -275.16	2,998,964.01 2,998,964.01
86787EBE6 TRUIST BANK	1,665,000.00 1,665,000.00	2.80 A	05/17/2022 04/17/2022	1,708,103.40	102.5945 0.31	17,353.00 95.03	1,708,198.43 1,725,551.43
9128286V7 UNITED STATES TREASURY	5,900,000.00 5,900,000.00	2.13 AAA	05/31/2021 05/31/2021	5,916,673.07	100.3386 0.10	42,021.29 3,304.33	5,919,977.40 5,961,998.69
912796D71 UNITED STATES TREASURY	34,300,000.00 34,300,000.00	0.00 A-1+	04/06/2021 04/06/2021	34,299,952.36	99.9999 0.01	0.00 13.34	34,299,965.70 34,299,965.70
9127965A3 UNITED STATES TREASURY	8,000,000.00 8,000,000.00	0.00 A-1+	05/06/2021 05/06/2021	7,999,822.67	99.9988 0.01	0.00 81.33	7,999,904.00 7,999,904.00
912796A25 UNITED STATES TREASURY	18,000,000.00 18,000,000.00	0.00 A-1+	05/13/2021 05/13/2021	17,999,496.00	99.9977 0.02	0.00 90.00	17,999,586.00 17,999,586.00
912796F79 UNITED STATES TREASURY	9,000,000.00 9,000,000.00	0.00 A-1+	05/04/2021 05/04/2021	8,999,943.85	99.9984 0.02	0.00 -87.85	8,999,856.00 8,999,856.00
912796F95 UNITED STATES TREASURY	20,500,000.00 20,500,000.00	0.00 A-1+	05/18/2021 05/18/2021	20,499,478.11	99.9966 0.03	0.00 -175.11	20,499,303.00 20,499,303.00
91412HJH7 UNIVERSITY CALIF REVS	1,515,000.00 1,515,000.00	0.16 AA	05/15/2022 05/15/2022	1,515,000.00	99.9210 0.25	144.05 -1,196.85	1,513,803.15 1,513,947.20
90331HPK3 US BANK NA	2,000,000.00 2,000,000.00	0.40 AA-	01/21/2022 12/21/2021	2,002,389.04	100.0876 0.26	1,569.67 -637.04	2,001,752.00 2,003,321.67
92646KS45 Victory Receivables Corporation	3,000,000.00 3,000,000.00	0.00 A-1	05/04/2021 05/04/2021	2,999,670.00	99.9882 0.13	0.00 -24.18	2,999,645.82 2,999,645.82
92646KU83 Victory Receivables Corporation	1,500,000.00 1,500,000.00	0.00 A-1	07/08/2021 07/08/2021	1,499,346.67	99.9609 0.14	0.00 67.58	1,499,414.25 1,499,414.25
92646KU18 Victory Receivables Corporation	2,000,000.00 2,000,000.00	0.00 A-1	07/01/2021 07/01/2021	1,999,241.66	99.9642 0.14	0.00 42.78	1,999,284.44 1,999,284.44
---	331,893,000.00	0.40	06/13/2021	332,506,990.58	100.1901	331,449.70	332,506,102.62
---	331,893,000.00	AA+	06/11/2021		0.11	-887.97	332,837,552.32

## Summary

Identifier, Description	Base Original Units, Base Current Units	Coupon, Rating	Final Maturity, Effective Maturity	Base Book Value	Market Price, Yield	Base Accrued Balance, Base Net Total Unrealized Gain/Loss	Base Market Value, Base Market Value + Accrued
---	330,060,747.01	0.40	06/13/2021	330,674,737.59	100.7392	331,449.70	330,673,849.63
---	330,060,747.01	AA+	06/12/2021		0.11	-887.97	331,005,299.33

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# Portfolio Holdings

US Dollar

As of 31 March 2021

WC-Santa Clara Family HealthPI

Account: XXXX5000

Investment Strategy: Short Duration Fixed Income

Primary Benchmark: ICE BofA 3-Month US Treasury Bill Index



**Asset  
Management**

\* Grouped by: Asset Class. \* Groups Sorted by: Asset Class. \* Weighted by: Base Market Value + Accrued. \* Holdings Displayed by: Position.

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**Santa Clara Family  
Health Plan™**

**Unaudited Financial Statements  
For The Nine Months Ended March 31, 2021**

# Agenda

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# Financial Highlights



	<u>MTD</u>		<u>YTD</u>	
Revenue	\$108 M		\$944 M	
Medical Expense (MLR)	\$99 M	91.8%	\$878 M	93.1%
Administrative Expense (% Rev)	\$4.6 M	4.3%	\$49.0 M	5.2%
Other Income/(Expense)	\$238K		(\$149K)	
<b>Net Surplus (Net Loss)</b>	<b>\$4.5 M</b>		<b>\$16.4 M</b>	
Cash and Investments			\$520 M	
Receivables			\$507 M	
Total Current Assets			\$1,037 M	
Current Liabilities			\$845 M	
Current Ratio			1.23	
Tangible Net Equity			\$225 M	
% of DMHC Requirement			<b>655.6%</b>	

# Financial Highlights

<b>Net Surplus (Net Loss)</b>	<ul style="list-style-type: none"> <li>▶ Month: Surplus of \$4.5M is \$7.0M or 278.8% favorable to budget of \$2.5M loss.</li> <li>▶ YTD: Surplus of \$16.4M is \$21.6M or 414.7% favorable to budget of \$5.2M loss.</li> </ul>
<b>Enrollment</b>	<ul style="list-style-type: none"> <li>▶ Month: Membership was 276,842 (4,683 or 1.7% higher than budget of 272,159).</li> <li>▶ YTD: Member Months YTD was 2,410,764 (18,593 or 0.8% lower than budget of 2,429,357).</li> </ul>
<b>Revenue</b>	<ul style="list-style-type: none"> <li>▶ Month: \$107.8M (\$16.9M or 18.6% favorable to budget of \$90.9M).</li> <li>▶ YTD: \$943.9M (\$70.3M or 8.0% favorable to budget of \$873.6M).</li> </ul>
<b>Medical Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$99.0M (\$11.0M or 12.5% unfavorable to budget of \$88.0M).</li> <li>▶ YTD: \$878.4M (\$47.7M or 5.7% unfavorable to budget of \$830.7M).</li> </ul>
<b>Administrative Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$4.6M (\$1.1M or 19.3% favorable to budget of \$5.7M).</li> <li>▶ YTD: \$49.0M (\$1.4M or 2.7% favorable to budget of \$50.4M).</li> </ul>
<b>Tangible Net Equity</b>	<ul style="list-style-type: none"> <li>▶ TNE was \$225.1M (represents approximately two months of total expenses).</li> </ul>
<b>Capital Expenditures</b>	<ul style="list-style-type: none"> <li>▶ YTD Capital Investments of \$3.8M vs. \$6.9M annual budget, primarily Community Resource Center.</li> </ul>



Santa Clara Family  
Health Plan™

Detail Analyses

# Enrollment



- Total enrollment of 276,842 members is 4,683 or 1.7% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 22,967 members or 9.0%.
- Medi-Cal enrollment has been increasing since January 2020, largely COVID enrollment (beginning in March 2020 annual eligibility redeterminations were suspended).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 9.6%, Medi-Cal Dual enrollment has increased 4.1%, and CMC enrollment has grown 9.9% also due largely to the suspension of disenrollments.

	For the Month March 2021				For Nine Months Ending March 31, 2021				Prior Year Actuals	Δ FY21 vs. FY20
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)		
Medi-Cal	266,962	262,795	4,167	1.6%	2,324,392	2,346,661	(22,269)	(0.9%)	2,119,625	9.7%
Cal Medi-Connect	9,880	9,364	516	5.5%	86,372	82,696	3,676	4.4%	74,842	15.4%
<b>Total</b>	<b>276,842</b>	<b>272,159</b>	<b>4,683</b>	<b>1.7%</b>	<b>2,410,764</b>	<b>2,429,357</b>	<b>(18,593)</b>	<b>(0.8%)</b>	<b>2,194,467</b>	<b>9.9%</b>

## Santa Clara Family Health Plan Enrollment By Network March 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	33,351	12%	9,880	100%	43,231	16%
SCVHHS <sup>1</sup> , Safety Net Clinics, FQHC <sup>2</sup> Clinics	133,883	50%	-	0%	133,883	48%
Palo Alto Medical Foundation	7,221	3%	-	0%	7,221	3%
Physicians Medical Group	45,631	17%	-	0%	45,631	16%
Premier Care	15,852	6%	-	0%	15,852	6%
Kaiser	31,024	12%	-	0%	31,024	11%
<b>Total</b>	<b>266,962</b>	<b>100%</b>	<b>9,880</b>	<b>100%</b>	<b>276,842</b>	<b>100%</b>
Enrollment at June 30, 2020	244,888		8,987		253,875	
Net Δ from Beginning of FY21	9.0%		9.9%		9.0%	

<sup>1</sup> SCVHHS = Santa Clara Valley Health & Hospital System

<sup>2</sup> FQHC = Federally Qualified Health Center

# Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD MARCH-2021

		2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	FYTD var	%
NON DUAL	Adult (over 19)	23,873	24,051	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	5,412	20.6%
	Child (under 19)	92,843	93,374	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	3,384	3.5%
	Aged - Medi-Cal Only	10,753	10,801	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	11,459	252	2.2%
	Disabled - Medi-Cal Only	10,882	10,851	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	10,811	-111	(1.0%)
	Adult Expansion	69,272	70,458	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	12,124	16.3%
	BCCTP	11	11	11	11	11	11	11	11	11	11	10	10	11	0	0.0%
	Long Term Care	367	380	398	405	402	406	407	409	389	393	388	380	373	-32	(7.9%)
	<b>Total Non-Duals</b>	<b>208,001</b>	<b>209,926</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>240,599</b>	<b>21,029</b>	<b>9.6%</b>

DUAL	Adult (21 Over)	320	311	320	321	327	320	337	354	353	353	352	355	361	40	12.5%
	SPD (21 Over)	23,541	23,443	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	698	3.0%
	Adult Expansion	136	134	190	241	261	289	358	410	498	537	590	662	742	501	207.9%
	Long Term Care	1,231	1,235	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	-194	(15.5%)
	<b>Total Duals</b>	<b>25,228</b>	<b>25,123</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>26,363</b>	<b>1,045</b>	<b>4.1%</b>

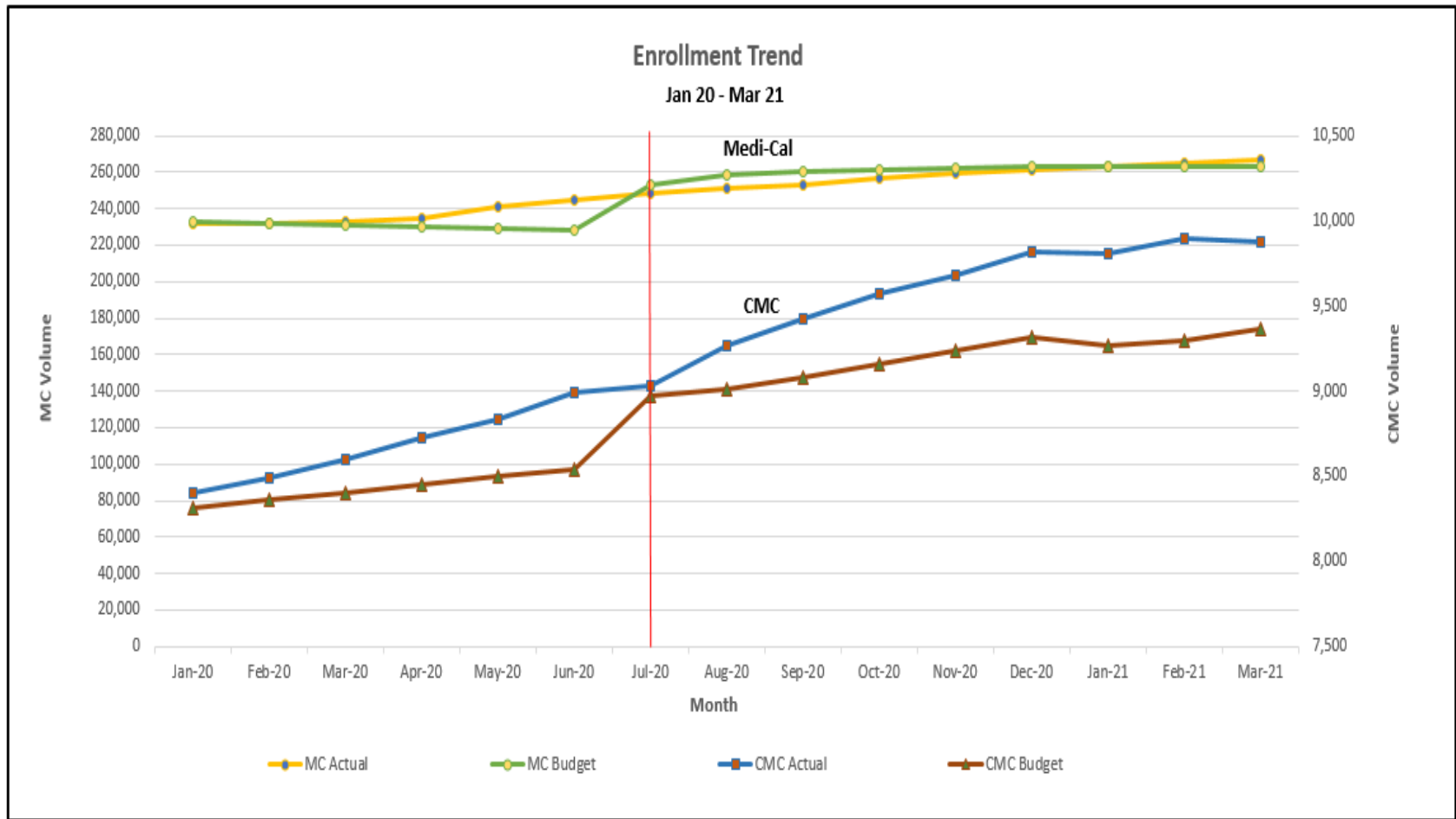
<b>Total Medi-Cal</b>	<b>233,229</b>	<b>235,049</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>	<b>22,074</b>	<b>9.0%</b>
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CMC	CMC Non-Long Term Care	8,388	8,511	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	921	10.5%
	CMC - Long Term Care	213	214	212	212	215	211	216	210	209	207	193	187	184	-28	(13.2%)
	<b>Total CMC</b>	<b>8,601</b>	<b>8,725</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>	<b>893</b>	<b>9.9%</b>

<b>Total Enrollment</b>	<b>241,830</b>	<b>243,774</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>276,842</b>	<b>22,967</b>	<b>9.0%</b>
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# Enrollment Trend

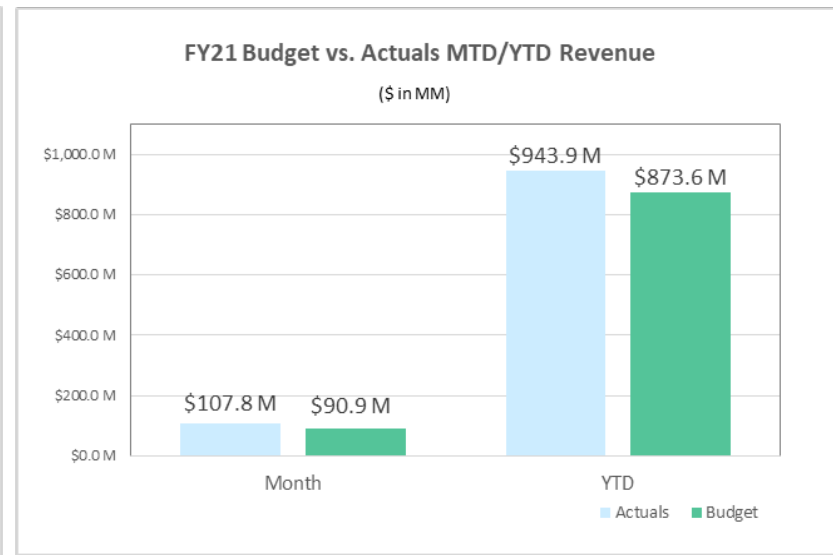
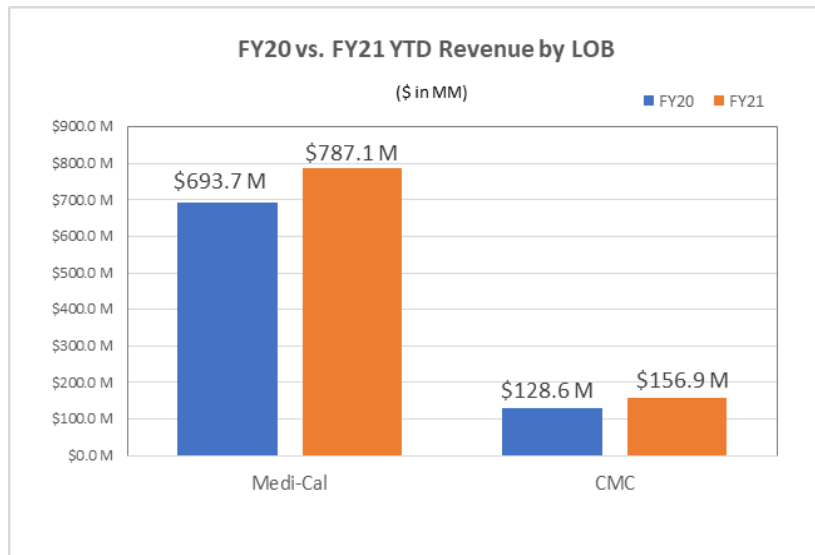


- Budgeted enrollment, represented by the green & red lines, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the gold & blue lines, has grown steadily.

# Revenue

Current month revenue of \$107.8M is \$16.9M or 18.6% favorable to budget of \$90.9M. The current month variance was primarily due to the following:

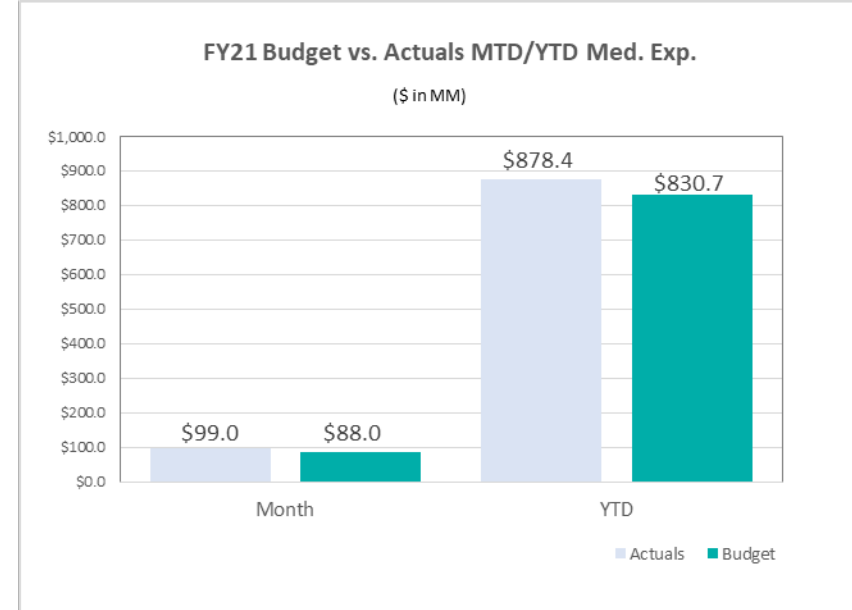
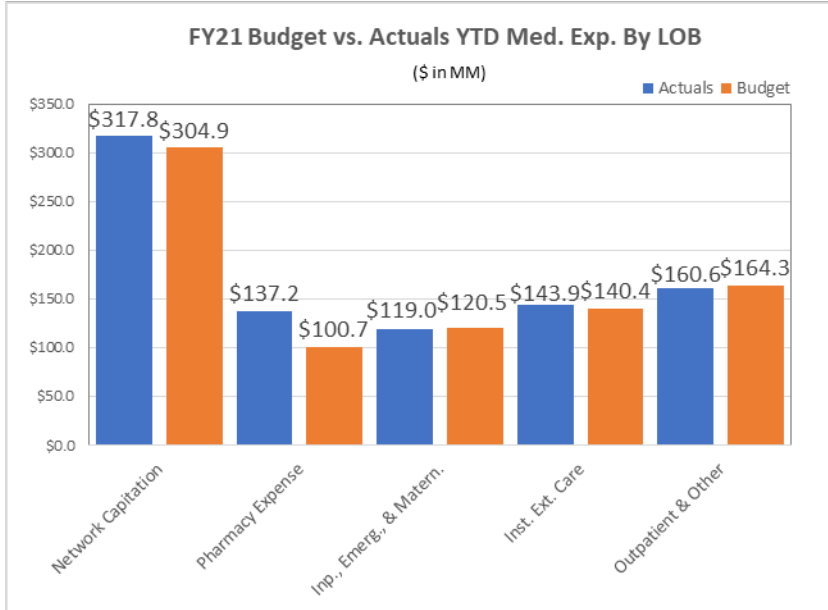
- MCAL Non-Dual revenue is \$14.9M net favorable to budget primarily due to the pharmacy carve-out suspension (with associated medical expense offset) coupled with favorable enrollment & rate variances in certain categories of aid.
- MCAL Dual MLTSS revenue is \$1.1M favorable to budget due to a favorable enrollment to budget and higher CY20 rates.
- CMC revenue is \$913K favorable to budget due to a favorable enrollment to budget and higher CY20 rates.
- MCAL Supplemental Kick revenue is \$38K net favorable to budget due to increase utilization in Health Homes and BHT services, offset with lower maternity utilization.



# Medical Expense

Current month medical expense of \$99.0M is \$11.0M or 12.5% unfavorable to budget of \$88.0M. The current month variance was due largely to:

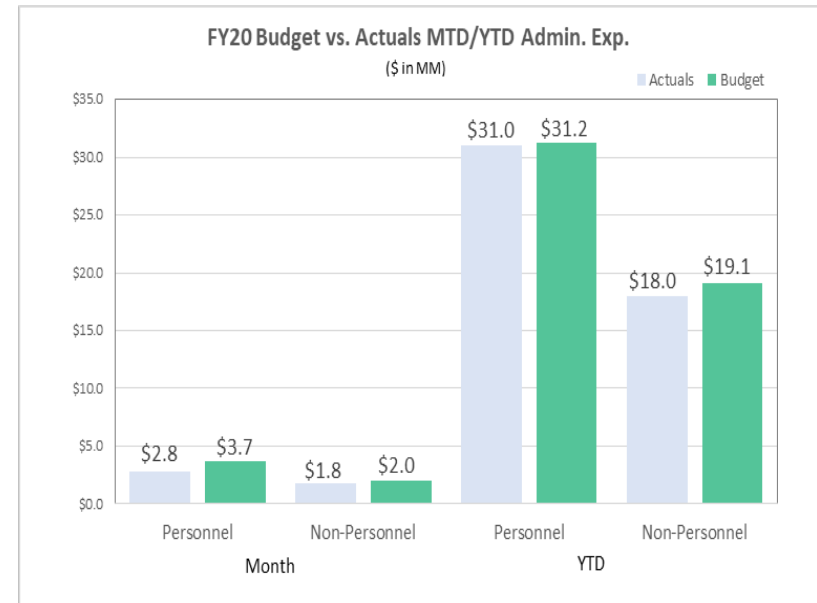
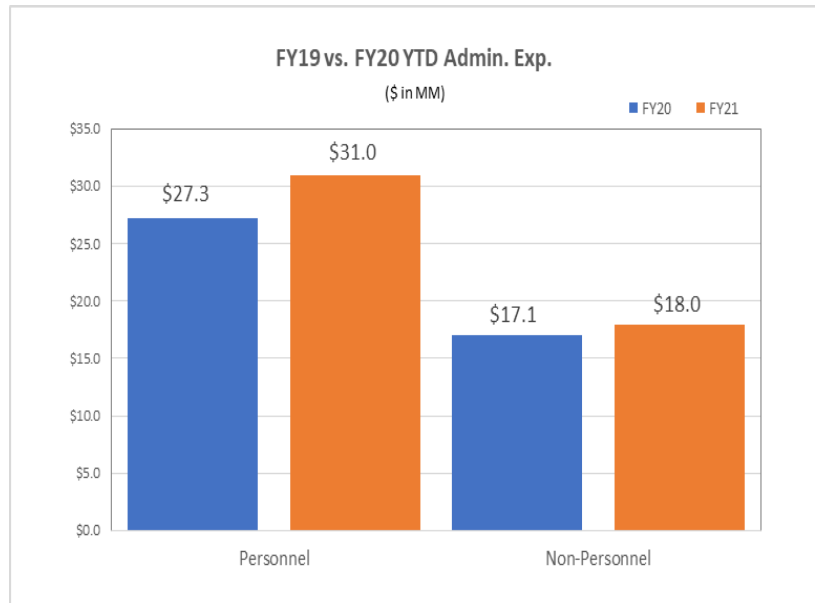
- Pharmacy expenses were \$12.6M or 345% unfavorable to budget due to postponement of the pharmacy carve-out from managed care (offset with favorable revenue variance).
- Fee-For-Service expenses reflects a \$3.6M or 7.8% favorable variance due to a general downward trend of utilization and lower LTC enrollment and resulting utilization.
- Capitation expense is \$2.1M or 6.0% unfavorable to budget due to retroactive capitation rate expense true-up and additional accruals.



# Administrative Expense

Current month expense of \$4.6M is \$1.1M or 19.3% favorable to budget of \$5.7M. The current month variances were primarily due to the following:

- Personnel expenses were \$899K or 24.1% favorable to budget due to lower headcount than budget, partly offset by increased retirement expense accruals vs. budget.
- Non-Personnel expenses were \$210K or 10.4% favorable to budget due to timing of budget spending in certain large categories of outside services expenses.



# Balance Sheet

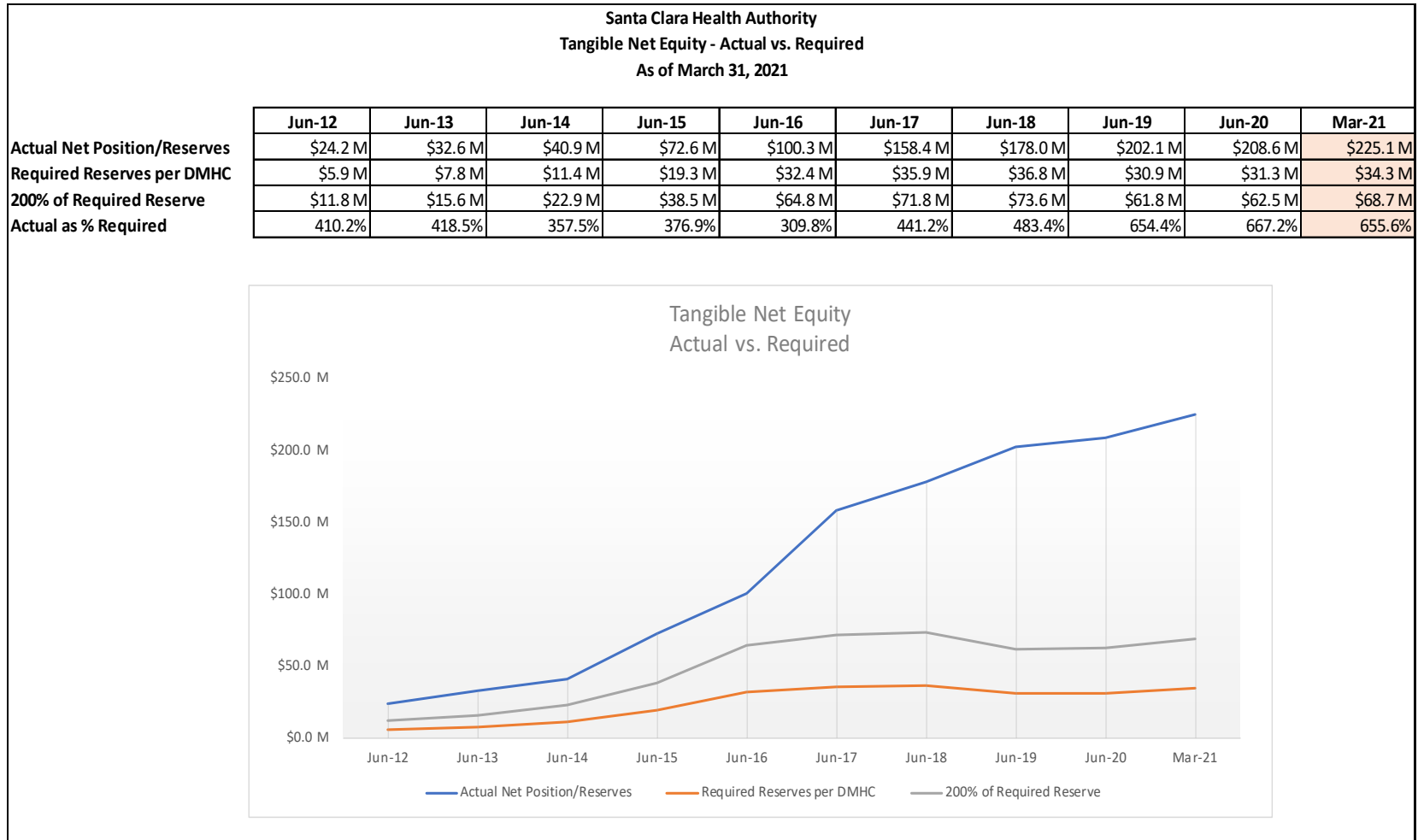
- Current assets totaled \$1.04B compared to current liabilities of \$844.6M, yielding a current ratio (Current Assets/Current Liabilities) of 1.23:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by \$186.1M compared to the cash balance as of year-end June 30, 2020 due to the timing of inflows and outflows. \$129M was disbursed from Wells Fargo account in mid April to Hospitals for Directed Payments.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
<b>Short-Term Investments</b>				
County of Santa Clara Comingled Pool	\$157,013,467	0.92%	\$100,000	\$1,121,175
Wells Fargo Investments	<u>\$331,005,299</u>	0.08%	<u>\$10,891</u>	<u>\$228,467</u>
	\$488,018,766		\$110,891	\$1,349,642
<b>Cash &amp; Equivalents</b>				
Bank of the West Money Market	\$94,384	0.10%	\$697	\$13,123
Wells Fargo Bank Accounts	<u>\$31,486,127</u>	0.01%	<u>\$360</u>	<u>\$4,935</u>
	\$31,580,511		\$1,058	\$18,058
<b>Assets Pledged to DMHC</b>				
Restricted Cash	\$425,000	0.42%	\$0	\$1,105
<b>Petty Cash</b>				
	\$500	0.00%	\$0	\$0
<b>Month-End Balance</b>	<u><b>\$520,024,777</b></u>		<u><b>\$111,948</b></u>	<u><b>\$1,368,805</b></u>

- County of Santa Clara Comingled Pool funds have longer-term investments currently with a higher yield than WFB investments.
- Overall cash and investment yield is lower than budget (0.33% actual vs. 1.4% budgeted).

# Tangible Net Equity

- TNE was \$225.1M - representing approximately two months of the Plan's total expenses.



# Reserves Analysis

SCFHP RESERVES ANALYSIS MARCH 2021			
Financial Reserve Target #1: Tangible Net Equity			
	Approved	Expended	Balance
<b>Unrestricted Net Assets</b>			<b>\$179,789,178 *</b>
Board Designated Funds (Note 1):			
Special Project Funding for CBOs	\$4,000,000	\$662,727	\$3,337,274
Innovation & COVID-19 Fund	\$16,000,000	\$2,169,999	\$13,830,001
Subtotal	\$20,000,000	\$2,832,726	\$17,167,275
Net Book Value of Fixed Assets			\$27,678,940
Restricted Under Knox-Keene Agreement			\$425,000
Total Tangible Net Equity (TNE)			\$225,060,393
Current Required TNE			\$34,328,616
TNE %			655.6%
<b>SCFHP Target TNE Range:</b>			
350% of Required TNE (Low)			\$120,150,158
500% of Required TNE (High)			\$171,643,082
<b>Total TNE Above/(Below) SCFHP Low Target</b>			<b>\$104,910,235</b>
<b>Total TNE Above/(Below) High Target</b>			<b>\$53,417,310</b>
Financial Reserve Target #2: Liquidity			
Cash & Investments			\$520,024,777
Less Pass-Through Liabilities:			
Hospital Directed Payments			(125,040,228)
MCO Tax Payable to State of CA			(27,447,737)
Whole Person Care / Prop 56			(49,776,444)
Other Pass-Through Liabilities (Note 2)			(53,961,133)
<b>Total Pass-Through Liabilities</b>			<b>(256,225,543)</b>
Net Cash Available to SCFHP			263,799,234
SCFHP Target Liquidity (Note 3)			
45 Days of Total Operating Expense			(140,546,992)
60 Days of Total Operating Expense			(187,395,990)
Liquidity Above/(Below) SCFHP Low Target			<b>123,252,241</b>
Liquidity Above/(Below) High Target			<b>\$76,403,244</b>

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

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

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

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

# Capital Expenditures

- Majority of the capital variances are Community Resource Center, hardware, software, and building improvements due to timing of certain projects.

<b>Expenditure</b>	<b>YTD Actual</b>	<b>Annual Budget</b>
Community Resource Center	\$2,841,628	\$3,507,100
Hardware	\$263,035	\$1,282,500
Software	\$181,703	\$1,194,374
Building Improvements	\$470,620	\$866,500
Furniture & Equipment	\$0	\$28,000
<b>TOTAL</b>	<b>\$3,756,986</b>	<b>\$6,878,474</b>





**Santa Clara Family  
Health Plan™**

Financial Statements

# Income Statement



## Santa Clara County Health Authority INCOME STATEMENT For Nine Months Ending March 31, 2021

	Mar-2021	% of	Mar-2021	% of	Current Month Variance		YTD Mar-2021	% of	YTD Mar-2021	% of	YTD Variance	
	Actuals	Rev	Budget	Rev	\$	%	Actuals	Rev	Budget	Rev	\$	%
<b>REVENUES</b>												
MEDI-CAL	\$ 90,352,176	83.8%	\$ 74,365,495	81.8%	\$ 15,986,681	21.5%	\$ 787,055,364	83.4%	\$ 728,002,086	83.3%	\$ 59,053,278	8.1%
CMC MEDI-CAL	3,963,664	3.7%	2,908,171	3.2%	1,055,493	36.3%	34,495,345	3.7%	26,353,014	3.0%	8,142,330	30.9%
CMC MEDICARE	13,533,327	12.5%	13,675,935	15.0%	(142,608)	-1.0%	122,394,392	13.0%	119,290,931	13.7%	3,103,461	2.6%
TOTAL CMC	17,496,991	16.2%	16,584,106	18.2%	912,885	5.5%	156,889,737	16.6%	145,643,945	16.7%	11,245,791	7.7%
<b>TOTAL REVENUE</b>	<b>\$ 107,849,167</b>	<b>100.0%</b>	<b>\$ 90,949,601</b>	<b>100.0%</b>	<b>\$ 16,899,566</b>	<b>18.6%</b>	<b>\$ 943,945,101</b>	<b>100.0%</b>	<b>\$ 873,646,031</b>	<b>100.0%</b>	<b>\$ 70,299,070</b>	<b>8.0%</b>
<b>MEDICAL EXPENSES</b>												
MEDI-CAL	\$ 83,449,081	77.4%	\$ 72,411,580	79.6%	\$ (11,037,500)	-15.2%	\$ 737,778,350	78.2%	\$ 693,147,409	79.3%	\$ (44,630,941)	-6.4%
CMC MEDI-CAL	2,295,807	2.1%	3,027,527	3.3%	731,720	24.2%	26,571,409	2.8%	27,140,377	3.1%	568,968	2.1%
CMC MEDICARE	13,233,192	12.3%	12,511,319	13.8%	(721,874)	-5.8%	114,033,734	12.1%	110,443,522	12.6%	(3,590,212)	-3.3%
TOTAL CMC	15,528,999	14.4%	15,538,845	17.1%	9,847	0.1%	140,605,143	14.9%	137,583,899	15.7%	(3,021,244)	-2.2%
HEALTHY KIDS	0	0.0%	0	0.0%	0	0.0%	7,303	0.0%	0	0.0%	(7,303)	0.0%
<b>TOTAL MEDICAL EXPENSES</b>	<b>\$ 98,978,079</b>	<b>91.8%</b>	<b>\$ 87,950,426</b>	<b>96.7%</b>	<b>\$ (11,027,654)</b>	<b>-12.5%</b>	<b>\$ 878,390,796</b>	<b>93.1%</b>	<b>\$ 830,731,308</b>	<b>95.1%</b>	<b>\$ (47,659,489)</b>	<b>-5.7%</b>
<b>MEDICAL OPERATING MARGIN</b>	<b>\$ 8,871,087</b>	<b>8.2%</b>	<b>\$ 2,999,175</b>	<b>3.3%</b>	<b>\$ 5,871,912</b>	<b>195.8%</b>	<b>\$ 65,554,305</b>	<b>6.9%</b>	<b>\$ 42,914,723</b>	<b>4.9%</b>	<b>\$ 22,639,581</b>	<b>52.8%</b>
<b>ADMINISTRATIVE EXPENSE</b>												
SALARIES AND BENEFITS	\$ 2,827,713	2.6%	\$ 3,726,488	4.1%	\$ 898,776	24.1%	\$ 31,007,996	3.3%	\$ 31,239,484	3.6%	\$ 231,488	0.7%
RENTS AND UTILITIES	36,262	0.0%	43,275	0.0%	7,013	16.2%	358,376	0.0%	336,560	0.0%	(21,816)	-6.5%
PRINTING AND ADVERTISING	12,798	0.0%	77,429	0.1%	64,632	83.5%	178,319	0.0%	668,088	0.1%	489,769	73.3%
INFORMATION SYSTEMS	359,761	0.3%	351,656	0.4%	(8,105)	-2.3%	2,486,425	0.3%	3,068,900	0.4%	582,475	19.0%
PROF FEES/CONSULTING/TEMP STAFFING	754,381	0.7%	918,417	1.0%	164,036	17.9%	8,541,139	0.9%	8,610,724	1.0%	69,585	0.8%
DEPRECIATION/INSURANCE/EQUIPMENT	380,384	0.4%	376,741	0.4%	(3,643)	-1.0%	3,214,916	0.3%	3,246,804	0.4%	31,888	1.0%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	47,699	0.0%	66,006	0.1%	18,307	27.7%	621,278	0.1%	585,692	0.1%	(35,586)	-6.1%
MEETINGS/TRAVEL/DUES	108,248	0.1%	106,514	0.1%	(1,734)	-1.6%	738,790	0.1%	988,742	0.1%	249,952	25.3%
OTHER	111,692	0.1%	81,042	0.1%	(30,650)	-37.8%	1,838,494	0.2%	1,622,228	0.2%	(216,266)	-13.3%
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<b>\$ 4,638,938</b>	<b>4.3%</b>	<b>\$ 5,747,569</b>	<b>6.3%</b>	<b>\$ 1,108,631</b>	<b>19.3%</b>	<b>\$ 48,985,731</b>	<b>5.2%</b>	<b>\$ 50,367,221</b>	<b>5.8%</b>	<b>\$ 1,381,489</b>	<b>2.7%</b>
<b>OPERATING SURPLUS (LOSS)</b>	<b>\$ 4,232,149</b>	<b>3.9%</b>	<b>\$ (2,748,394)</b>	<b>-3.0%</b>	<b>\$ 6,980,543</b>	<b>254.0%</b>	<b>\$ 16,568,573</b>	<b>1.8%</b>	<b>\$ (7,452,498)</b>	<b>-0.9%</b>	<b>\$ 24,021,071</b>	<b>322.3%</b>
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	\$ 65,750	0.1%	\$ 60,000	0.1%	\$ (5,750)	-9.6%	\$ 719,971	0.1%	\$ 540,000	0.1%	\$ (179,971)	-33.3%
GASB 68 - UNFUNDED PENSION LIABILITY	(156,500)	-0.1%	75,000	0.1%	231,500	308.7%	1,758,958	0.2%	675,000	0.1%	(1,083,958)	-160.6%
<b>NON-OPERATING EXPENSES</b>	<b>\$ (90,750)</b>	<b>-0.1%</b>	<b>\$ 135,000</b>	<b>0.1%</b>	<b>\$ 225,750</b>	<b>167.2%</b>	<b>\$ 2,478,929</b>	<b>0.3%</b>	<b>\$ 1,215,000</b>	<b>0.1%</b>	<b>\$ (1,263,929)</b>	<b>-104.0%</b>
INTEREST & INVESTMENT INCOME	\$ 111,948	0.1%	\$ 350,000	0.4%	\$ (238,052)	-68.0%	\$ 1,368,805	0.1%	\$ 3,150,000	0.4%	\$ (1,781,195)	-56.5%
OTHER INCOME	35,248	0.0%	33,668	0.0%	1,580	4.7%	961,157	0.1%	299,923	0.0%	661,233	220.5%
<b>NON-OPERATING INCOME</b>	<b>\$ 147,197</b>	<b>0.1%</b>	<b>\$ 383,668</b>	<b>0.4%</b>	<b>\$ (236,472)</b>	<b>-61.6%</b>	<b>\$ 2,329,962</b>	<b>0.2%</b>	<b>\$ 3,449,923</b>	<b>0.4%</b>	<b>\$ (1,119,962)</b>	<b>-32.5%</b>
<b>NET NON-OPERATING ACTIVITIES</b>	<b>\$ 237,947</b>	<b>0.2%</b>	<b>\$ 248,668</b>	<b>0.3%</b>	<b>\$ (10,722)</b>	<b>-4.3%</b>	<b>\$ (148,968)</b>	<b>0.0%</b>	<b>\$ 2,234,923</b>	<b>0.3%</b>	<b>\$ (2,383,891)</b>	<b>-106.7%</b>
<b>NET SURPLUS (LOSS)</b>	<b>\$ 4,470,096</b>	<b>4.1%</b>	<b>\$ (2,499,725)</b>	<b>-2.7%</b>	<b>\$ 6,969,822</b>	<b>278.8%</b>	<b>\$ 16,419,606</b>	<b>1.7%</b>	<b>\$ (5,217,574)</b>	<b>-0.6%</b>	<b>\$ 21,637,180</b>	<b>414.7%</b>

# Balance Sheet



**SANTA CLARA COUNTY HEALTH AUTHORITY**  
As of March 31, 2021

	Mar-2021	Feb-2021	Jan-2021	Mar-2020
<b>Assets</b>				
Current Assets				
Cash and Investments	520,024,777	362,000,143	384,167,611	300,653,651
Receivables	507,477,386	650,794,128	502,763,948	583,619,915
Prepaid Expenses and Other Current Assets	9,506,927	8,901,299	10,789,770	11,735,059
<b>Total Current Assets</b>	<b>1,037,009,089</b>	<b>1,021,695,570</b>	<b>897,721,329</b>	<b>896,008,625</b>
Long Term Assets				
Property and Equipment	51,142,872	51,070,144	50,645,446	46,531,020
Accumulated Depreciation	(23,463,932)	(23,133,032)	(22,794,622)	(19,978,087)
Total Long Term Assets	27,678,940	27,937,112	27,850,825	26,552,933
<b>Total Assets</b>	<b>1,064,688,028</b>	<b>1,049,632,682</b>	<b>925,572,153</b>	<b>922,561,558</b>
<b>Deferred Outflow of Resources</b>	<b>8,402,260</b>	<b>8,402,260</b>	<b>8,402,260</b>	<b>9,237,609</b>
<b>Total Assets &amp; Deferred Outflows</b>	<b>1,073,090,288</b>	<b>1,058,034,942</b>	<b>933,974,413</b>	<b>931,799,167</b>
<b>Liabilities and Net Assets:</b>				
Current Liabilities				
Trade Payables	6,086,219	8,087,827	6,472,762	10,498,821
Deferred Rent	48,757	48,585	48,414	0
Employee Benefits	3,097,436	3,002,306	2,948,693	1,952,566
Retirement Obligation per GASB 75	2,833,868	2,768,118	2,702,368	3,228,453
Deferred Revenue - Medicare	0	0	0	500,000
Whole Person Care / Prop 56	49,776,444	49,144,350	47,108,193	32,701,914
Payable to Hospitals (SB90)	104,014	20,688	37,715,808	0
Payable to Hospitals (SB208)	124,936,215	124,936,215	203,428	0
Pass-Throughs Payable	330,470	330,470	26,787	54,383,626
Due to Santa Clara County Valley Health Plan and Kaiser	29,732,966	29,466,215	22,286,701	29,553,631
MCO Tax Payable - State Board of Equalization	27,447,737	18,230,783	9,115,391	24,307,710
Due to DHCS	53,630,663	52,760,437	45,976,921	37,964,537
Liability for In Home Support Services (IHSS)	419,268,582	419,268,582	419,268,582	416,092,527
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	119,021,715	117,508,759	112,316,256	101,899,745
<b>Total Current Liabilities</b>	<b>844,609,111</b>	<b>833,867,361</b>	<b>714,484,332</b>	<b>721,377,554</b>
Non-Current Liabilities				
Net Pension Liability GASB 68	1,758,958	1,915,457.68	2,071,958	638,923
<b>Total Non-Current Liabilities</b>	<b>1,758,958</b>	<b>1,915,457.68</b>	<b>2,071,958</b>	<b>638,923</b>
<b>Total Liabilities</b>	<b>846,368,069</b>	<b>835,782,819</b>	<b>716,556,289</b>	<b>722,016,477</b>
<b>Deferred Inflow of Resources</b>	<b>1,661,827</b>	<b>1,661,827</b>	<b>1,661,827</b>	<b>2,994,548</b>
<b>Net Assets</b>				
Board Designated Fund: Special Project Funding for CBOs	3,337,274	3,337,274	3,377,274	3,820,000
Board Designated Fund: Innovation & COVID-19 Fund	13,830,001	13,830,001	13,830,001	16,000,000
Invested in Capital Assets (NBV)	27,678,940	27,937,112	27,850,825	26,552,933
Restricted under Knox-Keene agreement	425,000	425,000	530,350	305,350
Unrestricted Net Equity	163,369,573	163,111,401	163,052,338	155,447,470
Current YTD Income (Loss)	16,419,606	11,949,509	7,115,510	4,662,389
<b>Total Net Assets / Reserves</b>	<b>225,060,393</b>	<b>220,590,296</b>	<b>215,756,297</b>	<b>206,788,142</b>
<b>Total Liabilities, Deferred Inflows and Net Assets</b>	<b>1,073,090,288</b>	<b>1,058,034,942</b>	<b>933,974,413</b>	<b>931,799,167</b>

# Cash Flow Statement

	<u>Mar-2021</u>	<u>Year-to-date</u>
Cash Flows from Operating Activities		
Premiums Received	261,253,090	1,223,492,896
Medical Expenses Paid	(97,198,373)	(851,686,341)
Administrative Expenses Paid	(6,104,552)	(184,314,224)
<b>Net Cash from Operating Activities</b>	<b>157,950,165</b>	<b>187,492,332</b>
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(72,728)	(3,756,986)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	147,197	2,329,962
<b>Net Increase/(Decrease) in Cash &amp; Cash Equivalents</b>	<b>158,024,633</b>	<b>186,065,307</b>
Cash & Investments (Beginning)	362,000,143	333,959,470
Cash & Investments (Ending)	<b>520,024,777</b>	<b>520,024,777</b>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	4,322,899	14,089,644
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	330,900	2,727,134
Changes in Operating Assets/Liabilities		
Premiums Receivable	143,316,742	303,529,330
Prepays & Other Assets	(605,627)	356,772
Accounts Payable & Accrued Liabilities	(1,125,137)	(137,692,427)
State Payable	10,087,181	(23,981,535)
IGT, HQAF & Other Provider Payables	266,751	(5,212,109)
Net Pension Liability	(156,500)	1,758,958
Medical Cost Reserves & PDR	1,512,956	31,916,564
<b>Total Adjustments</b>	<b>153,627,266</b>	<b>173,402,688</b>
<b>Net Cash from Operating Activities</b>	<b>157,950,165</b>	<b>187,492,332</b>

# Statement of Operations by Line of Business - YTD



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

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
<b>P&amp;L (ALLOCATED BASIS)</b>					
REVENUE	\$787,055,364	\$34,495,345	\$122,394,392	\$156,889,737	\$943,945,101
<b>MEDICAL EXPENSE</b>	\$737,778,350	\$26,571,409	\$114,033,734	\$140,605,143	\$878,390,796
(MLR)	93.7%	77.0%	93.2%	89.6%	93.1%
<b>GROSS MARGIN</b>	\$49,277,014	\$7,923,936	\$8,360,658	\$16,284,594	\$65,554,305
<b>ADMINISTRATIVE EXPENSE</b>	\$40,843,988	\$1,790,125	\$6,351,618	\$8,141,743	\$48,985,731
(% of Revenue Allocation)					
<b>OPERATING INCOME/(LOSS)</b>	\$8,433,025	\$6,133,811	\$2,009,040	\$8,142,851	\$16,568,573
(% of Revenue Allocation)					
<b>OTHER INCOME/(EXPENSE)</b>	(\$124,208)	(\$5,444)	(\$19,316)	(\$24,759)	(\$148,968)
(% of Revenue Allocation)					
<b>NET INCOME/(LOSS)</b>	\$8,308,817	\$6,128,367	\$1,989,725	\$8,118,092	\$16,419,606
<b>PMPM (ALLOCATED BASIS)</b>					
REVENUE	\$338.61	\$399.38	\$1,417.06	\$1,816.44	\$391.55
MEDICAL EXPENSES	\$317.41	\$307.64	\$1,320.26	\$1,627.90	\$364.36
GROSS MARGIN	\$21.20	\$91.74	\$96.80	\$188.54	\$27.19
ADMINISTRATIVE EXPENSES	\$17.57	\$20.73	\$73.54	\$94.26	\$20.32
OPERATING INCOME/(LOSS)	\$3.63	\$71.02	\$23.26	\$94.28	\$6.87
OTHER INCOME/(EXPENSE)	(\$0.05)	(\$0.06)	(\$0.22)	(\$0.29)	(\$0.06)
NET INCOME/(LOSS)	\$3.57	\$70.95	\$23.04	\$93.99	\$6.81
<b>ALLOCATION BASIS:</b>					
MEMBER MONTHS - YTD	2,324,392	86,372	86,372	86,372	2,410,764
REVENUE BY LOB	83.4%	3.7%	13.0%	16.6%	100.0%



Santa Clara Family  
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Appendix

# Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD APRIL-2021

		2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	FYTD var	%
<b>NON DUAL</b>	Adult (over 19)	24,051	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	5,807	22.1%
	Child (under 19)	93,374	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	3,699	3.8%
	Aged - Medi-Cal Only	10,801	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	11,459	11,509	302	2.7%
	Disabled - Medi-Cal Only	10,851	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	10,811	10,772	-150	(1.4%)
	Adult Expansion	70,458	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	13,482	18.1%
	BCCTP	11	11	11	11	11	11	11	11	11	10	10	11	9	-2	(18.2%)
	Long Term Care	380	398	405	402	406	407	409	389	393	388	380	373	375	-30	(7.4%)
	<b>Total Non-Duals</b>	<b>209,926</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>240,599</b>	<b>242,678</b>	<b>23,108</b>	<b>10.5%</b>

0

<b>DUAL</b>	Adult (21 Over)	311	320	321	327	320	337	354	353	353	352	355	361	357	36	11.2%
	SPD (21 Over)	23,443	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,167	659	2.8%
	Adult Expansion	134	190	241	261	289	358	410	498	537	590	662	742	802	561	232.8%
	Long Term Care	1,235	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	-210	(16.8%)
	<b>Total Duals</b>	<b>25,123</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>26,363</b>	<b>26,365</b>	<b>1,047</b>	<b>4.1%</b>

<b>Total Medi-Cal</b>	<b>235,049</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>	<b>269,043</b>	<b>24,155</b>	<b>9.9%</b>
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<b>CMC</b>	CMC Non-Long Term Care	8,511	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	970	11.1%
	CMC - Long Term Care	214	212	212	215	211	216	210	209	207	193	187	184	179	-33	(15.6%)
	<b>Total CMC</b>	<b>8,725</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>	<b>9,924</b>	<b>937</b>	<b>10.4%</b>

<b>Total Enrollment</b>	<b>243,774</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>276,842</b>	<b>278,967</b>	<b>25,092</b>	<b>9.9%</b>
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## Santa Clara County Health Authority COVID-19 Funding Request Summary

<b>Organization Name:</b>	YMCA of Silicon Valley (YMCA)
<b>Project Name:</b>	Expanded Summer Nutrition Program for Children and Families
<b>Date Submitted to SCFHP:</b>	May 21, 2021
<b>Contact Name and Title:</b>	Sandy Berlin Walker, President and CEO
<b>Requested Amount:</b>	\$100,000
<b>Time Period for Project Expenditures:</b>	June – August 2021
<b>Proposal Submitted to:</b>	Executive/Finance Committee
<b>Date Submitted for Review:</b>	May 27, 2021

### Summary of Proposal:

- Funding for YMCA Expanded Summer Food Service Program (SFSP) Nutrition Manager to manage all ordering, compliance, training for staff and volunteers and direct administration of the YMCA Summer Feeding Program at 26 SFSP open meal sites to serve the increased number of children and families in need throughout Silicon Valley this summer.
- Funding for SFSP Nutrition Administrative Assistant, responsible for all administrative paperwork, including meal tracking and billing.
- Funding for part-time YMCA Food Distribution Site Directors for six YMCA sites to oversee compliance with regulations, along with accepting daily food deliveries, and recruiting and leading volunteers and staff during daily food distribution.

### Summary of Projected Outcome/Impact:

Over the course of the summer, the YMCA will coordinate the distribution of an estimated total of 155,880 meals and snacks to children in the lowest-income neighborhoods.



## Evaluation Relative to SCFHP COVID-19 Funding Criteria

Criteria	Met/Not Met
1. Demonstrate the need is directly related to the COVID-19 pandemic.	Met
2. Demonstrate the project targets those in the most acute need.	Met
3. Indicate if a one-time need; if longer-term program, how will the need be sustained with resources other than SCFHP.	Not met (funding was also provided for Summer 2020), but expect need to lessen as hiring and return to work increases.
4. Demonstrate the applicant is making maximum use of own resources, including reserves and emergency funds.	Met
5. Indicate if funding is being sought from other potential sources.	Met
6. Indicate if a loan/advance could meet the need.	No information provided
7. Indicate if the request is health care-related (e.g., provider network stabilization).	Indirectly related (food)
8. Funds are not to be used for other expenses and may not supplant normal recurring funding.	Met
9. Funds are to be used exclusively for direct service provision and not for indirect overhead.	Met; staff positions to be funded with this grant are required of USDA SFSP sponsor and meal service providers, but are not fully funded by the federal funding



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**YMCA of Silicon Valley COVID-19  
Expanded Summer Nutrition Program for Children and Families  
Proposal for Santa Clara Family Health Plan**

This proposal is submitted to ask for the Santa Clara Family Health Plan Board's financial support for the Y's **Expanded Summer Nutrition Program** for the summer 2021. We deeply appreciated your support for our **Emergency Hunger Relief** efforts in 2020. The funding you provided in 2020 enabled the YMCA to expand the network of feeding sites and partnerships significantly reaching more children and families who are food insecure and disproportionality impacted by the pandemic, serving more than 101,000 meals and snacks over the summer.

We ask you to join the YMCA of Silicon Valley again this summer to support that expanded nutrition delivery system and underwrite the leadership required to coordinate volunteers and partners to reach the children and families facing food insecurity along with the challenges of stress and instability created by this pandemic.

The impact of COVID-19 on the YMCA of Silicon Valley's delivery system has been significant. A 75% reduction in revenue from membership and program registrations caused us to reduce our staff head count by 75%. Despite the elongated shut downs and required protocols, our Y has continued to serve our community. We have partnered with healthcare providers, school districts and local government in response to the COVID-19 pandemic. Adjusting to meet urgent needs, the Y transformed several of our Y facilities, along with local elementary school sites, to be Community Response Centers. These Y centers have been providing essential services that are part of the YMCA of Silicon Valley's COVID-19 Response Efforts including:

- **Critical Care Camps for Essential Workers' children** with capacity to care for up to 220 children daily
- **Learning Labs** for 1,500 children whose parents need to work outside their residence while supporting student learning while providing healthy nutrition and activities between virtual lessons
- **Food Distribution** for youth in partnership with school districts, libraries and for older adults at Senior Centers in Gilroy and Morgan Hill
- **Blood Drives** in partnership with American Red Cross
- **Support for teachers and students** working via distance learning
- **Virtual YMCA Diabetes Prevention Programs** among the many health, wellness, educational and family programs offered virtually and free to the community
- **Early Learning Readiness** for preschool children and their caregivers to keep children learning and building their literacy readiness
- **Youth and Government** engaged middle and high school youth in a civic education program to learn the political process and the important of their participation

We are pleased to share that, with the vaccine adoption increasing, our communities are starting to open and people are feeling safer to engage and participate in person. We also know that the challenges of food insecurity are increasing as families are facing new dimensions of health concerns and instability.

Food banks and meal service providers have always been needed to fill the gaps in food assistance created by federal safety net programs that have eligibility limitations. With this dramatic increase in demand, food banks and meal service providers must fill a much larger gap than before the



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pandemic. For example, Second Harvest Food Bank of Silicon Valley has reported that they are now helping an average of 500 households apply for CalFresh (California's version of SNAP or the food stamp program) each month— a 150% increase from the normal monthly average.

YMCA of Silicon Valley is a long-time and well-regarded United States Department of Agriculture (USDA) food program sponsor and meal service provider. While schools have been closed for in-person learning, the Y partnered with schools to offer in-person Learning Labs on campus, providing free meals alongside distance learning support and enrichment. Some schools were also able to provide access to meals for students in need through drive-up and take-away food distribution. A number of these school-based options will end when school is out in early June. Research shows, six out of seven low-income youth who receive free or reduced price school meals during the school year lose access to this resource during a typical summer, and the need will be even greater this summer.

As the school year distribution comes to an end and our community faces a reduced availability of summer programs where food is often served, the Y will be able to provide food distribution at Summer Food Service Program (SFSP) meal sites to meet the high demand for food assistance during summer 2021 in Santa Clara County by coordinating the distribution of approximately 4,516 meals and snacks daily at 38 sites located in low-income neighborhoods, including YMCA facilities, school partner sites and community-based partner locations (libraries, shelters for homeless families with children, churches, and community-based agencies).

The pandemic has exacerbated issues that contribute to both hunger and learning loss for youth. The Y is addressing these challenges by providing hunger relief to families in need in conjunction with educational enrichment for children. Alongside open meal site food distribution at our Y facilities, the Y will offer Summer Enrichment Day Camp at six (6) YMCA locations in Santa Clara County this summer. In these Special Camps, youth will receive a rich mix of academic support, enrichment, art, STEM and physical activity. Free healthy meals will be served in these programs as part of the SFSP, serving up to 366 campers of working families each week for eight weeks this summer. In addition to our day camps at our Y facilities, our Y is partnering with 15 Title I schools to provide free meals alongside learning and enrichment for 1,158 kids participating in the 6-week, in-person YMCA Summer Learning Program, designed to combat learning loss due to pandemic related restrictions on in-person learning and the typical summer slide.

Over the course of the summer, the Y will coordinate the distribution of an estimated total of 155,880 meals and snacks at a total of 38 locations to children in the lowest-income neighborhoods. In addition, we will again partner with Second Harvest Food Bank to provide meals for the adults in the family.

We are diligently following CA Department of Education food distribution guidance, as well as federal, state and county COVID-19 food service safety modification orders critical to reducing the spread of the virus. Meal service for children not enrolled in the Special Camps will continue to be drive-up and take-away. We are in ongoing communication with our partners, staff and volunteers to maintain safe practices to ensure children and families receive nutritious meals during this time of increased need for food assistance.

The Y respectfully requests **\$100,000 from Santa Clara Family Health Plan** to support the delivery of this **Expanded Summer Nutrition Program**. It is essential that we raise the funds needed to subsidize staff who are coordinating the expanded food operations and who will, in turn, deliver these services to those who need it the most.



Specifically, these funds would support a portion of the direct staff costs for:

- **SFSP Nutrition Manager**, who is responsible for ordering, compliance and training of all staff and volunteers and the direct administration of the YMCA Summer Feeding Program at all 26 sites.
- **SFSP Nutrition Administrative Assistant**, who is responsible for all administrative paperwork including meal tracking and billing.
- **Y Food Distribution Program Site Directors** for six Y sites. These Program Site Directors oversee compliance with regulations along with accepting daily food deliveries, and recruiting and leading volunteers and staff during daily food distribution.

Though the responsibilities of these staff positions are required as a USDA SFSP sponsor and meal service provider, federal funding provided to food program sponsors does not provide full support to cover the costs to run these food service programs, only reimbursement for the cost of food and a small allowable percentage for administrative and meal service products. The financial impact of this pandemic continues to effect the Y's financial position and ability to subsidize the meal program.

Your support is critical for the Y to expand this **Summer Nutrition Program**. Ten months into our current FY21 fiscal year, the Y is projecting an annual reduction in revenue of \$52 million and a June 30 year-end operating loss of \$4.2 million which has depleted our \$5.4 million in cash reserves prior to the pandemic. We have well-developed business plans to recover this impact but it will take time and has required the plan to liquidate our association offices to sustain our delivery system. We continue to hold \$10 million in endowment funds and successfully obtained a Payroll Protection Program loan in March 2021. This will provide the cash to support our recovery plans.

We continue to raise money to support critical services and are close to achieving our summer program support fundraising goal of \$2 million. With the Y system's reduction due to the pandemic, we do not have the ability to subsidize the **Expanded Summer Nutrition Program** and also provide the critical financial assistance needed for children to attend summer camp and learning recovery programs.

Together the Y and SCFHP can increase food access and distribution to children and families who need it most. The California Department of Education provides pass through funding from the USDA as reimbursement for the cost of meals and limited non-food costs for the SFSP. Funds from Santa Clara Family Health Plan would supplement, and not supplant, any other funding for the YMCA Summer Feeding Program. A grant from the SCFHP would be a meaningful portion of the \$230,000 we need to raise to administer and coordinate the SFSP. The Y is also raising funds to provide financial assistance for Summer Day Camps across the region for up to 500 children daily throughout the summer ahead.

This pandemic has affected organizations, communities and individuals from all walks of life, locally and across the globe. The YMCA **Expanded Summer Nutrition Program** is a critical component for family stability and can be a stop gap to homelessness. If food is covered, unemployment benefits can go to cover rent or housing. With the Santa Clara Family Health Plan Board's support, the Y can ensure more kids and their families will have access to nutrition this summer.

Sources:

- National Summer Learning Association
- Second Harvest Food Bank
- Food Research and Action Center
- Insight Center for Community Economic Development
- Bureau of Labor and Statistics

Regular Meeting of the

## Santa Clara County Health Authority Compliance Committee

Thursday May 27, 2021, 2:00 PM – 3:00 PM

Santa Clara Family Health Plan, Teleconference

6201 San Ignacio Ave, San Jose, CA 95119

# MINUTES

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### Members Present

Tyler Haskell, Interim Compliance Officer  
Neal Jarecki, Chief Financial Officer  
Sue Murphy, Board Member  
Laurie Nakahira, D.O., Chief Medical Officer  
Christine M. Tomcala, Chief Executive Officer  
Chris Turner, Chief Operating Officer  
Laura Watkins, VP Marketing and Enrollment  
Ngoc Bui-Tong, VP Strategies and Analysis  
Teresa Chapman, VP Human Resources  
Jonathan Tamayo, Chief Information Officer

### Staff Present

Barbara Granieri, Controller  
Daniel Quan, Medicare Manager  
Alejandro Rodriguez, Compliance Analyst  
Alicia Zhao, Audit Program Manager  
Sylvia Luong, Audit Program Manager  
Mai-Phuong Nguyen, Oversight Manager  
Anna Vuong, Compliance Manager  
Alexandra Gutierrez, Compliance Coordinator  
Sonia Lopez, Compliance Coordinator  
Rita Zambrano, Executive Assistant

### 1. Roll Call

Tyler Haskell, Interim Compliance Officer, called the meeting to order at 2:01 pm. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

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

**It was moved, seconded,** and the February 26, 2021 Regular Compliance Committee minutes were **unanimously approved** as amended.

**Motion:** Ms. Murphy

**Second:** Ms. Tomcala

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

### 4. Compliance Staffing Update

Mr. Haskell provided staffing changes within the Compliance Department, welcoming Alexandra Gutierrez as the Compliance Coordinator, Alejandro Rodriguez as the Compliance Analyst, and Alicia Zhao as the Compliance Audit Program Manager.

## 5. Regulatory Audit Report

Mr. Haskell provided an update regarding the Medicare Data Validation (MDV) audit, stating that Advent was engaged to conduct the audit and that we should have the results in the next few weeks. In addition, he provided an update on potential findings from the California Department of Health Care Services (DHCS) audit and stated that the preliminary findings should be available sometime this summer. Mr. Haskell also provided updates on the Department of Managed Health Care (DMHC) audit, a follow-up from the 2019 audit. Mr. Haskell explained that DMHC did not provide feedback and expected the report in June or July.

Mr. Haskell stated that all tasks from the 2020 DHCS corrective action plans had been completed except for a reconfiguration of the PCP assignment process. Ms. Murphy asked for clarification about the finding for the delegation of UM as DHCS and DMHC both had similar findings. Chris Turner, Chief Operations Officer, stated that NCQA standards should be included in the new contract language, offering more clarity and specificity for the delegated activities.

## 6. Oversight Activity Report

- a. Mai-Phuong Nguyen, Oversight Manager, presented the compliance dashboard and corrective action plans issued for missed metrics. Ms. Nguyen also stated that Claims would no longer handle the metric for non-contracted provider disputes. Ms. Nguyen explained that this metric will be handled by G&A moving forward based on new regulations and will appear as N/A on the compliance dashboard.
- b. Daniel Quan, Medicare Manager presented the 3-Year Audit Schedule and reported on audits in the planning, pending, and reporting stage. Mr. Quan also presented preliminary findings for the delegation audit of Premier Care (PCNC) and the internal audits of UM and Quality.

## 7. Fraud, Waste, and Abuse Report

Ms. Nguyen presented the 2021 year-to-date report for Fraud, Waste, & Abuse (FWA), stating sources for suspected FWA cases reported by the internal business units, the compliance hotline, and the compliance email address. In addition, Ms. Nguyen shared that there have been 23 leads with 7 cases opened for preliminary investigation. Ms. Murphy asked if the monitoring of improper opioid prescriptions occurs, and Dr. Nakahira responded that both patients and providers are monitored.

## 8. Compliance Policy

Mr. Haskell presented the updated Policy DE.09: Delegation Revocation.

**It was moved, seconded and the DE.09 Delegation Revocation was unanimously approved.**

**Motion:** Ms. Murphy

**Second:** Ms. Tomcala

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

## 8. Adjournment

The meeting was adjourned at 2:47pm, the next meeting will be on Aug 26, 2021.

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Susan G. Murphy, Secretary

## POLICY

<b>Policy Title:</b>	<b>Delegation Revocation</b>	<b>Policy No.:</b>	DE.09 v3
<b>Replaces Policy Title (if applicable):</b>	Delegation Revocation Process	<b>Replaces Policy No. (if applicable):</b>	DE009, DE209
<b>Issuing Department:</b>	Compliance	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> CMC	

### I. Purpose

The purpose of this policy is to establish the Santa Clara Family Health Plan (SCFHP) requirements for revoking a delegation agreement with a First Tier, Downstream or Related Entity (FDR) or delegated entity for one or more delegated services.

### II. Policy

SCFHP will revoke a delegation agreement with an FDR or delegated entity for one or more areas of service, when the FDR/delegated entity has consistently shown an unwillingness or inability to correct non-compliance. The contract and/or delegation agreement shall define the progressive disciplinary actions and interventions that would take place prior to revocation of the agreement. The contract/ delegation agreement shall also define any circumstance that might occur which may lead to immediate revocation, such as loss of necessary accreditation or certification status or exclusion from participation in state or federal government funded programs.

### III. Responsibilities

The Compliance Department is responsible for carrying out the terms of this policy.

A. The Compliance Department is responsible for:

1. Recommending and initiating the revocation delegation process and all subsequent correspondence related to this action.
2. Seek approval, inform, and/or provide update on revocation of delegation to the Oversight Workgroup and Compliance Committee.

B. Contracting Department is responsible for any contractual changes between SCFHP and the FDR/delegated entity.

C. The Quality Department is responsible for reporting revocation of delegation to the Quality Improvement Committee, if applicable



**POLICY**

**IV. References**

DHCS: SCFHP Contract with DHCS Exhibit A, Attachment 4  
 CMS: Three-Way contract between SCFHP, DHCS, CMS  
 NCQA: NCQA Health Plan Standards, 2020

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
Daniel Quan Manager, Medicare Compliance		Tyler Haskell Interim Compliance Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Delegation Oversight Committee	4/28/2016	n/a
v2	Revised			



## POLICY

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<b>Replaces Policy Title (if applicable):</b>	Delegation Revocation Process	<b>Replaces Policy No. (if applicable):</b>	DE009, DE209
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### III. Responsibilities

The Compliance Department is responsible for carrying out the terms of this policy.

A. The Compliance Department is responsible for:

1. Recommending and initiating the revocation delegation process and all subsequent correspondence related to this action.
2. Seek approval, inform, and/or provide update on Reporting Oversight Workgroup and Compliance Committee.

B. Contracting Department is responsible for any contractual changes between SCFHP and the FDR/delegated entity.

C. The Quality Department is responsible for reporting revocation of delegation to the Quality Improvement Committee, if applicable

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 CMS: Three-Way contract between SCFHP, DHCS, CMS  
 NCQA: NCQA Health Plan Standards, 20~~2017~~

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
<a href="#">Leanne Kelly</a> <a href="#">Compliance Audit Program</a> Manager		Tyler Haskell Interim Compliance Officer		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Delegation Oversight Committee	4/28/2016	n/a
v2	Revised			

Regular Meeting of the  
**Santa Clara County Health Authority**  
**Quality Improvement Committee**

Wednesday, April 14, 2021, 6:00 PM – 8:00 PM  
Santa Clara Family Health Plan, Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes - Approved

### Members Present

Ali Alkoraishi, MD  
Nayyara Dawood, MD  
Jennifer Foreman, ND  
Jimmy Lin, MD  
Christine Tomcala, Chief  
Executive Officer

### Specialty

Adult & Child Psychiatry  
Pediatrics  
Pediatrics  
Internist

### Staff Present

Chris Turner, Chief Operating Officer  
Laura Watkins, Vice President , Marketing and  
Enrollment  
Johanna Liu, PharmD, Director, Quality &  
Process Improvement  
Angela Chen, Interim Director, Case  
Management  
Lucile Baxter, Manager, Quality & Health  
Education  
Mai Phuong Nguyen, Manager, Oversight  
Victor Hernandez, Program Manager,  
Grievance and Appeals  
Theresa Zhang, Manager, Communications  
Byron Lu, Process Improvement Program  
Manager, Quality Improvement.  
Nancy Aguirre, Administrative Assistant  
Sandra Walle, Coordinator, Quality  
Improvement

### Members Absent

Jeffery Arnold, MD  
Laurie Nakahira, D.O.,  
Chief Medical Officer  
Ria Paul, MD, Chair

Geriatric Medicine  
  
Emergency Medicine

### 1. Roll Call

Johanna Liu, PharmD, Director, Quality and Process Improvement, acting Chair, called the meeting to order at 6:05 pm. Roll call was taken.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

Minutes of the February 9, 2021 Quality Improvement Committee (QIC) meeting were reviewed when a quorum was established.

**It was moved, seconded and the minutes of the February 9, 2021 QIC meeting were unanimously approved.**

**Motion:** Dr. Alkoraishi

**Second:** Dr. Lin

**Ayes:** Dr. Dawood, Dr. Foreman , Ms. Tomcala

**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

#### 4. CEO Update

Christine Tomcala, Chief Executive Officer, reported the current Plan membership is approximately 279,000 members. Of which, approximately 10,000 are Cal MediConnect (CMC) members and 269,000 are Medi-Cal (MC) members. This reflects a slight increase from the previous report in February, 2021. However, a lot of these members' aren't new members, but rather members whose redeterminations are on hold due to the public health emergency.

Ms. Tomcala announced the Governing Board has approved a new Strategic Plan as well as a new Mission, Vision and Values for our organization. Further details will be disclosed at a later date.

Ms. Tomcala shared that although SCFHP has not yet officially opened the Blanca Alvarado Community Resource Center, two vaccination clinics have been held there. Between both vaccination clinic days, 300 Johnson & Johnson vaccines were distributed. Now that the Johnson & Johnson vaccine production is paused, it is unknown as to when the next vaccination clinic will be. SCFHP looks forward to continuing to host vaccine clinics potentially going forward.

This concludes Ms. Tomcala's update. No questions were asked.

#### 5. Assessment of Member Cultural and Linguistic Needs and Preferences

This item was deferred to the following QIC meeting.

#### 6. Review of Quality Improvement (QI) Program Evaluation 2020

Lucille Baxter, Quality and Health Education Manager, presented the QI Program Evaluation 2020. The QI Program Evaluation 2020 includes four different categories: Clinical Improvement; Safety of Clinical Care; Quality of Service; and Members' Experience.

The Clinical Improvement category contains five sections: Quality Measures & Improvement Performance; Quality Improvement Projects (QIP); Performance Improvement Projects (PIP); Initial Health Assessment (IHA); and Health Outcomes Survey (HOS).

Dr. Lin asked if SCFHP sends providers a Gaps of Care list of their patients in need of appointments. Ms. Baxter explained the Gaps of Care list will be available on the Provider Portal in May, 2021, and will be updated monthly thereafter.

The Safety of Clinical Care category contains three sections: Facility Site Review (FSR) & Medical Record Review (MRR); Provider Preventable Conditions (PPCs); and Potential Quality of Care (PQI).

The Quality of Service category includes Access & Availability of Services. The Members' Experience category includes two sections: Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Grievance and Appeals.

Based on the results from the QI Program Evaluation, Ms. Baxter stated that the QI Program is adequately resources to meet, maintain, and improve areas around the quality and safety of clinical care and service, as well as member experience. The Quality Improvement Committee structure allows the departmental areas to gain clinical insights and understanding from the committee members; this is possible through the participation of practitioners and leadership involvement in the QI program. Updates to the QI program were discussed in the QI Program Description that was approved by the Quality Improvement Committee in February 2021.

**It was moved, seconded and the QI Program Evaluation 2020 was unanimously approved.**

**Motion:** Dr. Lin

**Second:** Dr. Dawood

**Ayes:** Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala

**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 7. Review of QI Work Plan 2021

Ms. Baxter presented the QI Work Plan 2021. The QI Work Plan is divided into four QI Activity categories: Quality of Clinical Care; Quality of Service; Members' Experience; and Safety of Clinical Care.

Ms. Baxter reviewed the deliverables, goals and objectives, previous barriers/issues, the timeframe, and staff responsible of each QI Activity.

**It was moved, seconded and the QI Work Plan 2021 was unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Dawood  
**Ayes:** Dr. Alkoraishi, Dr. Foreman, Dr. Lin, Ms. Tomcala  
**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 8. Health Outcomes Survey (HOS)

Byron Lu, Process Improvement Program Manager, Quality Improvement, presented the HOS 2020. Mr. Lu explained the Medicare HOS is the first patient-reported outcomes measure used in Medicare managed care. HOS is mandatory for all Medicare Advantage contracts and is a multi-year survey, including the baseline survey and a follow up survey two years later. The data sources for HOS are the survey responses and the HEDIS rates. Mr. Lu noted there were a total of 226 HOS Cohort '20 respondents with a 59.1% response rate.

Mr. Lu presented the Physical Health and Mental Health results over two cohorts. Also reviewed were the performance measurements for Multiple Chronic Condition, BMI, and Prevalence of Chronic Medical Conditions.

There are two measures of functional health: Improving or Maintaining Physical Health; and Improving or Maintaining Mental Health. Also included are three HEDIS Effectiveness Care Measures: Improving Bladder Control – MUI; Monitoring Physical Activity – FAD; and Reducing the Risk of Falling – FRM.

Mr. Lu reviewed the HOS projected Star Rating for 2021 and 2022, as well as the Interventions.

## 9. Annual Review of QI Policies

Dr. Liu reviewed the QI policies: QI.03, QI.04, QI.06, QI.08, QI.09, QI.11, QI.12, and QI. 28. Angela Chen, Interim Director, Case Management (CM) reviewed the CM policies: QI.13, QI.15, QI.19, QI.30, QI.31, and QI.32.

- a. QI.03 – No changes made
- b. QI.04 – No changes made
- c. QI.06 – No changes made
- d. QI.08 – No changes made
- e. QI.09 – No changes made
- f. QI.11 – No changes made
- g. QI.12 – Further edits will be made, as this policy is transferring departments
- h. QI.13 – Updated
- i. QI.15 – Updated
- j. QI.19 – Updated
- k. QI.28 – No changes made
- l. QI.30 – Newly developed, to be incorporated in a training module
- m. QI.31 – Newly developed, to be incorporated in a training module
- n. QI.32 – Newly developed, to be incorporated in a training module

**It was moved, seconded, and the QI Policies were unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Dawood  
**Ayes:** Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala  
**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 10. Grievance and Appeals Report Q4 2020

Victor Hernandez, Quality Assurance Program Manager, Grievance and Appeals (G&A), presented the G&A Report Q4 2020. Mr. Hernandez noted the decrease in cases received in Q2 2020 and Q3 2020. However, in Q4 2020, SCFHP had more cases this year than last year by about 1,000.

Mr. Hernandez reviewed the cases received as well as the G&A rate per 1,000 members for MC and CMC. Also reviewed were the top three MC and CMC Grievance categories. Mr. Hernandez noted an unusual trend within the top 3 Grievance categories: Inappropriate Billing made it to the top three MC Grievances.

Ms. Tomcala asked if there were any commonalities regarding this unusual trend. Mr. Hernandez will take a closer look at this data and report back at the following QIC meeting.

Mr. Hernandez reviewed the G&A by network, vendor, reason, and rational for overturns.

**It was moved, seconded, and the G&A Report Q4 2020 were unanimously approved.**

**Motion:** Ms. Tomcala  
**Second:** Dr. Lin  
**Ayes:** Dr. Alkoraishi, Dr. Dawood, Dr. Foreman  
**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 11. Compliance Report

Mai Phuong Nguyen, Manager, Oversight, presented the Compliance Report, specifically, the Fraud, Waste, and Abuse (FWA) program. SCFHP is committed to implementing FWA awareness for all staff, governing board members, as well as providers and members, as all are important sources for identifying potential FWA.

Ms. Nguyen reviewed the number of ways SCFHP works to prevent FWA, including a Compliance Hotline, Compliance Electronic Mailbox, FWA Awareness, FWA training, and Internal and External Audits.

Ms. Nguyen noted in 2020, SCFHP added an internal Special Investigations Unit (SIU) team to its FWA program. During the period of January through March 2021, the SIU team has received 18 suspected FWA leads.

## 12. Utilization Management Committee (UMC)

Dr. Lin reviewed the draft UMC minutes for the 01/20/2021 meeting.

**It was moved, seconded, and the draft minutes of the 01/20/2021 UMC meeting were unanimously approved.**

**Motion:** Dr. Alkoraishi  
**Second:** Dr. Dawood  
**Ayes:** Dr. Foreman, Dr. Lin, Ms. Tomcala  
**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 13. Consumer Advisory Board (CAB)

In lieu of Dr. Nakahira, Dr. Liu reviewed the draft CAB minutes for the 03/04/2021 meeting.

**It was moved, seconded, and the draft minutes of the 03/04/2021 CAB meeting were unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Dawood  
**Ayes:** Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala  
**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

## 14. Pharmacy and Therapeutics Committee (P&T)

Dr. Lin reviewed the draft P&T minutes for the 03/18/2021 meeting.

**It was moved, seconded, and the draft minutes of the 03/18/2021 P&T meeting were unanimously**

approved.

**Motion:** Dr. Alkoraishi

**Second:** Dr. Dawood

**Ayes:** Dr. Foreman, Dr. Lin, Ms. Tomcala

**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

#### 15. Credentialing Committee Report

In lieu of Dr. Nakahira, Dr. Lin reviewed the 02/03/2021 Credentialing Committee Report.

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

**Motion:** Dr. Alkoraishi

**Second:** Dr. Lin

**Ayes:** Dr. Dawood, Dr. Foreman, Ms. Tomcala

**Absent:** Dr. Arnold, Dr. Nakahira, Dr. Paul

#### 16. Adjournment

The next QIC meeting will be held on June 9, 2021. The meeting was adjourned at 7:55 pm.

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Ria Paul, MD, Chair

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Date



**Santa Clara Family Health Plan**  
**2020 QUALITY IMPROVEMENT PROGRAM**  
**ANNUAL EVALUATION**

QIC Approval Date: Pending



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## **I. INTRODUCTION**

The Santa Clara County Health Authority, operating as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). SCFHP is a public agency contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. Since 2015, SCFHP has held a three-way contract with DHCS and the Centers for Medicare and Medicaid Services (CMS) to offer a Cal MediConnect Plan (Medicare-Medicaid Plan).

- SCFHP served 261,287 Medi-Cal enrollees in Santa Clara County in 2020.
- SCFHP served 9,820 Cal MediConnect (CMC) enrollees in Santa Clara County in 2020.

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

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program. The Plan's culture, systems and processes are structured to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods for monitoring, analysis, evaluation and improvement of the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, administrative and network services, and member satisfaction. Most of the activities are led by Quality and Process Improvement Department, in collaboration with cross-functional departments including: Utilization Management, Case Management, Long Term Services and Support, Pharmacy, Provider Network Operations and Behavioral Health.

## **II. CLINICAL IMPROVEMENT**

### **A. QUALITY MEASURES & PERFORMANCE IMPROVEMENT**

#### **Medi-Cal**

In 2020, SCFHP reported 39 Managed Care Accountability Set (MCAS) measures following directions from the California Department of Health Care Services (DHCS). MCAS measures consisted of the Healthcare Effectiveness Data Information Set (HEDIS) measures developed by the National Committee of Quality Assurance (NCQA) and CMS Adult and Child Core Sets. The calendar year of these 31 hybrids and 26 administrative measures was 2019 and the reporting year was 2020.

DHCS sets a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each quality measure. The MPL and HPL are the 50th and 90th percentiles of the national benchmarks, respectively. SCFHP sets a goal to meet MPL and strives to reach HPL for all measures. In addition, SCFHP also monitored the utilization and overutilization measures for quality improvement.

The goal was to exceed MPL for all MCAS measures. Quality Improvement (QI) Work that was approved at the Quality Improvement Committee was implemented in February 2020.

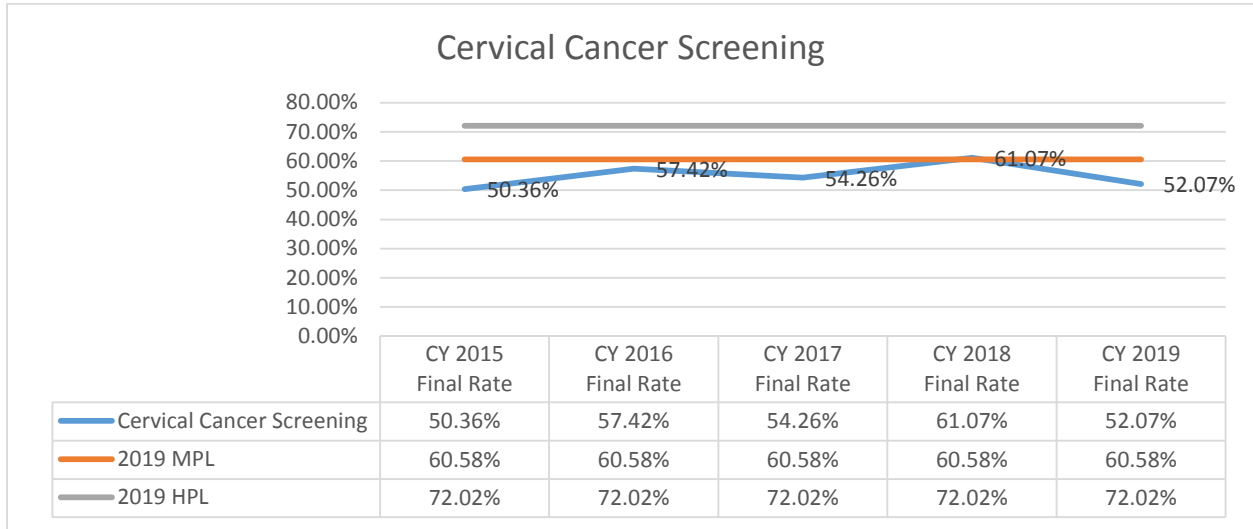
SCFHP developed work plans and implemented quality interventions based on barrier analyses to focus on the following measures in QI Work Plan of 2020:

1. Cervical Cancer Screening (CCS)
2. Childhood Immunization Status Combo 10 (CIS-10)
3. Comprehensive Diabetes Care – HbA1c Testing (CDC-HT)
4. Controlling Blood Pressure <140/90 mmHg (CBP)
5. Prenatal & Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)
6. Well-Child Visits in the 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> & 6<sup>th</sup> Years of Life (W34)

## 1. Cervical Cancer Screening (CCS)

Women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:

- Aged 21 - 64 years of age who had cervical cytology performed within the last 3 years (2017 – 2019)
- Aged 30 – 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (2015 – 2019)
- Aged 30 – 64 years of age who had cervical cytology/high-risk papillomavirus (hrHPV) testing performed within the last 5 years (2015-2019)



**CY 2019 Goal:** Met Cervical Cancer Screening rate at Medicaid 50<sup>th</sup> percentile - 60.65%

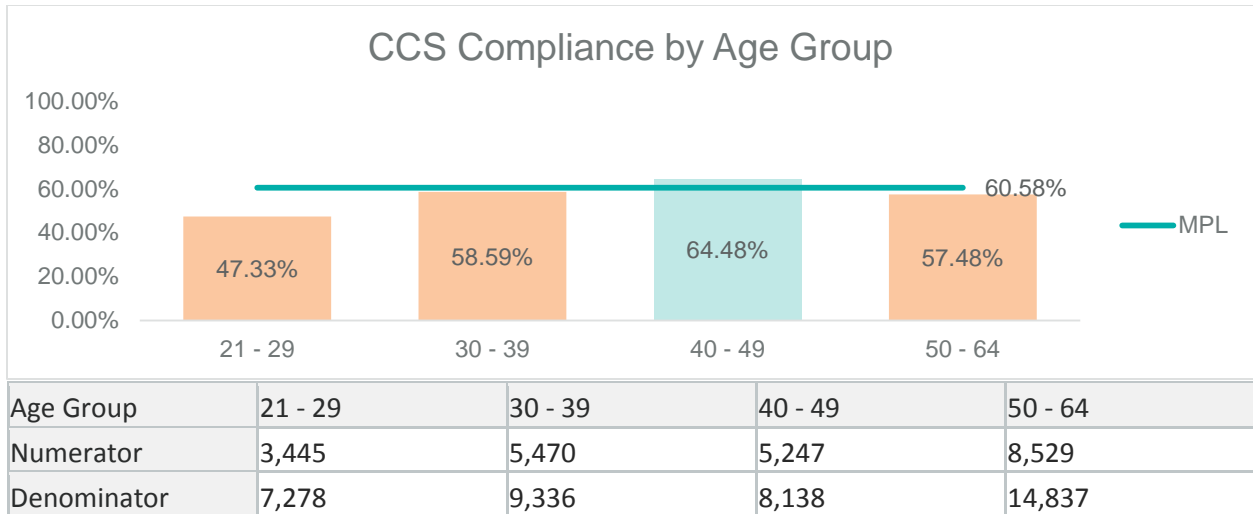
**CY 2019 Rate:** 52.07%\*

\*SCFHP was allowed to use the previous year's (CY 2018) rate – 61.07% for reporting this measure.

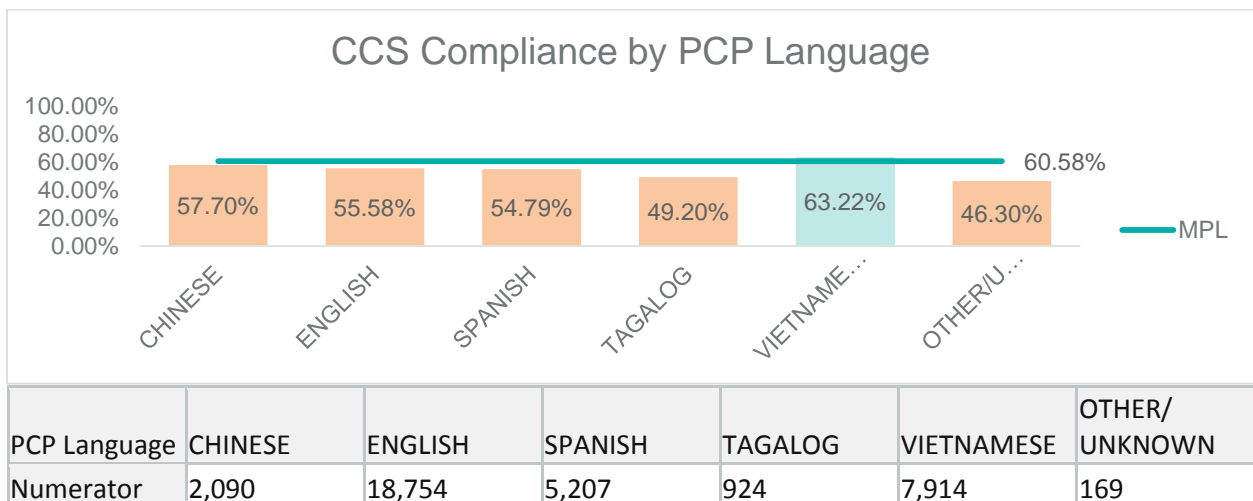
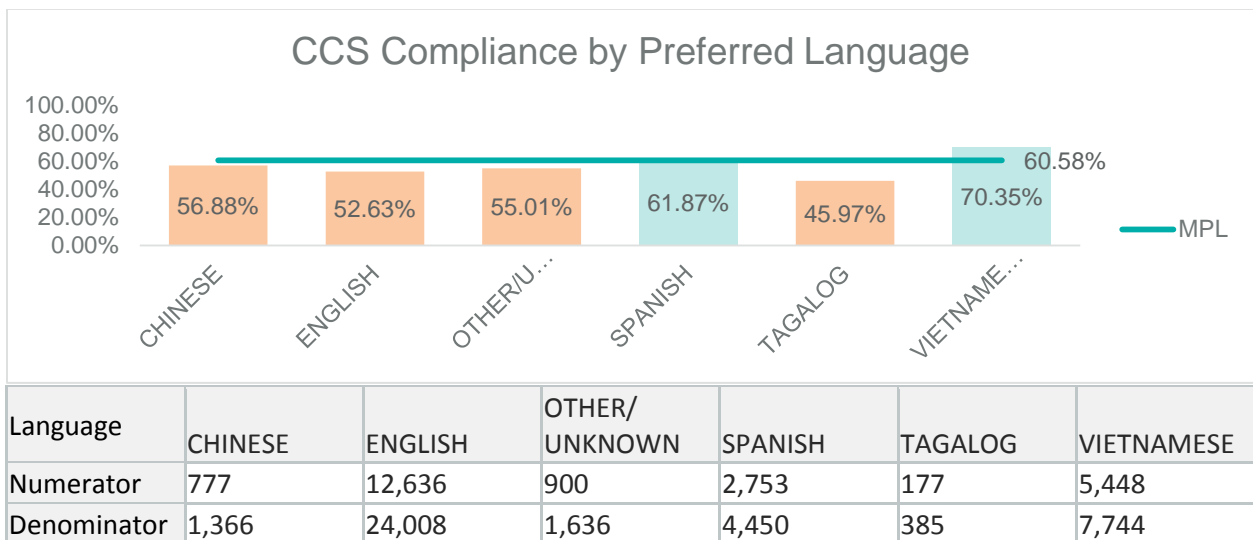
### Analysis:

CCS rate decreased by 9% compared to the previous year and did not meet the SCFHP goal of meeting MPL by 8.51%.

Looking at the different age groups, women ages 40 – 49 were the highest performing compared to all other age groups. The 21-29 age group had the lowest compliance.



SCFHP also analyzed performance by ethnicity and language for both members and PCPs to examine any disparities in cervical cancer screening.



Denominator	3,622	33,740	9,503	1,878	12,519	365
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Vietnamese-speaking were the highest performing group for both members and PCPs with rates of 70.35% and 63.22%, respectively. Tagalog speaking members and PCP were the lowest performing group with rates of 45.97% and 49.02%. PCPs could be one of the contributing factors for cervical cancer screening compliance.

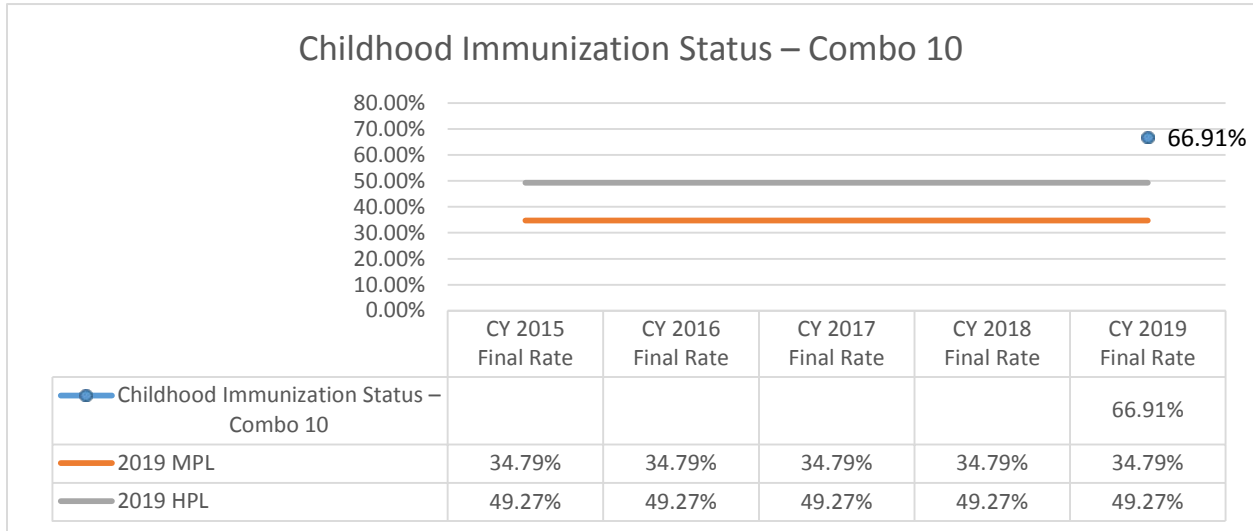
13,318 letters were sent to remind members of the importance of cervical cancer screening. 295 English speaking warm outreach calls were made and successfully assisted 79 members in scheduling with PCP or GYN appointment for well women visits in November. During outreach calls, the outreach team realized that there were difficulties in securing well women appointments due to the COVID-19 pandemic. A total of 1837 members were incentivized with a \$30 gift card of their choice for completing cervical cancer screenings. CCS is one of the Provider Pay for Performance measures. CCS and Chlamydia screening (CHL) is chosen as the topic of PDSA Quality Improvement Plan. Refer to QIP section for details.

**Follow-up & Strategies to be considered for future years:**

- Focus on younger age groups, especially ages 21 – 29
- Strengthen communication and education with PCPs on importance of cervical cancer screening

## 2. Childhood Immunization Status Combo 10 (CIS-10)

Children 2 years of age who had all combination 10 vaccines, including: 4 DTap; 3 IPV; 2 MMR; 3 Hib; 3 Hep B; 1 VZV; 4 PCV; 1 hep A; 2 or 3 RV and 2 flu vaccines by their second birthday.



**CY 2019 Goal:** Meet Childhood Immunization Status Combo 10 MPL (34.79%)

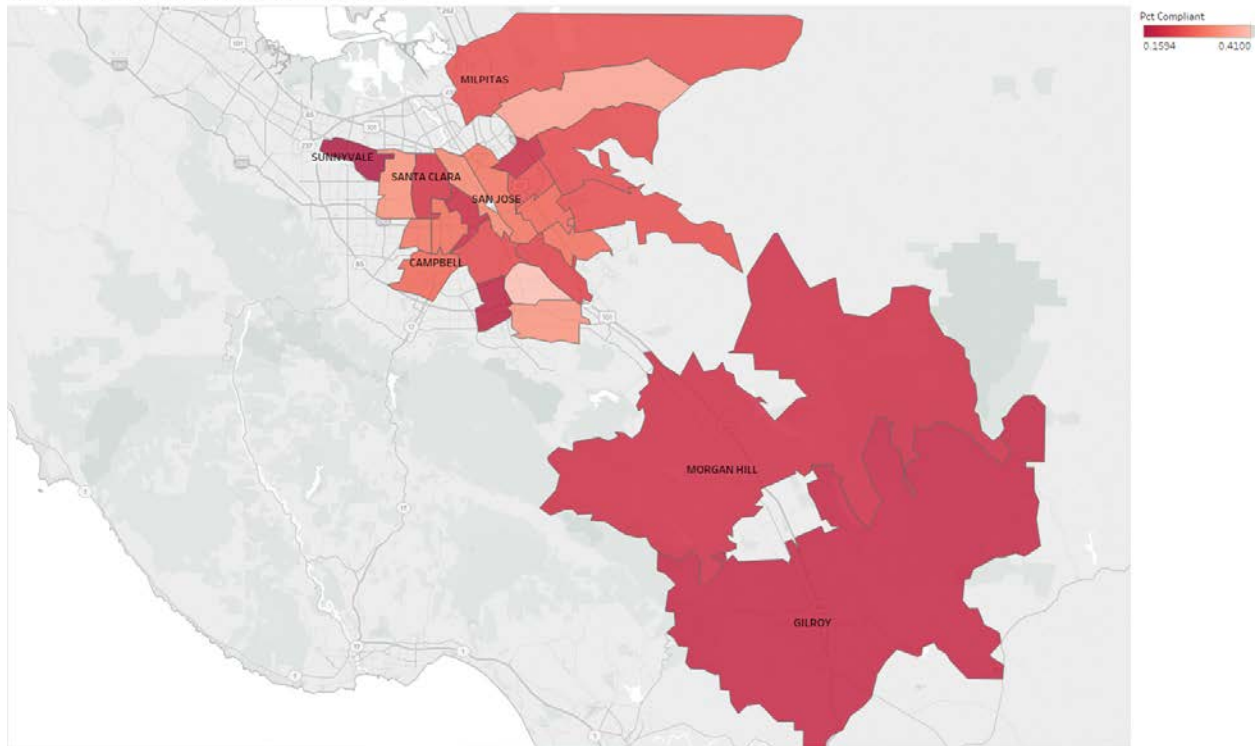
**CY 2019 Rate:** 66.91%

### Analysis:

CIS Combo 10 rate exceeded both MPL (34.79%) and HPL (49.27%). The administrative rate was 3.66%, and the majority of compliant data were obtained from medical record review instead of administrative data. Flu vaccine (75.91%) was one of the lowest compliance rates compared to any other vaccines (>83%). SCFHP also found that the Morgan Hill and Gilroy area were less compliant and corresponding to well child visits in the first 15 months of life (W15) findings. There is a lack of trending data on CIS-Combo 10 as it is a new MCAS measure.

After the MCAS measure modified the measure, SCFHP changed the Provider Pay for Performance measure into CIS-Combo 10 accordingly. “Don’t Wait Vaccinate” was campaigned in Provider Newsletters on the importance of childhood immunization in December. SCFHP also improved the HEDIS data by incorporating California Immunization Registry (CAIR) records as supplemental data. There are opportunities for earlier identification of members who have missed vaccinations.

Heat Map (Limited to zip codes with > 50 members)



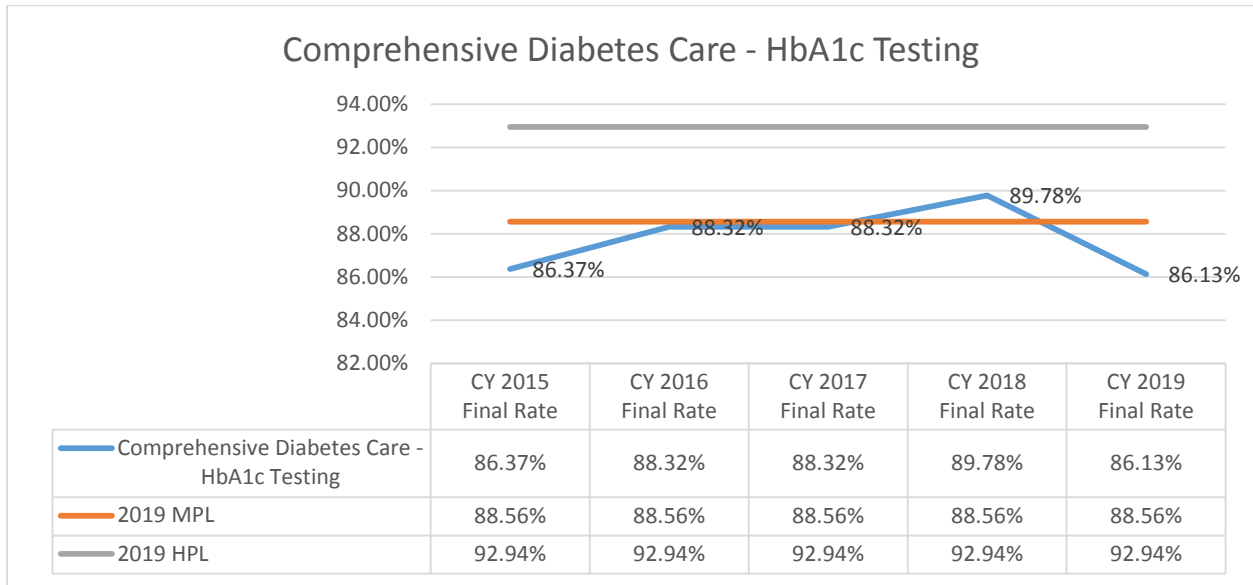
**Follow-up & Strategies to be considered for future years:**

- Continue to find opportunities of data incompleteness and incorporate CAIR data
- Focus on education to parents on the importance of flu vaccine
- Identify any access issues in the southern area of Santa Clara County



### 3. Comprehensive Diabetes Care – HbA1c Testing (CDC-HT)

Members 18 – 75 years of age with Diabetes who had Hemoglobin A1C (HbA1c) testing



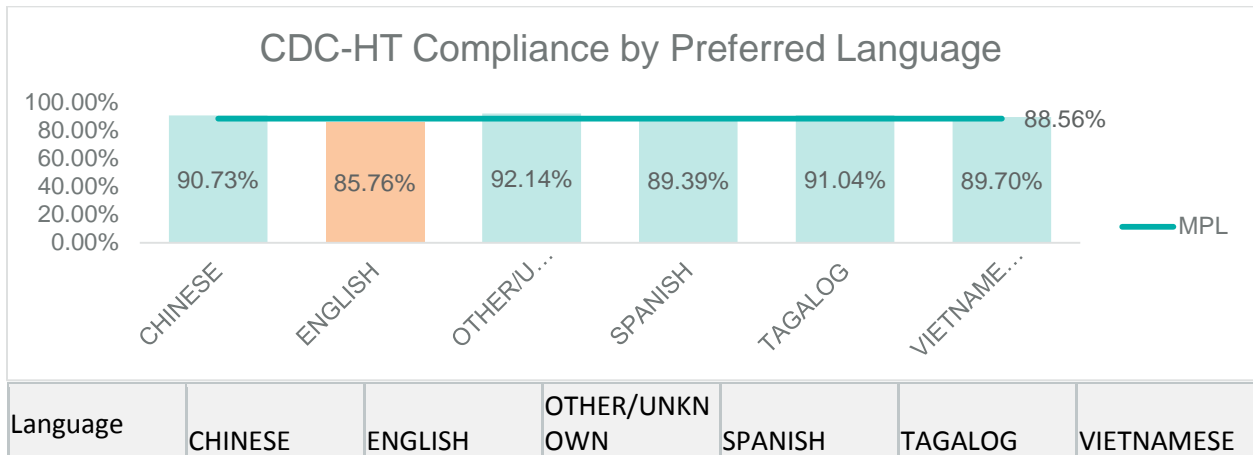
**CY 2019 Goal:** Met Comprehensive Diabetes Care HbA1C Testing rate at Medicaid 50<sup>th</sup> percentile 88.56%

**CY 2019 Rate (Measurement year 2019):** 86.13%

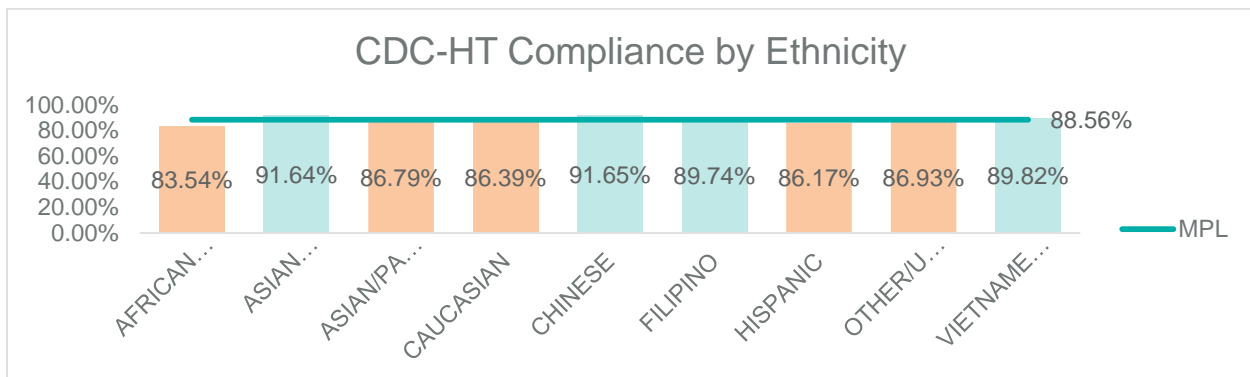
**Analysis:**

CDC HT rate was lower than previous measurement years. It did not meet goal and was below MPL (88.56%) by 2.43%. There are 10,834 diabetes members. 85.70% of the diabetes members (9,285) completed A1C testing, and SCFHP received the claims/encounter administratively. CDC HT is a hybrid measure. Eighty more compliance member data was found through medical record review. There are opportunities to improve the data.

English speaking and African American and Caucasian ethnic groups had lower compliance rates compared to Asian groups like Asian Indian, Chinese, Filipino and Vietnamese.

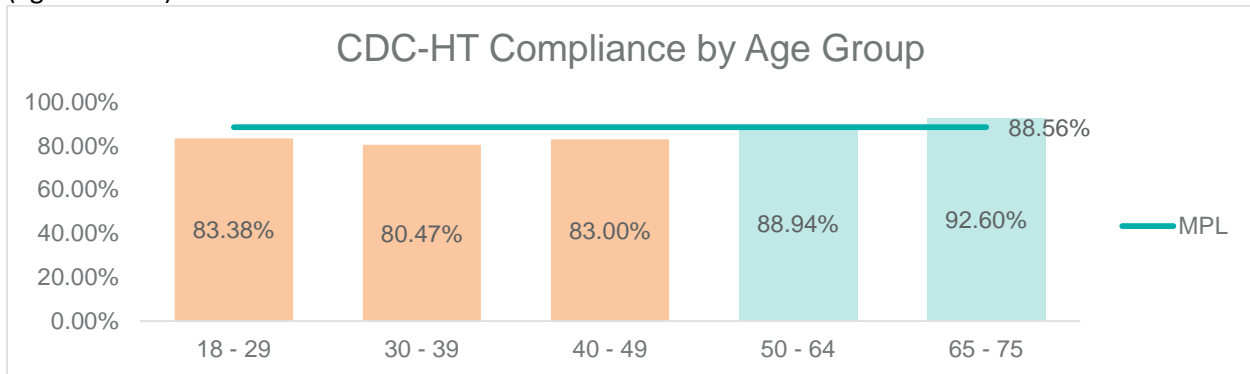


Numerator	284	4,353	563	1,238	193	1,324
Denominator	313	5,077	611	1,385	212	1,476



Ethnicity	AFRICAN AMERICAN	ASIAN INDIAN	ASIAN/PACIFIC ISLANDER	CAUCASIAN	CHINESE	FILIPINO	HISPANIC	OTHER/UNKNOWN	VIETNAMESE
Numerator	340	614	230	984	362	420	2,374	1,211	1,420
Denominator	407	670	265	1,139	395	468	2,755	1,394	1,581

In addition, the younger age groups (ages 18 – 49) are less compliant compared to the older age groups (ages 50 – 75).



Age Group	18 - 29	30 - 39	40 - 49	50 - 64	65 - 75
Numerator	301	515	1,094	5,106	939
Denominator	361	640	1,318	5,741	1,014

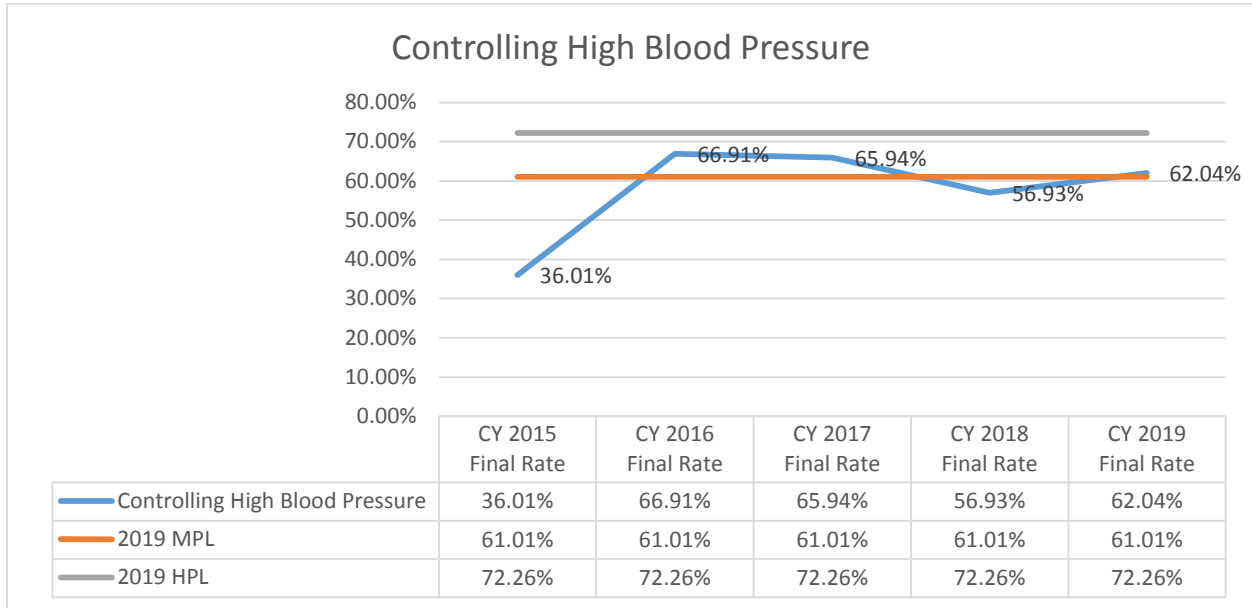
SCFHP mailed letters to 8,588 members on the reminder to complete the screening from July to October. Incentives were given to 7,700 Diabetes members who completed screenings as a \$30 gift card from January to December. The QI Outreach team conducted 2,784 warm outreach calls to members and assisted in scheduling appointments with PCPs to follow-up on their diabetes from September to December. Through outreach calls, SCFHP identified some barriers, such that members are not aware of their HbA1C result and do not check their levels often. Members who are non-compliant with medication sometimes lack understanding of the disease process. CDC-HT is one of the Provider Pay for Performance measures. Member Newsletter articles on Smoking and Diabetes were published in the fall.

**Follow-up & Strategies to be considered in future years:**

- Focus on younger age groups specifically those ages 18 – 49
- Strengthen communication and education regarding importance of managing diabetes to members
- Continue to improve administrative data on HbA1C testing and result

#### 4. Controlling Blood Pressure <140/90 mmHg (CBP)

Members 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled under 140/90 mmHg

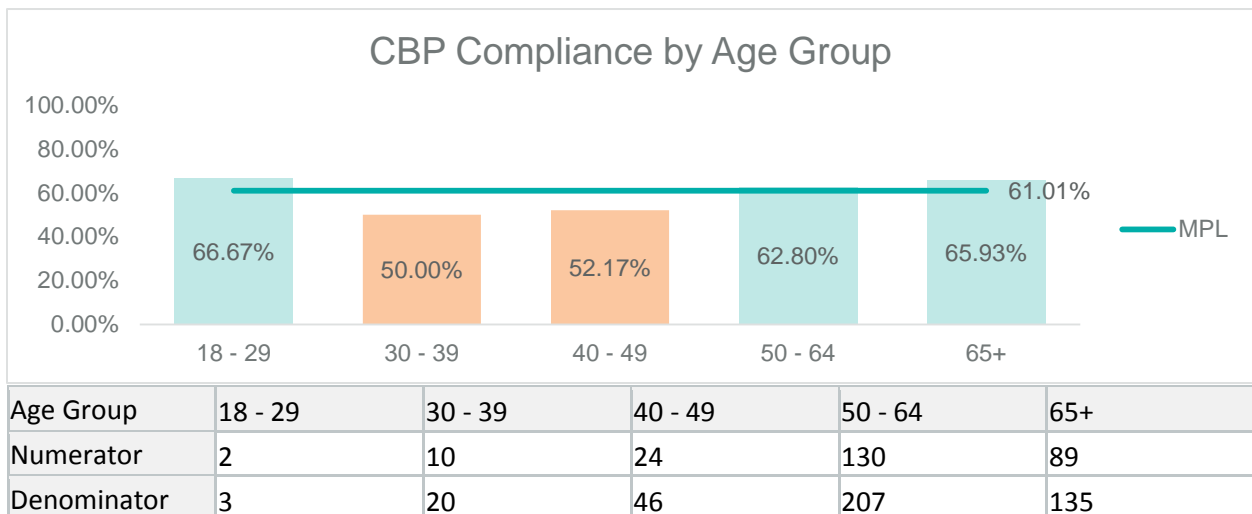


**CY 2019 Goal:** Meet Controlling Blood Pressure rate at Medicaid 50<sup>th</sup> percentile 61.01%

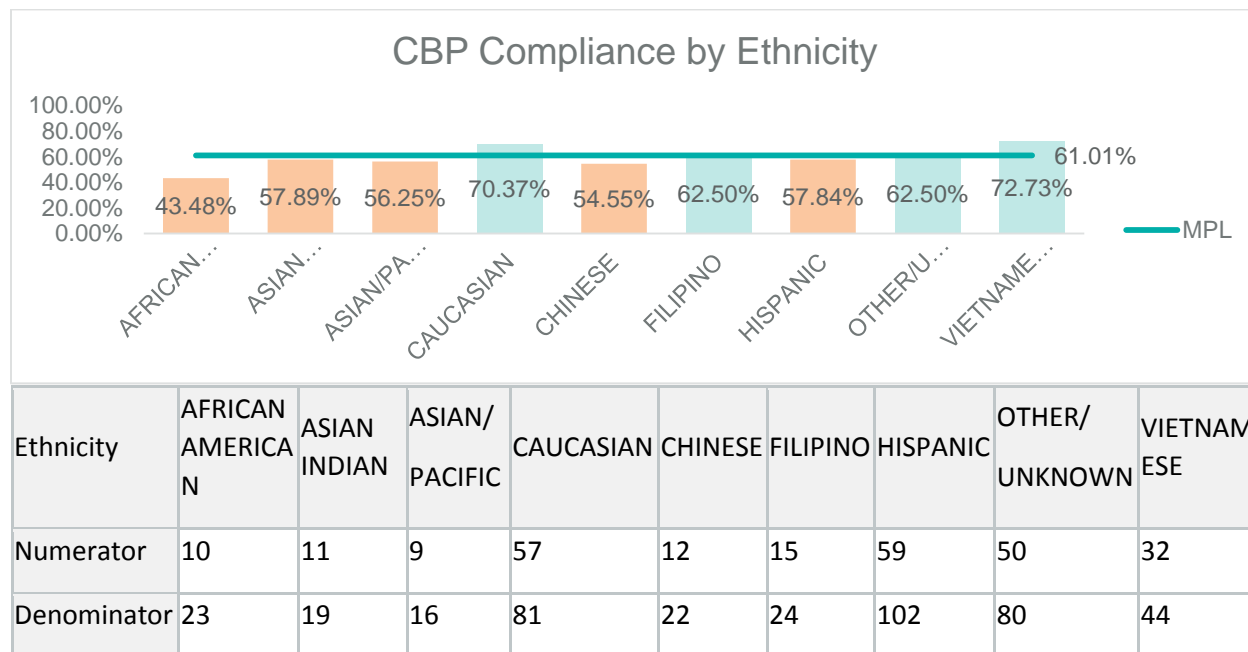
**CY 2019 Rate (Measurement year 2019):** 62.04%

**Analysis:**

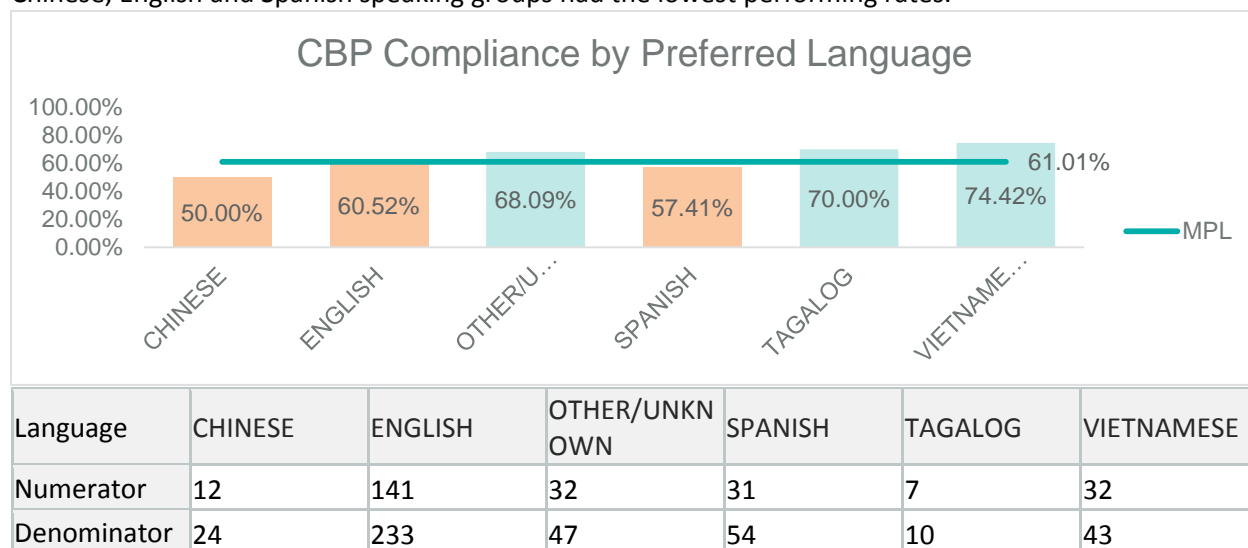
CBP rate met MPL. By using hybrid sample, similar to other chronic condition measures like Diabetes, younger age groups, specifically ages 30 – 49 had lower compliance rate compared to the older age groups (aged 50 – 85).



Based on the hybrid sample rates, African American, Asian Indian, Asian Pacific, Chinese and Hispanic member's blood pressure (BP) were not well controlled.



Chinese, English and Spanish speaking groups had the lowest performing rates.



The QI Outreach team comprised of Spanish speaking staff conducted 1,467 warm outreach calls to members who did not have an office visit and assisted in scheduling appointments with PCPs to follow-up on their hypertension. During outreach calls, many members did not know their BP reading. CBP is one of the measures for the Provider Pay for Performance program. SCFHP encouraged providers to submit supplemental data for BP reading for better analysis and intervention all year long. Member & Provider Newsletters were published on Hypertension in July. Due to the COVID-19 pandemic, SCFHP realized the importance of blood pressure home monitoring and members' ability to report BP during telehealth visits.

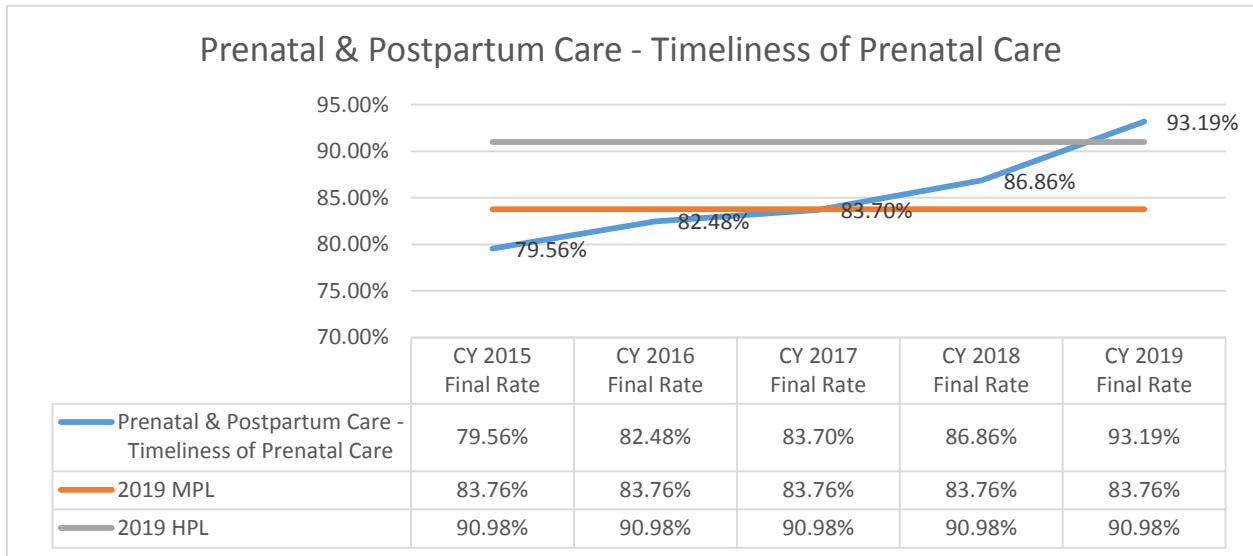
SCFHP partnered with a DME supplier to simplify the process of providing blood pressure monitors for members with hypertension in October.

**Follow-up & Strategies to be considered in future years:**

- Focus on younger age groups specifically those ages 30 – 49
- Reinforce the importance of BP control and self-management/accountability
- Advocate to ensure each hypertensive member for home monitoring BP
- Enroll members to Chronic Case Management and health education for healthy living style

## 5. Prenatal & Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)

Pregnant women with live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, receiving a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment

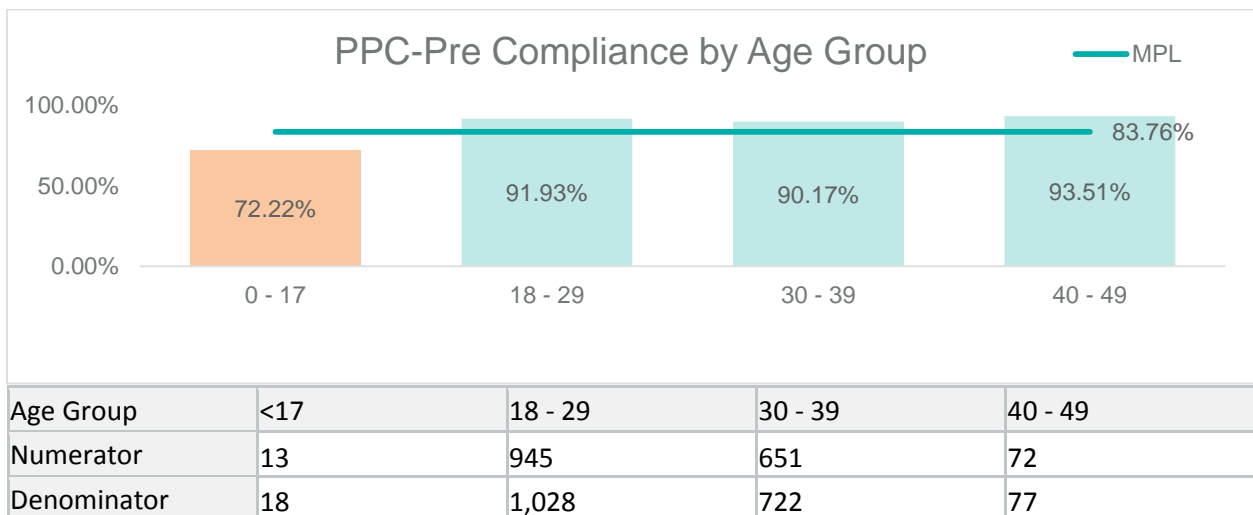


**CY 2019 Goal: 83.76%**

**CY 2019 Rate (Measurement year 2019): 93.19%**

### Analysis:

PPC-Pre exceeded the MPL and HPL goals by 2.21%. Even though the performance has exceeded the goal, SCFHP found opportunities to better serve our members under the age of 18.



For members ages 17 or below, the compliance rate of having prenatal visit in first trimester or within 42 days of enrollment was lower than any all other age groups. It scored 72.22% compared to the other age

groups at 90% or above. Teenage pregnancy carries extra health risks to both the mother and the baby, including premature birth and low birth weight.

Upon further analysis, SCFHP found the rate for postpartum visits was trending lower than prenatal visits in the last few years. CY 2016: 68.61%, CY 2017: 69.10% and CY 2018: 71.78%. This indicates that members may not have postpartum visits after delivery.

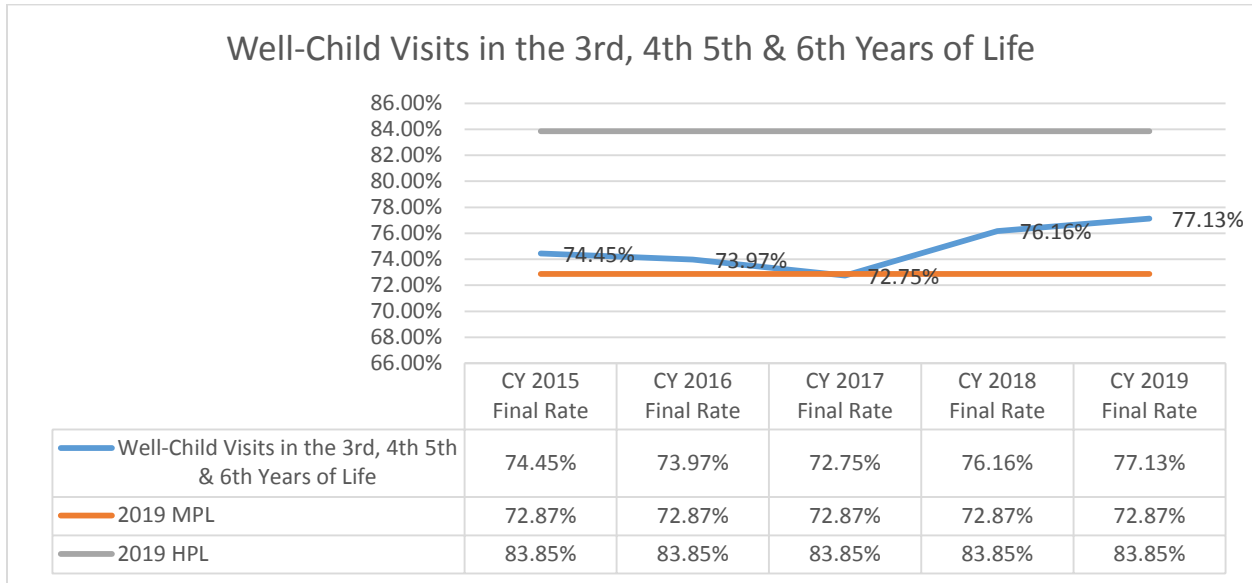
The Healthy Mom Healthy Baby program was implemented with incentives to encourage pregnant women to receive prenatal care visits in 3 stages of trimesters. The program was mainly through provider referral. The participation was relatively low. Only around 6% of pregnant members participated. SCFHP continued to partner with community organizations, including Black Infant Health, to offer community outreach and support for members during pregnancy. PPC-Pre is one of the Provider Pay for Performance measures.

**Follow-up & Strategies to be considered in future years:**

- Educate the importance of prenatal and postpartum visits during the COVID-19 pandemic through newsletters and social media.
- Modify the Healthy Moms Healthy Baby program to add focus on postpartum visits and expand participation.
- Early identification of teenage pregnancy through claims data for coordination of care and to analyze any disparities.



**6. Well-Child Visits in the 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> & 6<sup>th</sup> Years of Life (W34)**



**CY 2019 Goal: 72.87%**

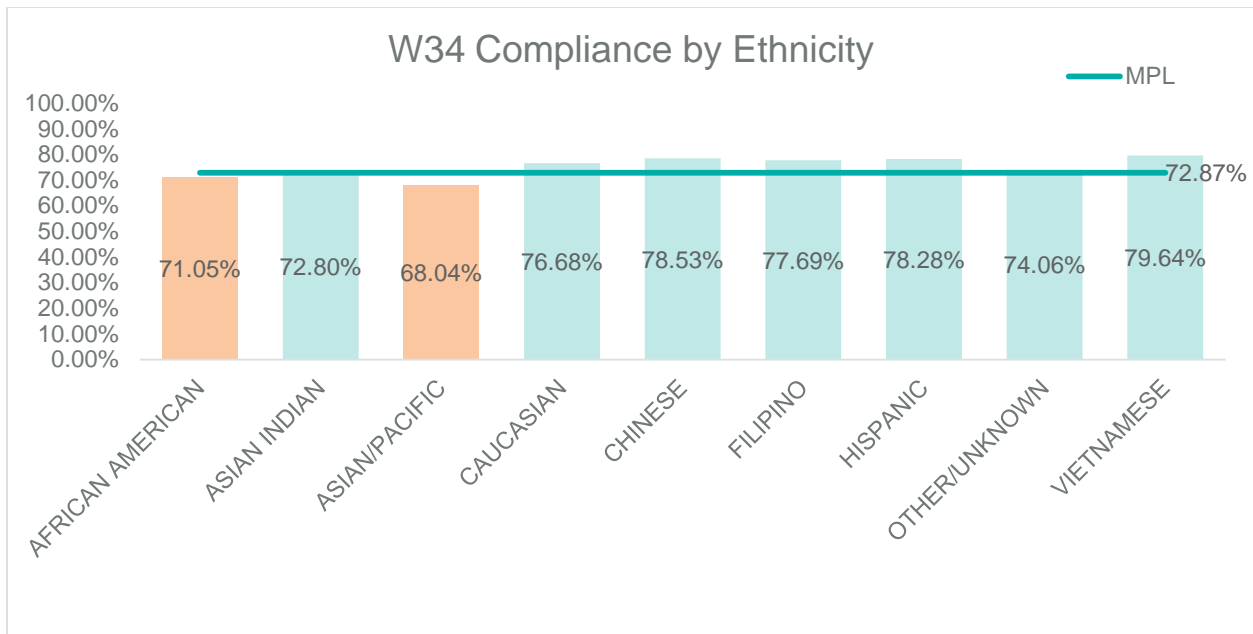
**CY 2019 Rate: 77.13%**

**Analysis:**

W34 exceeded the goal by 4.26% and slightly increased the rate by 0.97% compared to the previous calendar year.

There was no difference between genders of the well child visit for over 16,290 members of W34. Female children had a 77.29% compliance rate and male children performed at 77.56%. There was not much difference in performance based on preferred language of the parents or guardians.

However, two ethnic groups, African American and Asian/Pacific were among the lower performing. African American’s compliance rate was 71.05% and Asian/Pacific compliance rate was only 68.04%. SCFHP plans to conduct further analysis to determine root cause in measure performance for these two ethnic groups.



Ethnicity	AFRICAN AMERICAN	ASIAN INDIAN	ASIAN/PACIFIC	CAUCASIAN	CHINESE	FILIPINO	HISPANIC	OTHER/UNKNOWN	VIETNAMESE
Numerator	324	174	66	720	278	310	8,016	1,522	1,205
Denominator	456	239	97	939	354	399	10,240	2,055	1,513

8,521 parents/guardians received well-child visit reminder letters from August to November and incentives for a \$30 gift card. W34 was also one of the Provider Pay for Performance measures. SCFHP fully supported DHCS efforts to implement a comprehensive member outreach campaign to increase children’s utilization of preventive services through live calls to member for whom had landline and direct mail to those had wireless numbers in July. Live calls were made to 1,373 unique households for 1,690 members and PCP appointments were successfully scheduled on 62 calls. 19,624 direct member mailings were sent to members under age 7 who had not received a check-up or well-visit for preventive care services within the last six months. It covered developmental screening, blood lead screening, well visit, physical exam, nutrition screening, mental health screening, immunizations, dental, hearing and vision screenings.

**Follow-up & Strategies to be considered in future years:**

W34 has been retired and combined with Adolescent Well Care Visit (AWC) into a measure, Child and Adolescent Well Care Visit (WCV)

- Continue to strengthen member communication
- Focus on African American and Asian Pacific groups to have root cause analysis on barriers for further improvement

Below illustrate the results of all MCAS measures reported in 2020.

#	Measure Acronym	Measure (Measurement Year 2019)	Measure Type Methodology	Final Rate in 2020	MPL/HPL
1	PCR	Plan All-Cause Readmissions	Administrative	Observed: 10.39% Expected: 9.09%	Observed MPL: 8.22% Expected MPL: 16.29%  Observed HPL: 6.83% Expected HPL: 13.41%
2	AWC	Adolescent Well-Care Visits	Hybrid	51.82%	MPL: 54.26% HPL: 68.14%
3	ABA	Adult Body Mass Index Assessment	Hybrid	92.46%	MPL: 90.27% HPL: 95.88%
4	AMM-Acute	Antidepressant Medication Management – Acute Phase Treatment	Administrative	63.57%	MPL: 52.35% HPL: 65.95%
5	AMM-Cont	Antidepressant Medication Management – Continuation Phase Treatment	Administrative	49.87%	MPL: 36.51% HPL: 48.68%
6	AMR	Asthma Medication Ratio**	Administrative	62.31%	MPL: 63.6% HPL: 71.61%
7	BCS	Breast Cancer Screening	Administrative	66.72%	MPL: 58.73% HPL: 69.23%
8	CCS	Cervical Cancer Screening	Administrative	61.07%*  * Rate was rotated with CY 2018 value	MPL: 60.58% HPL: 72.02%

#	Measure Acronym	Measure (Measurement Year 2019)	Measure Type Methodology	Final Rate in 2020	MPL/HPL
9	CIS-10	Childhood Immunization Status – Combo 10	Hybrid	66.91%	MPL: 34.79% HPL: 49.27%
10	CHL	Chlamydia Screening in Women Ages 16 – 24**	Administrative	59.19%	MPL: 58.33% HPL: 71.58%
11	CDC-HT	Comprehensive Diabetes Care HbA1c Testing	Hybrid	86.13%	MPL: 88.56% HPL: 92.94%
12	CDC-H9	HbA1c Poor Control (>9.0%)	Hybrid	31.14%	MPL: 38.48% HPL: 27.98%
13	CBP	Controlling Blood Pressure <140/90 mmHg	Hybrid	62.04%	MPL: 61.01% HPL: 72.26%
14	IMA-2	Immunizations for Adolescents – Combo 2 (meningococcal, Tdap, HPV)	Hybrid	46.72%	MPL: 34.43% HPL: 47.2%
15	PPC-Pre	Prenatal & Postpartum Care – Timeliness of Prenatal Care	Hybrid	93.19%	MPL: 83.76% HPL: 90.98%
16	PPC-Pst	Prenatal & Postpartum Care – Postpartum Care	Hybrid	85.16%	MPL: 65.69% HPL: 74.36%
17	WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents: Body Mass Index Assessment for Children/Adolescents	Hybrid	89.29%	MPL: 79.09% HPL: 90.4%
18	W15	Well-Child Visits in the First 15 months of Life – Six or More Well Child Visit	Hybrid	75.43%	MPL: 65.83% HPL: 73.24%
19	W34	Well-Child Visits in the 3 <sup>rd</sup> 4 <sup>th</sup> 5 <sup>th</sup> & 6 <sup>th</sup> Years of Life	Hybrid	77.13%	MPL: 72.87% HPL: 83.85%

#	Measure Acronym	Measure (Measurement Year 2019)	Measure Type Methodology	Final Rate in 2020	MPL/HPL
20	AMB-ED*	Ambulatory Care: Emergency Department (ED) Visits	Administrative	38.84%	MPL: HPL:
21	ADD-Initi	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Initiation Phase	Administrative	39.84%	MPL: 43.41% HPL: 56.57%
22	ADD-C/M	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications – Continuation and Maintenance Phase	Administrative	49.87%	MPL: 55.5% HPL: 69.15%
23	CAP*	Children & Adolescents' Access to Primary Care Practitioners: 12-24 Months	Administrative	94.54%	MPL: 95.62% HPL: 97.82%
24	CAP*	Children & Adolescents' Access to Primary Care Practitioners: 25 Months – 6 Years	Administrative	88.69%	MPL: 87.87% HPL: 92.59%
25	CAP*	Children & Adolescents' Access to Primary Care Practitioners: 7-11 Years	Administrative	90.82%	MPL: 91.08% HPL: 95.85%
26	CAP*	Children & Adolescents' Access to Primary Care Practitioners: 12-19 Years	Administrative	88.49%	MPL: 90.23% HPL: 94.66%
27 28	CCW	Contraceptive Care: All Women Ages 15-44**: <ul style="list-style-type: none"> <li>• Most or moderately effective contraception</li> <li>• Long Acting Reversible Contraception (LARC)</li> </ul>	Administrative	MMEC: 15 – 20: 13.91% 21 – 44: 24.39%  LARC: 15 – 20: 2.47% 21 – 44: 5.47%	NA
29 30 31 32	CCP	Contraceptive Care: Postpartum Women Ages 15-44**: <ul style="list-style-type: none"> <li>• Most or moderately effective contraception – 3 days</li> <li>• Most or moderately</li> </ul>	Administrative	MMEC - 3 days: 15 – 20: 19.10% 21 – 44: 19.42%	NA

#	Measure Acronym	Measure (Measurement Year 2019)	Measure Type Methodology	Final Rate in 2020	MPL /HPL
		<p>effective contraception – 60 days</p> <ul style="list-style-type: none"> <li>• LARC – 3 days</li> <li>• LARC – 60 days</li> </ul>		<p>MMEC - 60 days: 15 – 20: 50.56% 21 – 44: 42.09%</p> <p>LARC – 3 days: 15 – 20: 14.61% 20 – 44: 9.65%</p> <p>LARC – 60 days: 15 – 20: 33.15% 20 – 44: 19.18%</p>	
33	DEV	Developmental Screening	Administrative	20.51%	NA
34	HVL	HIV Viral Load Suppression	Administrative	18 – 64: 3.58% 65+: 0%	NA
35	MPM-ACE/ARB	Annual Monitoring for Patients on Persistent Medications: ACE inhibitors or ARBs	Administrative	Not reported	NA
36	MPM-Diu	Annual Monitoring for Patients on Persistent Medications: Diuretics	Administrative	Not reported	NA
37	COB	Concurrent Use of Opioids and Benzodiazepines	Administrative	18 – 64: 13.15% 65+: 8.08%	NA
38	OHD	Use of Opioids at High Dosage in Persons Without Cancer	Administrative	0%	NA
39	CDF	Screening for Depression and Follow-Up Plan: Age 12 and Older**	Administrative	12 – 17: 0.21% 18 – 64: 1.51% 65+: 0.17%	NA

In conclusion, 14 of the 18 MCAS measures met MPL. 4 measures did not, including Cervical Cancer Screening (CCS), Asthma Medication Ratio (AMR), Comprehensive Diabetes Care (CDC-HT) and Adolescent Well Care (AWC).

Measure	Rank	Percentile
Childhood Immunizations – Combo 10	1	95th
Antidepressant Med Mgmt – Cont	3	90th
Well Child Visits in First 15 Months	3	90th
Breast Cancer Screening	5	75th
Antidepressant Med Mgmt – Acute	6	75th
All Cause Readmit -Expected Readmission	7	95th
Post Partum Care	10	95th
Diabetes Care – HbA1c>9	11	75th
Children and Adolescents Access to Primary Care – 7-11 Years <sup>1</sup>	13	25th
Immunizations for Adolescents – Combo 2	14	75th
Children and Adolescents Access to Primary Care – 12-19 Years <sup>1</sup>	15	25th
Children and Adolescents Access to Primary Care -25 Months – 6 Years <sup>1</sup>	15	50th
Follow Up Care for Children on ADHD Medication – Cont	16	10th
All Cause Readmit – Observed Readmission	16	95th

Measure*	Rank	Percentile
Prenatal Care	17	95th
Children and Adolescent BMI Percentile Documentation	17	75th
Well Child Visits 3-6 Years <sup>2</sup>	18	50th
All Cause Readmit –Observed to Expected Ratio	19	10th
Children and Adolescents Access to Primary Care – 12-24 Months <sup>1</sup>	21	25th
Adolescent Well Child <sup>2</sup>	23	25th
Follow Up Care for Children on ADHD Medication – Init	24	25th
Asthma Medication Ratio	27	25th
Adult BMI Assessment <sup>1</sup>	27	50th
Cervical Cancer Screening	29	50th
Controlling Blood Pressure	33	50th
Chlamydia Screening in Women	36	50th
Diabetes Care – HbA1c Testing	38	25th
Ambulatory Care – ED Visits <sup>3</sup>	51	< 10th

1. Measure has been retired in 2020
2. AWC and W34 will be combined into a new measure, WCV
3. Ambulatory Care—Emergency Department Visits summarizes utilization of ambulatory care for ED visits. This measure is reported in number of visits per 1,000 member months in the IDSS file. Higher or lower rates do not necessarily indicate better or worse performance.

 Held to MPL

Other than the above 6 focus measures, SCFHP monitored the measures performance monthly and shared results at Quality & Strategy Workgroup. Immediate quality activities would be intervened to maintain the quality clinic service standard.

**Chlamydia Screening (CHL)**, aged 24 member received warm outreach calls to remind the importance of chlamydia screening and educate that it can be done during well women exams. Overall, the feedback was good without embarrassment due to the sensitive topic. This measure was chosen to be part of short cycle PSDA Quality Improvement Plan with Cervical Cancer Screening. See PIP section for details.

**Asthma Medication Ratio (AMR)**, member incentives were offered per quarter and reminder letters were mailed from July to December. This measure was also included the Provider Pay for Performance program. In addition, warm outreach calls also made to 40 members who had controller medications that were not refilled regularly with a ratio > 0.3 and <0.5 by pharmacists and staff with pharmacy technician backgrounds. Members were assisted in connecting with pharmacies to refill the controller medications and educated on the proper use of relievers.

**Breast Cancer Screening (BCS)**, member incentives were offered and mailings were sent from July to December. Outreach calls were made to remind members of the importance of breast cancer screening. However, mammogram appointment availability was limited during the COVID-19 pandemic.

SCFHP also promoted **Flu vaccines** in the 4<sup>th</sup> quarter. The Flu-a-palooza campaign was kicked off in September internally with all departments. Each member facing staff reminded members to have flu vaccine at the end of each inbound and outbound call. Communication channeled in multiple ways to reach members and providers, including but not limited to on-hold messaging, postcard mailing, newsletter, website, social media posts. SCFHP partnered with Anthem on flu clinics giving vaccines. Flu stickers were also designed and distributed to providers.

## Cal MediConnect

CMS and the State have established a set of quality withhold measures, and MMPs will be required to meet established thresholds. Due to impacts from the Coronavirus Disease 2019 (COVID-19) public health emergency, SCFHP (MMP) is not required to submit HEDIS 2020 data covering the 2019 measurement year. However, SCFHP continued to monitor the quality withhold measure performance.

Rates of the measures are reflected for calendar year 2019:

#	Measure Acronym	Measure	Measure Type Methodology	Rate in CY 2019 (Reporting year 2020)	Withhold Threshold
1	CW6	Plan All-Cause Readmission	Administrative HEDIS	0.95	Met 1.0
2	CW7	Annual Flu Vaccine	CAHPS	78%	Met 69%
3	CW8	Follow-up After Hospitalization for Mental Illness	HEDIS	63%	Met 56%
4	CW12	Medication Adherence for Diabetes Medications	PDE	86%	Met 73%
5	CW13	Encounter Data	Encounter Data	97.39%	Met 80%
6	CAW7	BH shared accountability outcome measure	Compliance Reporting	108.42	Did not meet 88.56
7	CAW8	Documentation of care goals	Compliance Reporting	100%	Met 65%
8	CAW9	Interaction with care team	Compliance Reporting	40.40%	Did not meet 88%

SCFHP met 6 of the 8 quality withhold measures by collaborating cross-functionally across departments, including but not limited to: Quality, Medical Management, Behavioral Health, Pharmacy, Case Management and Marketing to implement interventions.

Other than Quality Withhold measures, SCFHP reported HEDIS Medicare measures for NCQA Accreditation and Medicare-Medicaid Plan (MMP). National Percentiles and Star Rating cut points are used as benchmarks and goals for improvement and comparison.

In addition, HEDIS measures are also required reporting for NCQA Accreditation & CMS Medicare Star Ratings. These measures are highlighted as follows:



#	Measure Acronym	Measure	Measure Type Methodology	Final rate in CY 2019	National 50 <sup>th</sup> Percentile	3-Star Cut Point
Effectiveness of Care: Prevention and Screening						
1	BCS	Breast Cancer Screening	Administrative	68.81%	74.11%	66%
2	COL	Colorectal Cancer Screening	Hybrid	64.72%	73.48%	62%
3	COA	Care for Older Adults - Advanced Planning - Medication Review - Functional Status Assessment - Pain Assessment	Hybrid	23.84% 89.78% 57.91% 88.32%	70.03% 95.73% 94.12% 96.84%	N/A 77% 71% 81%
Cardiovascular Conditions, Diabetes, Respiratory, Musculoskeletal Conditions						
	CBP	Controlling High Blood Pressure	Hybrid	63.26%	70.8%	62% (From Stars 2019)
	SPC	Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy - Statin Adherence 80%	Administrative	91.62% 83.66%	80.94% 81.08%	79% N/A
	CDC	Comprehensive Diabetes Care - BP Control (<140/90) - Eye Exam - HbA1C Control (<8%)	Hybrid	67.64% 79.81% 65.69%	70.13% 75.67% 69.1%	N/A 69% N/A
	SPD	Statin Therapy for Patients with Diabetes - Received Statin Therapy - Statin Adherence 80%	Administrative	79.29% 84.37%	74.12% 78.17%	N/A N/A
	PCE	Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid - Bronchodilator	Administrative	70.31% 89.06%	72.8% 81.32%	N/A N/A
	ART	DMARD for Rheumatoid Arthritis	Administrative	95.31%	78.05%	74%
4	OMW	Osteoporosis Management in Women Who Had a Fracture	Administrative	30%	48.48%	41%
Behavioral Health						
	AMM	Antidepressant Medication Management—Continuation Phase	Administrative	57.92%	56.6%	N/A
15	FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Administrative	85.98%	29.65%	N/A

#	Measure Acronym	Measure	Measure Type Methodology	Final rate in CY 2019	National 50 <sup>th</sup> Percentile	3-Star Cut Point
17	FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence— 7 days—Total	Administrative	10%	7.38%	N/A
Medication Management and Care of Coordination						
18	TRC	Transition of Care 65+ <ul style="list-style-type: none"> <li>- Notification of Inpatient Admission</li> <li>- Receipt of Discharge Information</li> <li>- Patient Engagement After Inpatient Discharge</li> <li>- Medication Reconciliation Post-Discharge</li> </ul>	Hybrid	34.06% 41.85% 86.62% 67.88%	5.9% 2.59% 80% 46.07%	N/A N/A N/A N/A
	FMC	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions—65+ years	Administrative	55.93%	54.85%	N/A
Access/Availability of Care						
19	IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment— Engagement of Treatment	Administrative	3.41%	3.88%	N/A
Risk Adjusted Utilization						
20	PCR	Plan All-Cause Readmissions—Observed Readmission Rate--Total— 65+ years	Administrative	14.20%	16.39%	N/A
21	EDU	Emergency Department Utilization—Observed Visits/1,000 Members— Total—65+ years	Administrative	26.37	388.4	N/A
22	AHU	Acute Hospital Utilization— Observed Discharges/1,000 Members—Total Acute— 65+ years	Administrative	12.55	183.38	N/A
23	HPC	Hospitalization for Potentially Preventable Complications—Observed Total ACSC Discharges/1,000 Members—Total	Administrative	1.67	33.38	N/A

#	Measure Acronym	Measure	Measure Type Methodology	Final rate in CY 2019	National 50 <sup>th</sup> Percentile	3-Star Cut Point
<b>Overuse/Appropriateness</b>						
	PSA	Non-Recommended PSA-Based Screening in Older Men	Administrative	18.73%	27.6%	N/A
	DDE	Potentially Harmful Drug Disease Interactions in Older Adults—Total	Administrative	30.14%	40.22%	N/A
	DAE	Use of High-Risk Medications in Older Adults	Administrative	No rate	N/A	N/A
	HDO	Use of Opioids at High Dosage	Administrative	7.90%	4.28%	N/A
	UOP	Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies	Administrative	2.56%	1.02%	N/A
<b>Health Outcome Survey &amp; CAHPS</b>						
25	FRM	Fall Risk Management	HOS	NA	N/A	54%
26	PNU	Pneumococcal Vaccination Status for Older Adults	CAHPS	76.85%	N/A	N/A
27	FVO	Flu Vaccinations for Adults Ages 65 and Older	CAHPS	83%	N/A	N/A
28	MSC	Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit	CAHPS		N/A	N/A

SCFHP tracked and trended the HEDIS measures to identify barriers for quality improvement to reach the national benchmark 50<sup>th</sup> percentile.

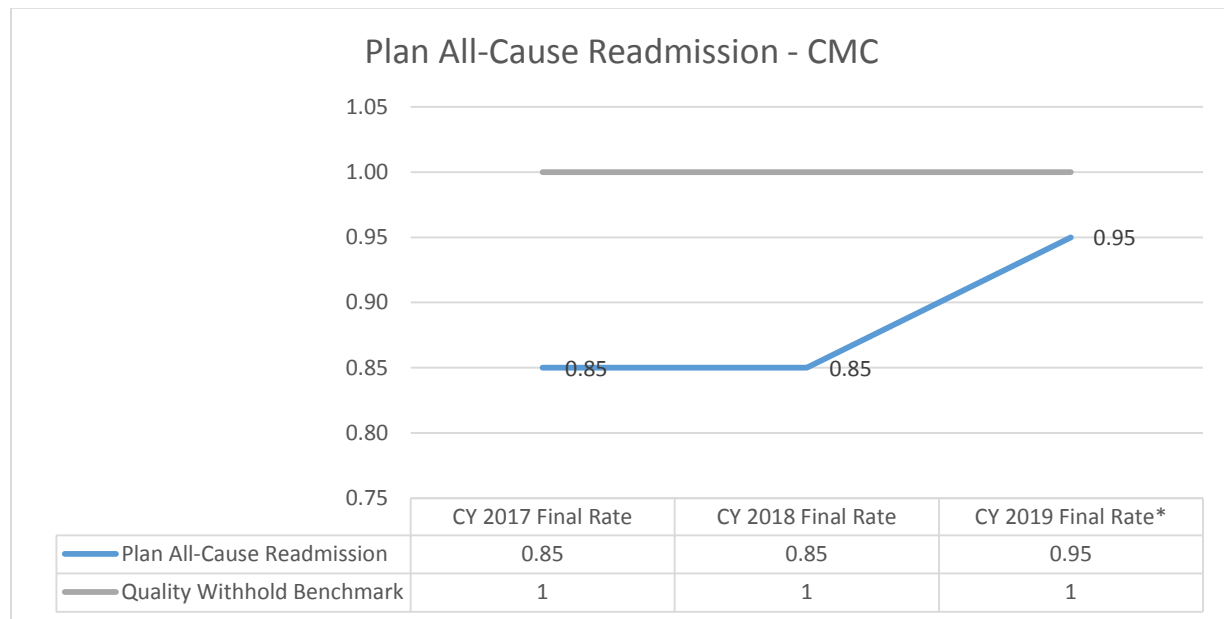
Besides providing education to members on importance of managing disease, preventive health and well-being through newsletters, providers were also educated on proper documentation and coding. In 2020, SCFHP conducted 2,096 in-home assessment to provide clinical assessment and health services by physician or nurse practitioner to member’s home prior to COVID-19 pandemic.

During in-home assessment, physician or nurse practitioner assess member’s health and safety, including but not limited to functional status, preventives services, physical and mental screenings, and medication review. The assessment is shared with member’s assigned PCP for coordination of care.

In addition, a care gap list is also provided to PCP for follow-up to address the missing service.

## 1. Plan All-Cause Readmission

The table below shows the ratio of the plan's observed readmission rate to the expected readmission rate. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.



\* Methodology changed in CY 2019 to remove outlier members from the final rate

**CY 2019 Goal: 1.0**

**CY 2019 Rate: 0.95**

### Analysis:

The PCR rate met the goal of having a ratio of observed to expected visits below 1. The methodology of this measure changed in measurement year 2019 to remove outlier members from the final rate. The main barrier for this measure is lack of timeliness of notification of discharge.

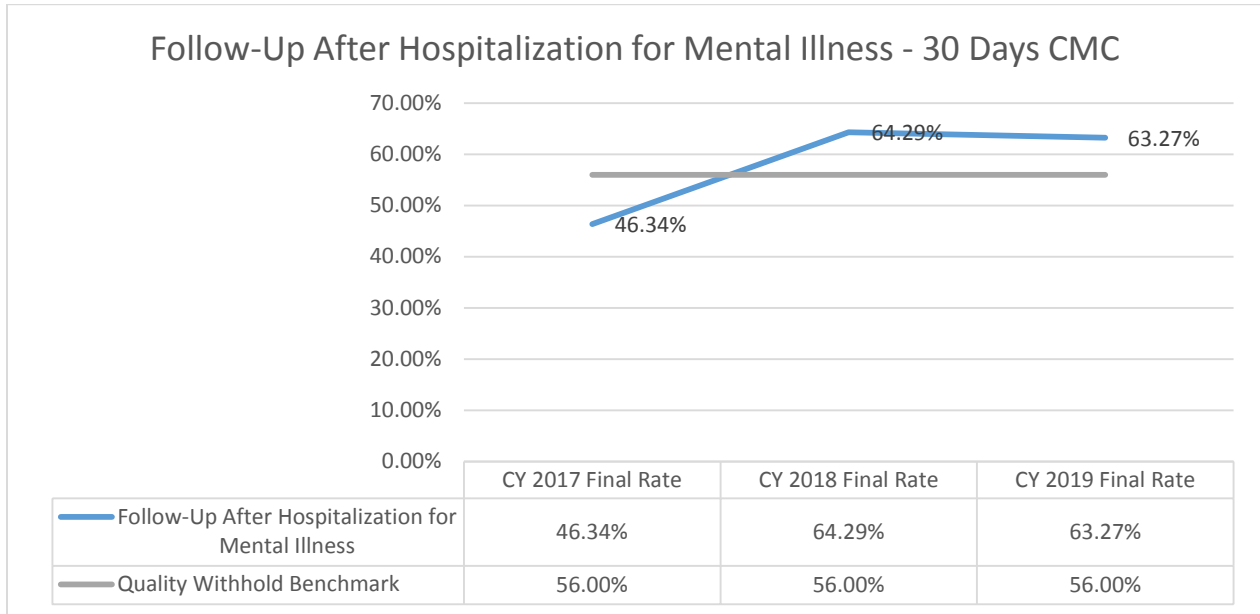
A cross-functional work group was set up, comprised of representatives from Utilization Management (UM), Case Management (CM), Quality and Information Technology (IT) departments for barrier analysis. Transition of Care (TOC) continued to complete follow up calls to members within 72 hours post discharge. Responsibility was redistributed from Case Management team to Utilization Management team due to limited staff resources to accommodate and the TOC task in April 2020. Notification letters were sent to PCPs with discharge information in an SBAR format for post discharge follow-up. IT infrastructure was built obtaining census data on admission and discharge from majority of the contracted hospitals.

### Follow-up & Strategies to be considered for future years:

SCFHP continues 2020 interventions and improve the census data on admission and discharge from contracted hospitals to address the barrier.

## 2. Follow-up After Hospitalization for Mental Illness

Discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.



**CY 2019 Goal:** 56%

**CY 2019 Rate:** 63.27%

The rate for this measure dropped slightly (about 1%) compared to the previous calendar year. However, the Quality Withhold benchmark was still met, with the final rate being 7% higher than the benchmark.

SCFHP selected this measure as a Chronic Care Performance Improvement Project in 2020.

SCFHP realized that inconsistent data and communication was received from the Santa Clara County Behavioral Health Department. The efforts made by the SCFHP behavioral health team, including keeping track of admission and discharges to Santa Clara Valley Medical Center, collaboration with acute social work staff on the barriers to follow up care prior discharge, and completing the transition of care (TOC) outreach once discharged, have shown to be successful. The outcomes were as follows:

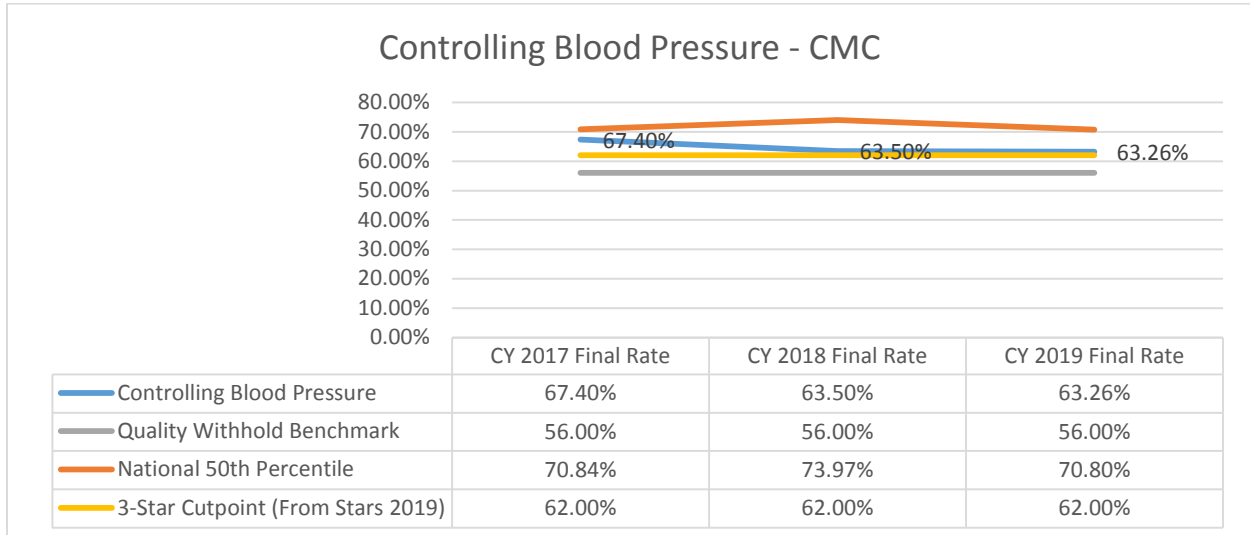
	Baseline 11/01/2017- 10/31/2018	Year 1 2/15/2019-2/14/2020	Year 2 2/15/2020-3/14/2021
Numerator	19	7	2
Denominator	44	9	2
Result	46.18%	77.78%%	100%

In measurement year 2 (2/15/2020 – 3/14/2021), there were 2 eligible members and both cases received completed TOC outreach. The number of discharges to home from SCVMC was smaller in 2020 than the previous measurement year. Assuming that the COVID-19 pandemic has changed health care access and processes, members who may have increased symptoms either do not present to services out of fear or there is no community/family available to witness the current unstable symptomology requiring an admission. Another factor may be that symptoms are more severe due to the pandemic so fewer members are discharged to home and are instead transferred to a lower level of care such as crisis residential or IMD setting.

The plan has identified best practices by developing coordination between the health plan behavioral health worker and the acute psychiatric social worker at the facility. Post discharge communication with the outpatient behavioral health treatment team has benefited the TOC transition process. The best practices have impacted smooth transition and communication for successful TOC. Although the admission rate is low, the practices of addressing barriers to care, coordination of discharge, maximizing current health plan benefits such as transportation and PCP appointments will continue to be practiced going forward.

### 3. Controlling Blood Pressure

Members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled.



**CY 2019 Goal:** 56%

**CY 2019 Rate:** 63.26%

**Analysis:**

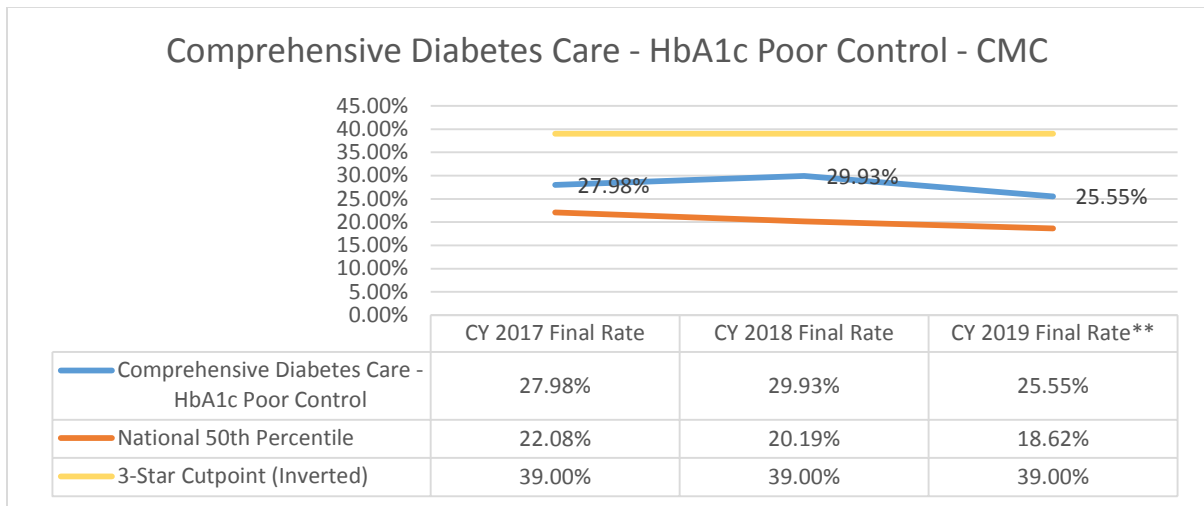
CBP met the Quality Withhold benchmark of 56% as well as the CMS Star Rating 3-star cut point (62%). However, it was short by 7.54% to reach the national 50<sup>th</sup> percentile. CBP is a hybrid measure and data is obtained for the sample during the HEDIS medical record review period. It is challenging to monitor and identify whether members have controlled blood pressure. During chart review, SCFHP identified that BP was not rechecked even if the first reading was >140/90 mmHg. Secondly, the care team did not initiate or intensify treatment during office visits if member’s BP was not at goal. Thirdly, there was poor patient participation in self-management behaviors.

Providers were encouraged to utilize telehealth for hypertension follow-up. They were also educated on proper coding and how to prescribe home blood pressure monitor to hypertensive member in order to submitting BP readings as supplemental data.

**Follow-up & Strategies to be considered for future years:**

- Ensure members have blood pressure monitors for home monitoring and reporting BP result to their PCP during telehealth follow-ups
- Health education for members on how to use BP monitors at home so they know their BP reading

#### 4. Comprehensive Diabetes Care – HbA1C Poor Control



*\*\* Repeated Stars benchmark for CY 2018 and CY 2019 as CY 2019 was not yet available*

**CY 2019 Goal: 39%**

**CY 2019 Rate: 25.55%**

#### Analysis:

CDC – HbA1C Poor Control (<9%) is a hybrid inverted rate measure. It scored 25.55% and met the CMS Star Rating 3-star cut point (62%). However, the rate was 6.93% below the national 50<sup>th</sup> percentile. The rate for this measure improved by 4.38% points from the previous year. This could be due to improved medication adherence for diabetes medications. CDC is a hybrid measure. Though SCFHP improved the data and received HbA1C results from a majority of the laboratories, the data are still incomplete. During analysis, 34.31% of the 411 sampled members had an HbA1C value higher than 8.

Member education on the importance of HbA1C testing through newsletter was published. Providers are encouraged to offer a standing lab order of HbA1C test. Member & Provider Newsletters on the importance of Diabetes care were published in fall. Providers are encouraged to submit HbA1C results and coding in encounter and/or supplemental data.

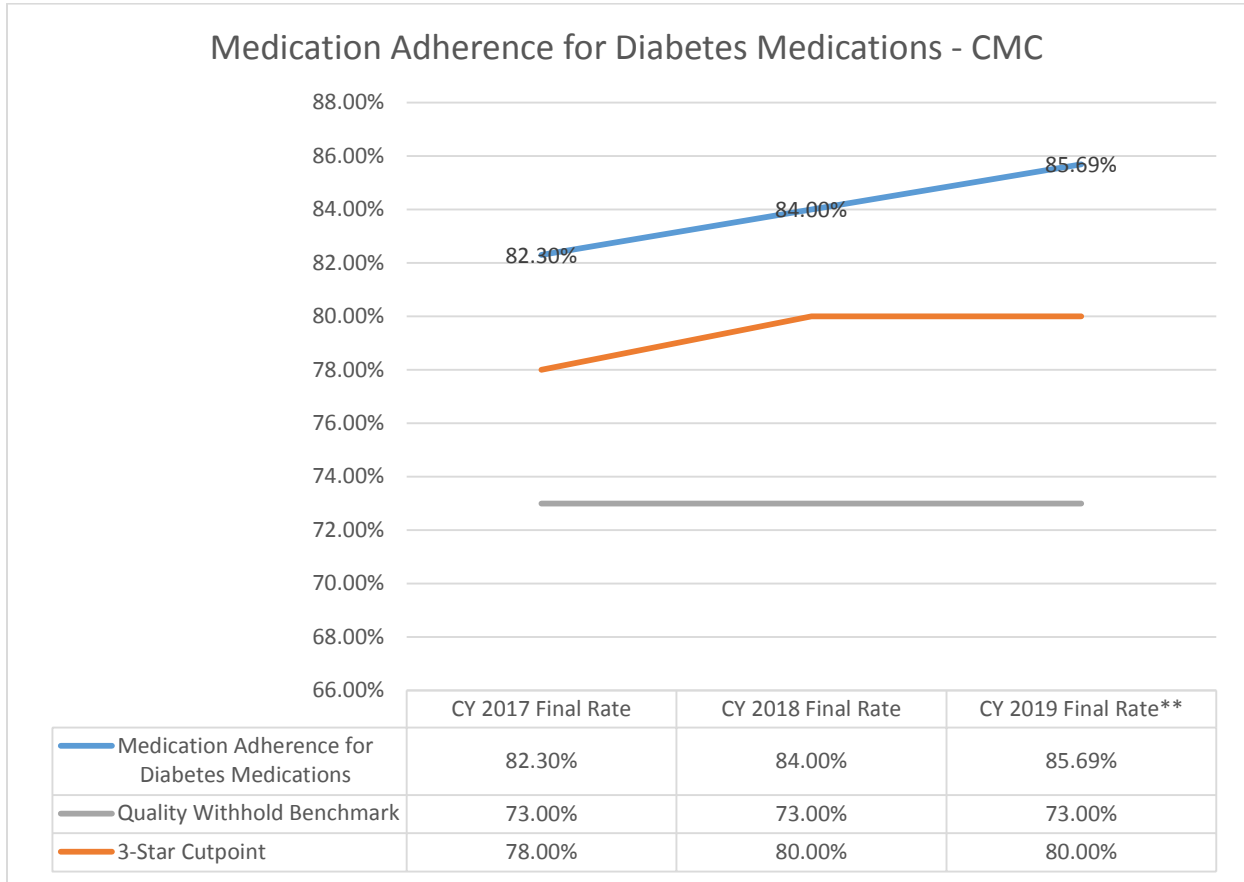
#### Follow-up & Strategies to be considered for future years:

- Improve supplemental data for HbA1C results
- Promote Diabetes Self-Management Education and Medical Nutrition Therapy to members with uncontrolled diabetes



## 5. Medication Adherence for Diabetes Medications

Members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.



\*\* Repeated Stars benchmark for CY 2018 and CY 2019 as CY 2019 was not yet available

**CY 2019 Goal:** 73%

**CY 2019 Rate:** 85.69%

### Analysis:

The rate for medication adherence for diabetes medications improved by 1.69% compared to the previous year. The Quality Withhold benchmark and the 3-Star cut point were both met for this measure.

Providers are encouraged to prescribe mail order and 90-days' supply of hypoglycemic medication to members, especially during COVID-19 pandemic.

### Follow-up & Strategies to be considered for future years:

- Continue to encourage the 90-days supply and mail order

## **B. QUALITY IMPROVEMENT PROJECT (QIP)**

SCFHP conducted Performance Measure Plan-Do-Study-Act (PDSA) QIP and COVID-19 Quality Improvement Plan (QIP) in 2020.

### **1. Performance Measure Plan-Do-Study Act (PDSA) Process QIP 2020**

For 2020, SCFHP implemented a Plan Do Study Act (PDSA) rapid cycle project that focused on preventive care of cervical cancer (CCS) and chlamydia (CHL) screening. The first cycle of the PDSA was implemented from October 1, 2020 to December 31, 2020. The global aim for the PDSA was to increase CCS and CHL measures to meet the minimum performance level of 60.58% and 58.33% respectively, for HEDIS 2021.

124 members were identified as non-compliant for both CCS and CHL screenings. Outreach efforts included warm calls to members with health education information and assistance with scheduling PCP appointments, with the goals that both screenings would be completed in one visit. Outreach staff were provided with a call script and asked to make at least 3 attempts to each member. Female staff were used to discuss both visits in detail to make the member felt more comfortable. The smart objective for this cycle was that 20% of the 124 (or 25 out of 124) identified members will respond by securing an appointment with QI Outreach Staff or schedule on their own with their PCP or GYN for CCS and CHL screenings by December 31, 2020.

A total of 227 calls were made for all 3 attempts. 135 voicemails or messages with family/household were left (59%), 23 members declined the service (10%), 35 members Outreach staff was unable to reach due to disconnected or wrong phone number or no voicemail (15.3%), while 20 members (8.7%) stated they had already completed the screening.

A total of 11 members were scheduled for appointments and another 5 indicated they recently scheduled their own appointment with their provider, totaling 16 members. SCFHP did not meet the 20% goal, but noted a 12.9% increase attributed to the intervention.

This PDSA cycle continues into 2021 and will run from January 1, 2021 to April 30, 2021.

### **2. COVID-19- Quality Improvement Plan (QIP) for 2020**

Due to the COVID-19- pandemic in 2020, DHCS required managed care plans to develop strategies and conduct interventions that support efforts to improvement member accessibility to preventive health services. As a part of the requirement, SCFHP was required to submit an initial description of interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care to members amidst COVID-19. A 6-month progress update on the interventions and/or strategies was also required to be submitted. The intervention period was October 1, 2020 to February 28, 2021. SCFHP focused on three strategies to increase the provision of healthcare services to members.

The first strategy was to maximize telehealth utilization during and beyond COVID-19 pandemic. Outreach calls were conducted to members with diagnoses of asthma, hypertension, and diabetes. Members were encouraged to schedule telehealth appointments and were provided information about SCFHP's 24/7 Nurse Advice Line. Overall, 2,753 members were on SCFHP's outreach call lists. 324 appointments or refills were scheduled as a result of outreach. 166 calls were made to the Nurse Advice Line. Telehealth appointments were also promoted to SCFHP's provider networks. Overall, 3,753 telehealth appointments were scheduled.

The second strategy was to maximize pharmacy benefits to eliminate the anxiety of members' access to medication and reduce the incidence of human-to-human coronavirus infections. 9,986 Medi-Cal providers used e-prescribing for 121,743 Medi-Cal members from October 1, 2020 to December 31, 2020. 79 hypertensive members received prescriptions for blood pressure cuffs.

The third strategy was to promote virtual health education to strengthen prevention of health and wellness and self-management of chronic illness. 4 out of 10 health education vendors started providing virtual classes, including: chronic illness self-management, asthma management, stress management and healthy living style during the QIP timeframe. 11 members were enrolled into the American Heart Association's hypertension workshops. 8 members were enrolled in Diabetes Self-Management Education program and 14 members were enrolled in the Medical Nutrition Therapy program.

This QIP is continuing till 2021 for second submission on progress update on the interventions and strategies.

## **C. PERFORMANCE IMPROVEMENT PROJECT (PIP)**

### **1. Disparity Performance Improvement Project**

The Disparity PIP focused on an identified health disparity based on, but not to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider or geographic area.

SCFHP has identified Adolescent Well Care Visit aged 19 – 21 to be Disparity Performance Improvement Project.

In Module 1 of the Disparity PIP, the SMART aim goal was defined as “By June 30, 2021 increase the percentage of adolescent well-care visits among individuals ages 19-21 in Network 20 Valley Health Plan from 16.7% compliance rate to 22.5% compliance rate.” The SMART aim goal’s baseline 16.7% identified 3,911 eligible members and 655 members in network 20 who have had at least one comprehensive well-care visit with a PCP during the measurement year. The goal was establish based on the 2019 HEDIS 25<sup>th</sup> percentile. Module 1 was validated on January 28<sup>th</sup>, 2020.

During module 2, the process map, FMEA and key drivers were developed and identified. The key drivers were to increase low participation rate in AWC visits, improve member awareness, and member’s appointment coordination. The plan developed gift card incentive program to promote the participation rate, clinic days to increase member awareness and educate the members on the importance of the visits. Module 2 was completed and validated on May 20<sup>th</sup>, 2020.

Though Disparity PIP that initiated in October, 2019 discontinued on June 30, 2020 as a result of the COVID-19 public health crisis following the direction of DHCS, SCFHP planned to continue this topic.

### **2. Childhood Health - Well-Child Visits in the First 15 Months of Life (W15) PIP**

SCFHP has identified that Well Child Visits in the First 15 months of life (W15) is a measure that needed additional focus as it had a low compliance rate and was a priority measure for the Plan.

During Module 1 of Childhood Health PIP, the SMART aim goal was “By June 30<sup>th</sup>, 2021, increase the percentage among Well-Child Visits in the First 15 month of Life (W15), from 35.11% compliance rate to 58.54% compliance rate in network 50 - Physician Medical Group”. The SMART aim baseline 35.11%, is comprised of 601 total eligible members in network 50 and 211 compliant members who have had at least 6 or more well-child visit with their PCP during the first 15 months of life during the measurement year. Goal was establish based on the CY 2019 HEDIS data. Module 1 was validated on February 21, 2020.

In Module 2, a process map was developed and failure modes and effects analysis (FMEA) was identified as well as the key driver diagram. The key drivers were to increase the W15 visit rate within the Physician’s Medical Group network, increase member awareness and to inform members of their scheduled visits and getting appointments scheduled. The plan developed incentive program to

increase the visit rates, visit coordination to ensure members attend the scheduled visit as well as scheduling the appropriate time. Module 2 was completed and validated on June 30<sup>th</sup>, 2020.

The Childhood Health PIP that initiated in October, 2019 discontinued on June 30, 2020 as a result of the COVID-19 public health crisis following the direction of DHCS. This measure was retired and modified into Well Child Visit in 30 months (W30).

#### **D. INITIAL HEALTH ASSESSMENT (IHA)**

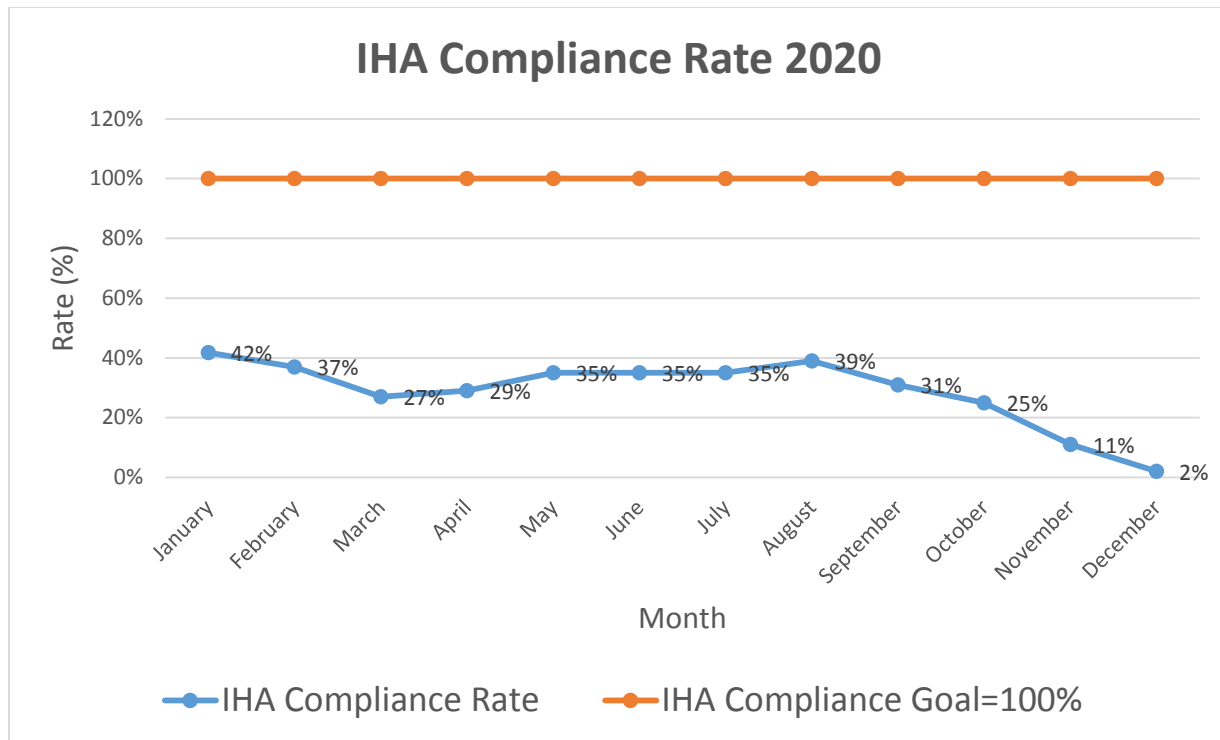
To ensure all SCFHP members complete an Initial Health Assessment (IHA) within 120 days of enrollment into the Plan and a Staying Healthy Assessment (SHA) form in accordance with the timeframes appropriate by age. The purpose of IHA is to enable a provider to comprehensively assess the member's acute, chronic, and preventative needs and coordinate member's needs with additional resources.

On an annual basis, SCFHP provides information regarding the IHA to plan members and providers in the member and provider newsletters and on the SCFHP website. SCFHP notify the newly assigned member to schedule a visit with the Primary Care Provider (PCP) within 120 days for an IHA by sending the welcome packet.

SCFHP promotes provider education for the IHA to its delegates and independent network providers. SCFHP incorporated IHA requirements in the provider packet to educate the provider on the importance of completing IHA. A training manual for the provider network was created to inform providers on the requirement and benefit of outreach to their new members. Provider network representatives promote provider portal use for new member assignments.

Facility site review nurses remind providers on IHA during Facility site review. The Plan monthly runs IHA compliance reports and conducts IHA medical record review quarterly to closely track the IHA compliance rate. Plan annually review IHA policy & procedure to incorporate new changes and improve overall IHA performance. The case manager reminds Seniors and Persons with Disability (SPD) members on IHA during Health Risk assessment screening. The health plan worked with the Long Term Support Service (LTSS) team to educate Skilled Nursing Facility (SNF), on IHA completion of Medi-Cal members.

The health plan monthly runs claims and encounter data to monitor the IHA compliance rate. A new methodology was implemented in 2020. Therefore, trending was not possible with the 2019 IHA rate. The rate for October to December 2020 is not accurate as claims are not complete for the last quarter of 2020. Based on the current rates, the Q2 (33%) compliance rate is lower than Q1 (35.33%) due to Public Health Emergency (PHE). IHA compliance rate picked up in Q3 (35%), as members started feeling more comfortable seeing providers in person or via tele-visit.



Each quarter, SCFHP’s QI Nurse randomly select 10 providers. Out of those 10, we then choose 5 members from each provider for review of IHA completion. In total, we reviewed 50 charts for IHA each quarter. Our list of providers comes from claims and/or encounter data. Out of those 50 requests, we received 40 responses in Q1, 45 in Q2, and 49 in Q3.

Credit can be given if a minimum of two outreach attempts to reach the members are documented in the medical record. In Q1, 31 charts needed outreach attempt as members didn’t establish care with a PCP. No outreach attempts were documented in the medical record. 37, and 26 charts needed an outreach attempt in Q2, and Q3, respectively. Only 3 charts in Q2 and 1 chart in Q3 had the documentation of the outreach attempts.

The score of most of the chart elements is at or above 50% except SHA. SHA remains the element with the greatest opportunity for improvements. None of the providers scored greater than 80% compliance rate; hence, education requires all the providers selected for IHA review, primarily due to missing SHAs. Adult visits are the most consistently fully compliant records. Missing mental status is the most common reason for the incomplete physical criteria.

Record retrieval remains problematic. 4 providers did not submit any response to IHA medical record requests. The health plan will provide IHA education material to all the providers. No CAPs were issued as DHCS temporarily suspending the requirement to complete an IHA, for any members newly enrolled in the MCP between December 1<sup>st</sup>, 2019, and the end of the public health emergency.

The health plan identified provider level, member level, and system-level barriers. The provider does not always check the health plan portal regularly for the newly assigned members list to initiate IHA outreach. Lack of documentation of outreach attempts in the medical record makes provider IHA non-compliant.

Lack of provider training on IHA requirements is one of the barriers. Limited staff in the clinic to support

providers on IHA due to Public Health Emergency (PHE). Inaccurate demographic information makes it difficult to reach out to Medi-Cal members to schedule appointments.

Members are hesitant to schedule visits with PCP due to Public Health Emergency. Many times members change their PCP in the first 120 days, which does not allow enough time for a visit to be scheduled with the PCP. Members may have other barriers, including getting to an appointment that is outside SCFHP's control.

Provider Network Operation team continue to encourage the provider to use the provider portal for newly enrolled member lists and the importance of documentation of outreach attempts in the medical record. QI team continues to provide ongoing support and education based on the provider's feedback. Provider network representatives continue to provide IHA education to providers upon on-site visits once the PHE is lifted.

The health plan published provider news articles throughout 2020 for providers and members on the importance of IHA. The health plan continues to work with the IHA collaborative workgroup every quarter to improve the overall IHA compliance rate.

QI Nurses continue to audit medical records to validate IHA compliance and report results to the Quality Improvement Committee. QI Nurses continue to work with the Provider Network Management team to train providers and delegates on the DHCS IHA requirement.



## E. Health Outcomes Survey (HOS)

SCFHP participates in the Medicare Health Outcomes Survey (HOS) to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement.

Each year a random sample of Medicare beneficiaries is drawn and surveyed from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees. In 2020, SCFHP received the 2017 -2019 Cohort 20 performance measurement response rate of 59.1%, with 220 eligible samples and 130 respondents. Compared to the HOS follow up response rate of 67.4% the plan’s response rate is 8.3% lower.

In response to the impact of the COVID-19 Public Health Emergency (PHE), administration of the 2020 HOS took place from August to November 2020 in accordance with the revised 2020 HOS Program Timeline.

The 2019 survey administration used the HOS 3.0 that was implemented in 2015. The HOS 3.0 uses the Veterans RAND 12-Item Health Survey (VR-12) as the core physical and mental health outcomes measures, and the four HEDIS Effectiveness of Care measures are Management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women. Outcomes would be available in Cohort 22 follow up report in 2022.

The trends in Physical Health results and Mental Health results performance was as expected in Cohort 20.

Trends in Physical Health Results over Three Cohorts are as below:

	Percent Better	Percent Same	Percent Worse	Percent Better + Same	Performance Result
<b>2017-2019 Cohort 20</b>	12.95%	60.40%	26.65%	73.35%	As expected (same as national average)
<b>2016-2018 Cohort 19</b>	15.20%	61.97%	22.83%	77.17%	As Expected (same as national average)

Trends in Mental Health Results over Three Cohorts are as below:

	Percent Better	Percent Same	Percent Worse	Percent Better + Same	Performance Results
<b>2017-2019 Cohort 20</b>	21.62%	61.73%	16.65%	83.35%	As expected (same as national average)
<b>2016-2018 Cohort 19</b>	15.21%	79.93%	10.86%	89.14%	Performed Better

The general health performance in the follow up group increased 3.2% to be in fair or poor condition compared to one year ago is about the same increase when compared to California overall performance at 2.4% increase and HOS total. Physical performance in slightly worse or much worse compared to one year ago, the Plan had 4.6% increase. Compared to California and HOS total at 2% and 3.6% increase. In the mental health comparative performance the plan had 2.6% increase when compared to one year ago in slightly worse and much worse condition. The California increase was lower at 1.9% and 1.8% in HOS total. The category can perform assumption at greater risk of mortality.

	General Health Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
SCFHP	50.0%	53.2%	39.7%	44.3%	23.6%	26.2%
California	30.5%	32.9%	28.2%	30.2%	14.0%	15.9%
HOS Total	23.8%	26.2%	23.6%	27.2%	10.5%	12.3%

The higher percentage of multiple (2 or more) chronic medical conditions table members can indicate the increase risk of the following outcomes: mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests and conflicting medical advice. The plan had an improvement with 2.7% decrease when compared to California and HOS total performance with 1.8% and 1.7% increase respectively.

	Multiple Chronic Medical Conditions	
	Baseline	Follow Up
SCFHP	79.7%	77.0%
California	75.1%	76.9%
HOS Total	76.1%	77.8%

The Healthy Days Measures served as indicators of populations with greater risk for disease or injury. In the 14 or more days of poor physical health, mental health, or activity limitations are considered indicative of poor well-being, the plan performed above the same compared to the baseline. When compared to slight increased percentage in California and HOS Total performance with 0.6% and 1.5% increase. The plan had 1.4% decreased in 14 or More Days of Poor Mental health while California and HOS Total had slight increase at 0.3% and 0.9% respectively. In the 14 or More Days of Activity Limitations the plan had 3.4% increase while California had 0.8% increase and 1.3% increase in HOS Total. The performance can be used to identify beneficiaries in poor health who may have undiagnosed conditions or are having difficulty managing stress or chronic diseases.

Healthy Days Measures						
	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental health		14 or More Days of Activity Limitations	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
SCFHP	37.4%	37.7%	20.2%	17.8%	22.0%	25.4%
California	20.6%	21.2%	12.6%	12.9%	14.1%	15.0%
HOS Total	17.8%	19.3%	9.6%	10.5%	11.9%	13.2%

The Body Mass Index (BMI) chart can identify the unhealthy weight range and are associated with increased chronic diseases, and in the case of the underweight, increased mortality for the elderly. The plan has a higher increase in underweight group at 3.9%, when compared to 0.6% and 0.4% increase in California and HOS Total. The percentage of overweight increased 3% and in California and HOS total had 0.5% and 0.9% decrease. The obese group stayed the same at 25.5%. Both California and HOS Total had 1.1% and 0.5% decrease.

	Underweight		Overweight		Obese	
	BMI<18.5		BMI 25 to 29.99		BMI > 30	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
SCFHP	1.8%	5.7%	30.0%	33.0%	25.5%	25.5%
California	2.5%	3.1%	35.8%	35.3%	25.3%	24.2%
HOS Total	1.7%	2.1%	37.8%	36.9%	31.6%	31.1%

SCFHP identified opportunities for our Cal MediConnect members to reduce health disparities and explore potential programmatic interventions aimed at maintaining or improving the overall health of the population. Quality Department tracked and trended member outcomes and experiences of care to address ongoing improvement. Cross-functional departments worked closely to implement an innovate care management approach. The Health education team found an extensive variety of resources to enhance patient education and care, offering health classes whose subjects range from physical activity, to wellness program; provide weight loss program; distribute newsletters to discuss topics important to a specific segment of the population and ensure that education is culturally appropriate.

### 3. PATIENT SAFETY

#### A. FACILITY SITE REVIEW & MEDICAL RECORDS REVIEW

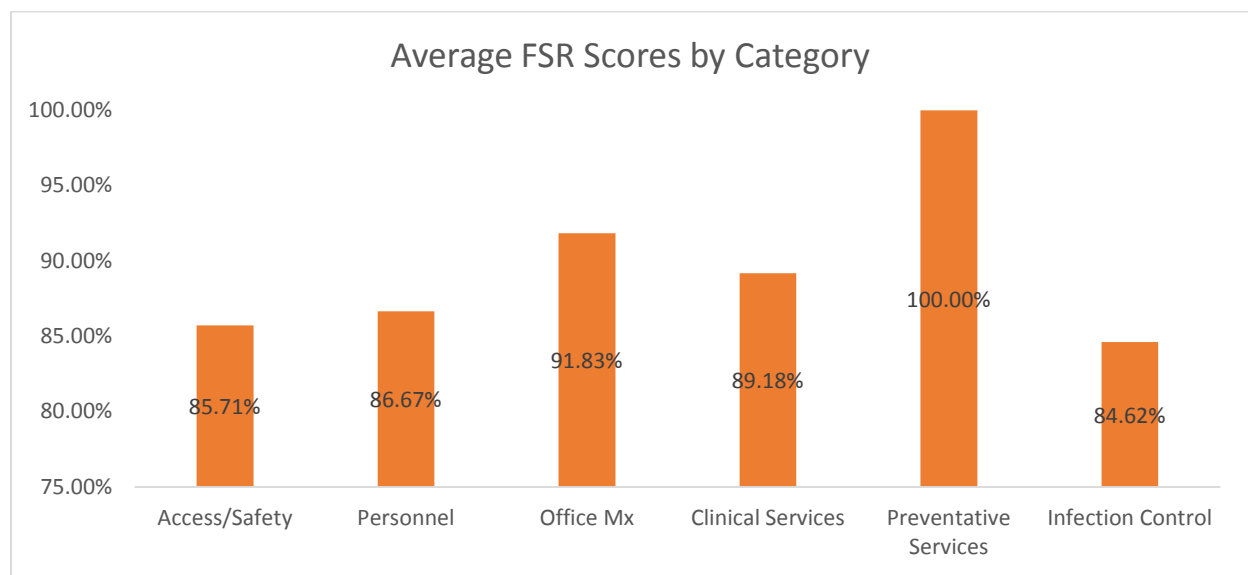
All contracted SCFHP Primary Care Providers (PCP's) receive Part A Facility Site Review (FSR), Part B Medical Records Review (MRR), and Part C Physical Accessibility Survey (PAR) evaluation every three years. All newly contracted SCFHP PCP's must complete and pass FSR Part A and C before being contracted with the plan. FSR Part B is completed within 90 days of the effective date. SCFHP PCPs who move office locations are reviewed within 30 days of the date QI is notified of the move.

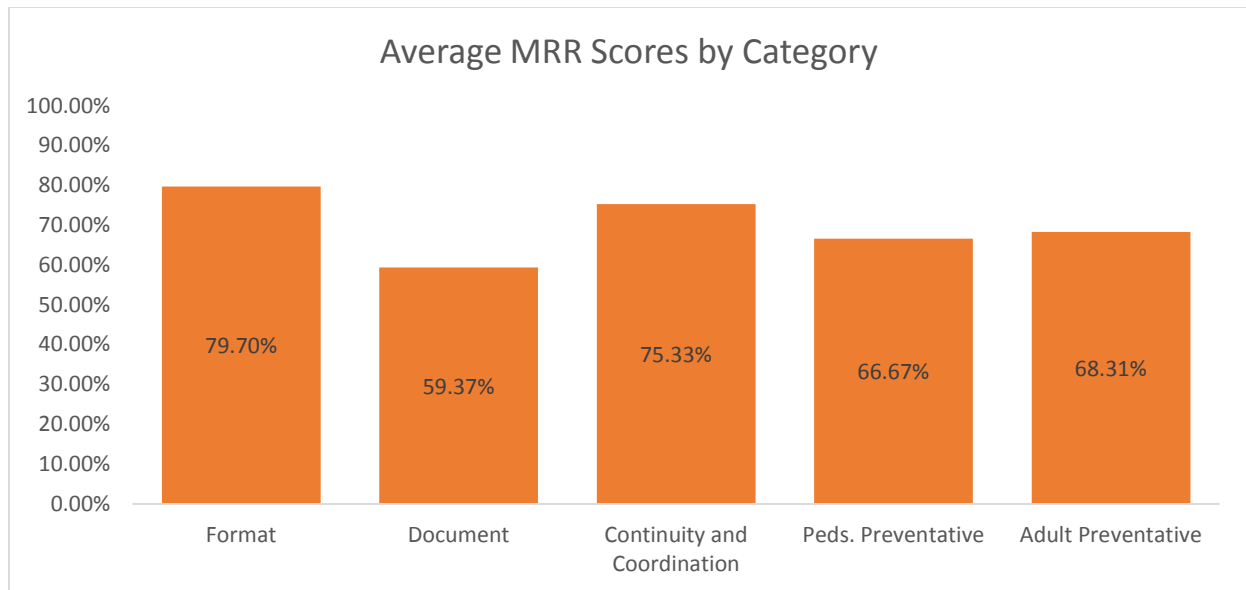
PCPs that score below 80% is monitored more frequently. If critical elements of deficiencies are identified, a score in any section of the site or medical record review below 90%, or there is a deficiency in Pharmacy or Infection Control or an overall score below 90%, then a Corrective Action Plan (CAP) is requested to be completed by the providers. SCFHP reviews the sites more frequently when determined based on monitoring, evaluation, or CAP follow-ups needs. QI Nures monitor CAPs.

SCFHP works collaboratively with Anthem Blue Cross on shared primary care provider facilities to minimize the audit duplication and support consistency of reviews in Primary care facilities.

SCFHP was only able to conduct 6 facility site visits (Part A, B, and C) in 2020 due to Public Health Emergency (PHE). Of the 6 Facility Site Reviews completed in 2020, the average Facility Site Review (FSR) score was 98%, and Medical Record Review (MRR) score was 85%. Out of 6, 2 provider sites have basic physical access, and 4 sites have limited physical access.

Three providers exempted passes FSR and MRR requirements. Three FSR and MRR corrective action plan issued, monitored, validated, and closed. The facility site review deficiencies were mainly identified among Infection control, access/safety, and Personnel criteria. The most common medical record review deficiencies were identified among document, adult, and pediatric prevention criteria.





#### Common Deficiencies identified in Facility Site Review:

- A written policy on referrals are not available
- Lack of Emergency medical supplies and emergency medication
- Needle stick safety precautions are not practices on site.
- Blood, other potentially infectious materials, and Regulated Wastes are not appropriately placed in leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
- Specialized equipment such as scales, EKG's is not always calibrated.
- There is no evidence that staff has received training and/or information on different topics such as infection control, biohazard waste handling, child/elder/domestic violence abuse, Patient confidentiality, etc.

#### Common Deficiencies identified in Adult Medical Record Review:

- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed
- TB risk assessments are not always documented
- Advance care directives are not documented in the medical record
- Adult immunization
- Vaccine Information Statement documentation is not completed
- Completion of Initial Health Assessment within 120 days of enrollment
- Referral for Breast and cervical cancer screening are not documented in the medical record

#### Common Deficiencies identified in Pediatric Medical Record Review:

- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed
- VIS documentation is not completed

SCFHP collaborated with Anthem Blue Cross to obtain results of site reviews as tonot duplicate site reviews of the same providers. There were 2 initial FSRs which were exempted pass and no correction

action plans required.

QI Nurses continue to work on FSR/MRR/PAR database software for use by reviewers in the office via the web interface. FSR staff attends mandated DHCS Site review workgroup meetings to stay connected with new changes from DHCS. SCFHP published a provider news article on the new FSR and MRR tool in June 2020. The new FSR and MRR tool and the guidelines are available on the SCFHP's website.

SCFHP's DHCS Master Trainer retired in July 2020. Master Trainer gave diabetic training on FSR, MRR, and PAR to the health plan's 2 potential site review nurses. SCFHP recently contracted with a Site Review Nurse Consultant to conduct pending site reviews.

SCFHP was not able to conduct on-site and virtual site visits between March-December 2020 due to extenuating circumstances surrounding COVID-19 and Public Health Emergency Orders. SCFHP defined the process to conduct virtual FSR in 2021.

## B. PROVIDER PREVENTABLE CONDITIONS (PPCs)

SCFHP tracked Provider Preventable Conditions by number of cases each month, number of cases per hospital to see any trends. There were total 89 cases in 2020. 71 were Medi-Cal and 18 were Medi-Cal-Connect.

Hospital	Number of Cases
SCVMC ACUTE CARE HOSPITAL	16
STANFORD MEDICAL CENTER HOSPITAL	13
REGIONAL MEDICAL CENTER OF SJ	10
EL CAMINO HOSPITAL-MOUNTAIN VIEW CAMPUS	5
O'CONNOR HOSPITAL	5
CAMDEN POST ACUTE CARE INC	4
THC-ORANGE COUNTY, LLC, KINDRED HOSP-SAN FRANCISCO BAY AREA	3
O'CONNOR HOSPITAL SNF-SUBACUTE	3
EL CAMINO HOSPITAL-LOS GATOS CAMPUS	3
VASONA CREEK HEALTHCARE CENTER	3
WHITE BLOSSOM CARE CENTER	2
THE RIDGE POST-ACUTE	2
KAISER HOSPITAL - SAN JOSE	2
SAINT LOUISE REGIONAL HOSPITAL	2
JOHN MUIR MEDICAL CENTER - HOSPITAL	1
PACIFIC HILLS MANOR	1
INTERMOUNTAIN MEDICAL CENTER	1
ASPEN RIDGE WEST	1
PETALUMA VALLEY HOSPITAL	1
CANYON SPRINGS POST-ACUTE	1
GOOD SAMARITAN HOSPITAL	1
MISSION SKILLED NURSING CENTER	1
SCVMC REHABILITATION UNITS	1
NATIVIDAD MEDICAL CENTER - SALINAS	1
IDYLWOOD CARE CENTER	1
CUPERTINO HEALTHCARE	1
EL CAMINO HOSPITAL - PSYCHIATRY UNIT	1
KAISER HOSPITAL - SANTA CLARA	1
AMBERWOOD GARDENS	1
LUCILE PACKARD CHILDREN'S HOSP	1

SCFHP also tracked the count of cases by Provider Preventable Conditions. The top conditions were catheter-associated urinary tract infection with 74 cases, comprised of 83.14% of 89 cases.

<b>Condition</b>	<b>Number of cases</b>
Catheter-associated urinary tract infection	74
Stage III or IV pressure ulcers	8
Vascular catheter-associated infection	2
Deep vein thrombosis/pulmonary embolism	1
Falls/trauma	1
Foreign object retained after surgery	1
Iatrogenic pneumothorax with venous catheterization	1
Manifestations of poor glycemic control	1
Surgical site infection	1

In 2020, the plan resolved the issue with obtaining the PPC report and redefined procedures. QI nurses are expecting to investigate cases as PQI, including but not limited to: wrong surgery/invasive procedure, surgery/invasive procedure on the wrong body part and wrong patient. There were no cases identified in 2020.



### **C. POTENTIAL QUALITY CARE OF ISSUES (PQI)**

The Potential Quality Issue (PQI) is a suspected deviation from the standard performance, clinical care, or outcome of care, requiring further investigation to determine whether the issue is substantiated to quality of care or opportunity for improvement.

The SCFHP PQI process aim is to identify, address, investigate, report, and resolve any potential quality of care issues (PQI) to ensure that services provided to members meet established professional quality of care standards and improve member outcomes. This includes Critical Incidents (CI) and Provider Preventable Conditions (PPC's).

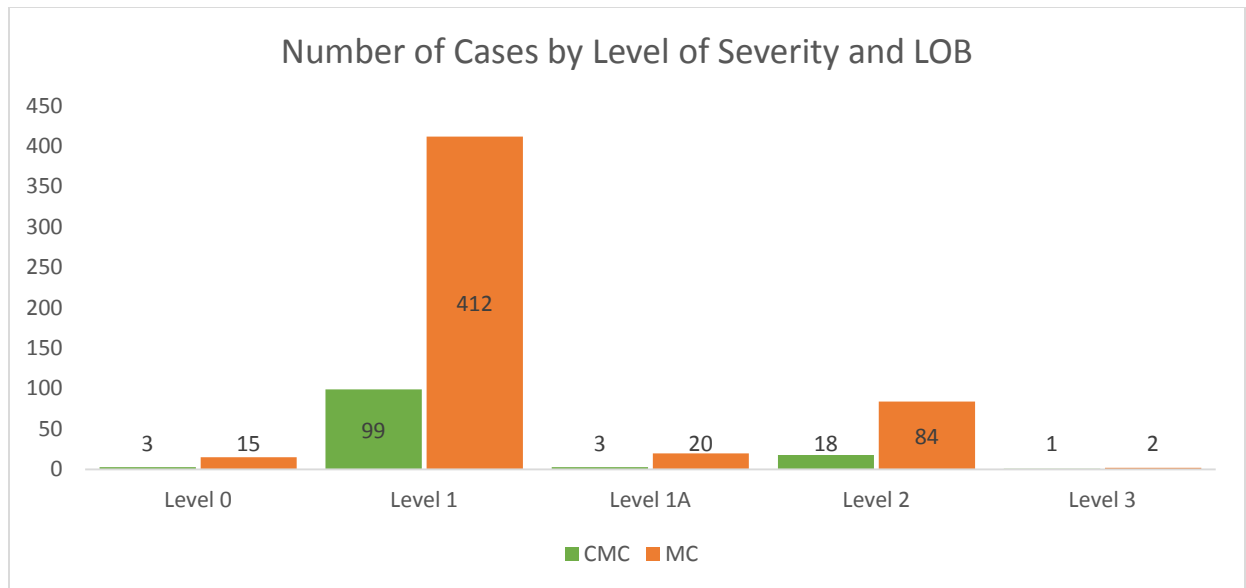
Grievance and Appeal (G&A) clinical specialists review PQI referrals and all the grievances to identify PQI and notify QI coordinators to request medical records for review. QI nurses review each PQI and CI case with Medical Director, track, and trend. QI Nurses give PQI training annually to all the member-facing departments at the health plan. QI nurses quarterly submit PQI reports to the credential and peer review committee. QI nurses also report PQI cases to the health plan's delegate network for re-credential purposes.

QI nurses weekly review any PQI cases with Medical Director. The Medical Director makes the final determination and assigns a severity level to each PQI case.

Description of each severity level:

- Level 0: Not our member/Not our provider
- Level 1: Quality of Care is Acceptable
- Level 1A: No Quality of Care found
- Level 2: Opportunity for Improvement, no adverse occurrence
- Level 3: Opportunity for Improvement, adverse occurrence
- Level 4: Immediate Jeopardy

SCFHP investigated total 657 PQI cases in 2020. Of those 657 closed cases, 18, 511, 23,102, 3 were level 0, 1, 1A, 2 and 3, respectively. Total 3 CAPs were issued, monitored, validated, and closed in 2020. Out of 3, 1 was against a provider, 1 against a pharmacy, and 1 against Skilled Nursing Facility (SNF).



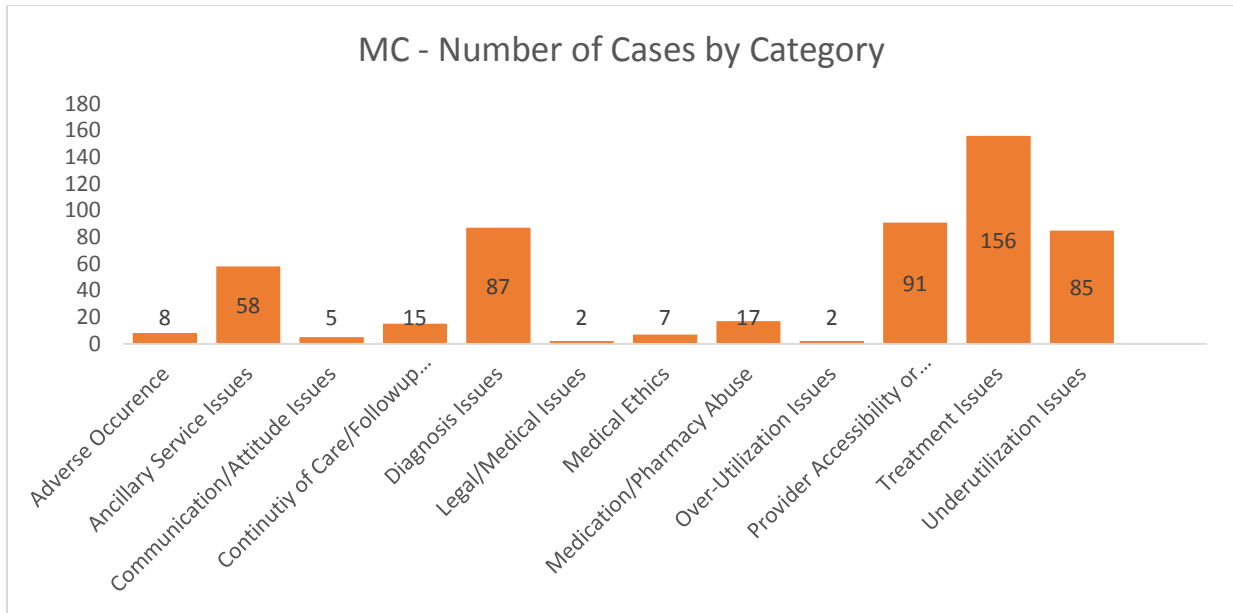
There was an increase in the number of PQIs in 2020 due to the following: increased grievances, process improvements, and improved communication between the Customer service team, Quality team, Grievance and Appeals team, and COVID-19 pandemic. The majority of PQIs reviewed were unsubstantiated or closed as Level 1- Quality of Care is Acceptable. The health plan defined the process to temporarily hold PCP auto-assignment based on the PQI cases closed at levels 2, 3 and, 4 with CAP. None of the PCP's auto-assignment was paused in 2020 by the health plan.

SCFHP identified 7 PQI's with critical incidents in 2020. Of those, 1 involved cab companies, 4 occurred at a skilled nursing facility (SNF), 1 involved a provider, and 1 involved a hospital. Critical Incidents are high-priority cases. Those cases against the SNFs were reported to the California Department of Public Health (CDPH) Licensing and Certification office in San Jose for investigation. SCFHP uses those findings to create a CAP. 2 CI cases were closed at level 2. Transportation-related CI PQI cases were referred to the provider network for further follow-up. One SNF level 2 case was referred to the LTSS team to provide education to SNF staff on safe discharge planning and encourage SNF on accurate documentation of medical records. Following levels were assigned to critical incident cases:

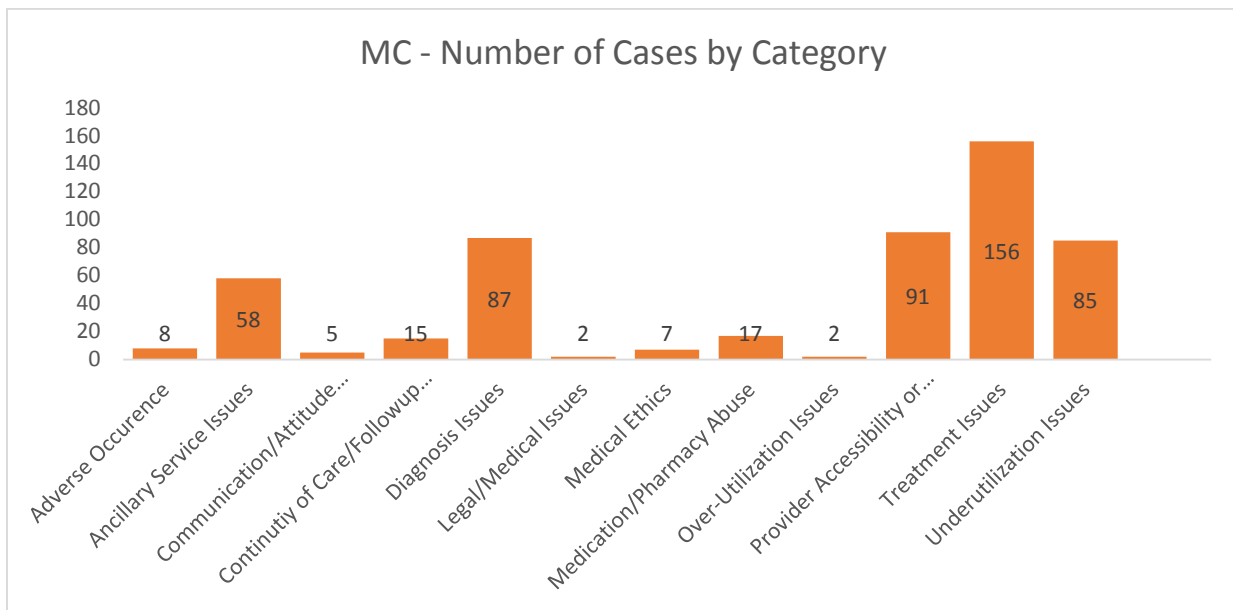
- Level 0- 1, no CAP
- Level 1- 4, no CAP
- Level 1A- 0
- Level 2- 2, no CAPs
- Level 3- 0
- Level 4- 0

QI Nurses assigns quality indicator to each PQI cases to determine the type of PQI.

The chart below showed the number of Medi-Cal PQIs by category. Treatment, access, and diagnosis-related PQI are primarily identified among Medi-Cal line of business.



The chart below showed the number of 3 represents the number of Cal MediConnect PQIs by category. The most common type of PQI among Cal- MediConnect LOB is treatment, diagnosis, and ancillary service related issues.



SCFHP continues to monitor the numbers and categories of PQI to improve our member safety and satisfaction.

#### 4. TIMELY ACCESS & AVAILABILITY

SCFHP makes every effort to ensure that its members receive timely access to appointments, medical services and after-hours care. When appointment and after-hours access are not being met, an analysis of findings is conducted and a corrective action plan is required (when applicable). Access reporting monitoring activities are reviewed in the Timely Access & Availability (TAA) Work Group and Quality Improvement Committee (QIC). The Work Group is represented by the following departments: Provider Network Operations, Quality, Utilization Management, Customer Service, Behavioral Health, Compliance, Grievance/Appeals, Contracting, and Marketing. The TAA work group and QIC reviews, evaluates, and makes recommendations as needed.

Refer to attachment for detailed report.



Accessibility of  
Provider Network An

Santa Clara Family Health Plan (SCFHP) administers Cal MediConnect (CMC); a dual eligible plan for members who qualify for both Medicare and Medi-Cal.

CMC enrollees receives Medicare and Medi-Cal benefits from one plan, such as, medical care, prescription medications, mental/behavioral health care, long-term services and supports (LTSS), and connection to social services. Other important benefits include vision care, transportation and hearing tests and aids.

Medi-Cal enrollees receive accessible, and cost-effective health care through managed care delivery systems. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

At least annually, SCFHP conducts a quantitative analysis against availability standards and a qualitative analysis on performance. SCFHP's performance measures are used to assess provider availability for primary care, high volume specialist(s), high impact specialist(s), and high volume behavioral health providers. SCFHP's goal is to maintain an adequate network and monitor how effectively the network meets the needs and preferences of its members.

For the CMC line of business, SCFHP identifies at least three (3) high-volume specialists (at minimum to include gynecology), two (2) high-volume behavioral health providers, and one (1) high impact provider (oncology), all of which are included in this assessment. Encounter data collection to identify high volume/impact providers is through QNXT; a claims management system. SCFHP's Internal Systems & Technology (IS&T) department extracts encounter data for a twelve (12) month period. The reports are used to identify high volume/impact specialists and behavioral health providers by the highest total of unique members seen. Network Access (Geo Access) reports are generated through the Quest Analytics system and are used to assess if provider availability meets SCFHP standards.

For the MC line of business, SCFHP follows the annual network certification procedure.

Refer to attachment for detailed report.



Availability of  
Provider Network An

## V. MEMBER EXPERIENCE

### A. CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

#### Medi-Cal

SCFHP conducted NCQA HEDIS 2019 Consumer Assessment of Healthcare Providers & Systems (CAHPS) 5.0H Child and Adult Medicaid survey in following DHCS direction every 2 years. The last CAHPS was conducted in 2019.

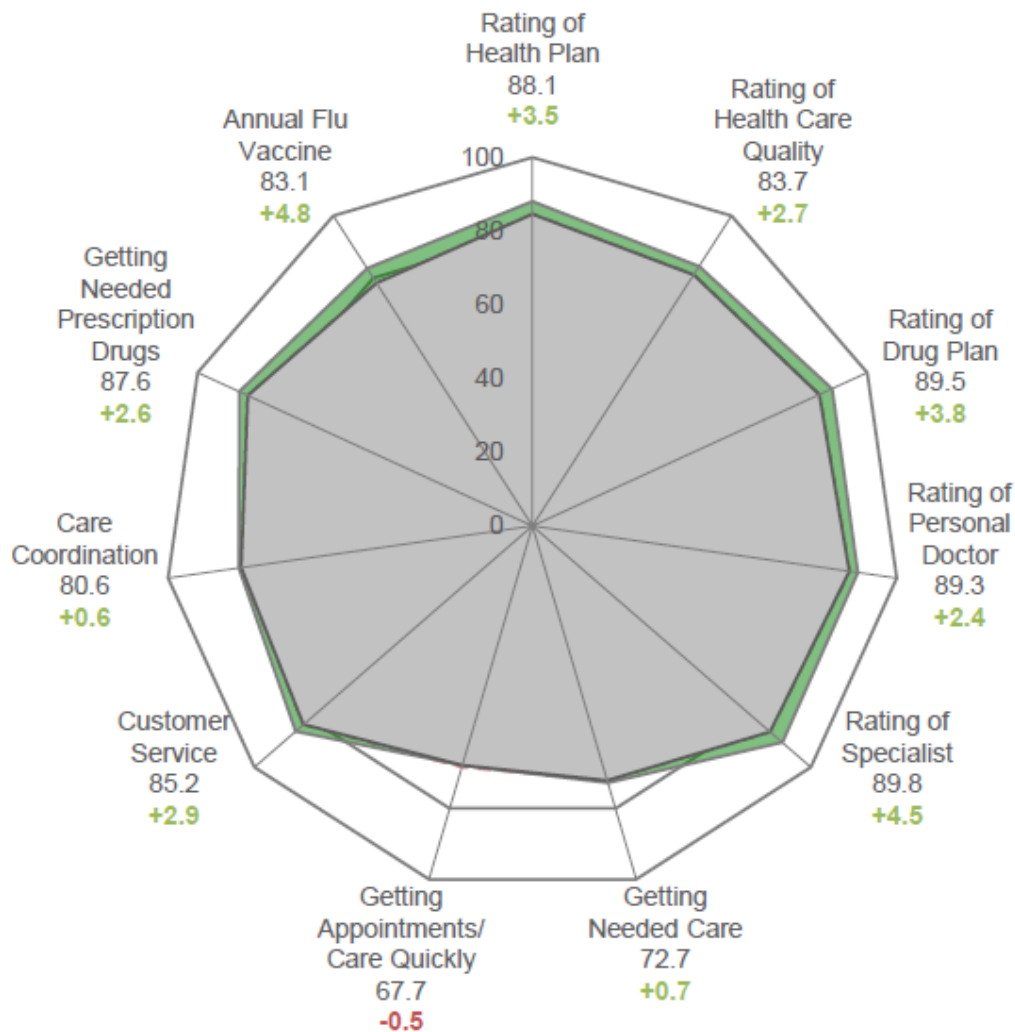
The next CAHPS will be conducted in 2021.

#### Cal MediConnect

SCFHP utilizes Consumer Assessment of Healthcare Providers & Systems (CAHPS) results to improve member satisfaction and use results to compare to Medicare Medicaid Plan's (MMP) National Data Benchmark average scores in all categories to reach health plan improvement and increase member satisfaction annually.

In 2020, the Plan response rate was 29.1%, which is a 0.3% increase over prior year, there were only 2 surveys completed by phone calls due to COVID-19 pandemic, all phone call operations were ceased. On March 30<sup>th</sup>, 2020, in accordance with CMS's request, all survey submissions were eliminated. Overall there were no significant changes compared to 2019; however there were moderate improvements and the gaps compared to 2019 results were closed in the following areas: Rating of Health Plan, Rating of Health Care Quality, Rating of Drug Plan, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Customer Service, Care Coordination Getting Needed prescription Drugs and Annual flu Vaccine.

Measure	Scaled Mean Scores 2020
Rating of Health Plan	88.1%
Rating of Health Care Quality	83.7%
Getting Needed Care	72.7%
Getting Care Quickly	67.7%
Customer Service	85.2%
Care Coordination	80.6%
Rating of Drug Plan	89.5%
Getting Needed Prescription Drugs	87.6%



SCFHP had the highest year-over-year increase in the Overall Rating of Drug Plan, improving from 85.7 in 2019 to 89.5 in 2020. This exceeded the vendor business MMP mean score and the 2019 CMS National Data benchmark. There were two questions that exceeded the CMS National Data benchmark in the following questions within the categories: Got help managing care and Ease of using health plan to fill prescriptions by mail.

The overall top three performing measures were the Rating of Health Plan, Rating of Health Plan and Rating of Specialist. The lowest three performing measures were Customer Service, Getting Needed Care and How Well Doctors Communicate.

The Plan's scores decreased from 2019 in Getting Appointments and Care Quickly. The Plan continues to educate providers and staff about Plan and regulatory appointment wait time requirement and standards for improvement opportunities.

The estimated star rating for NCQA Health Insurance for 2020 was not published by CMS due to COVID-19 but the health plan was able to complete the survey and in rating of health plan, flu vaccination (FVO), pneumococcal vaccination (PNU), advising smokers to quit (MSC). The results in 2020, rating of health plan scored 67.1% at 67<sup>th</sup> percentile. Flu vaccinations scored 84.9% ranking 90<sup>th</sup> percentile. Pneumococcal vaccination score 76.8% ranked 33<sup>rd</sup> percentile and advising smokers to quit scored 90.9% ranked 67<sup>th</sup> percentile. The plan will continue to evaluate and utilize the CAHPS score in NCQA accreditation.

SCFHP's response rate increased in 2020 to 29.1%, leveling the 2017 rate at 29%. The plan continued the implementation of 2 new survey languages (Chinese and Vietnamese). Providing the survey in Chinese significantly improved responses in 2020. The survey response rate increased from 0.65% in 2019 to 10.36% in 2020. The plan will continue to use this opportunity to improve response rate. There were no survey language barriers in the 2020 result compared to 55 surveys in 2019 and 116 surveys in 2018. The plan will look into adding Tagalog as a potential additional language.

Through the increase in responses, the Plan was able to obtain more actionable data, and the results continued to be categorized by provider groups. Since 2018, the plan had added more provider groups in 2019 and 2020. The stratified provider groups provided better understanding for the plan to better work with our partners to provide the best care to our members through provider education and have our provider network operations team to develop strategies to with our providers on providing timely access to care and getting needed care in time.



## B. GRIEVANCES & APPEALS

SCFHP's goal is to increase member satisfaction by addressing member grievances within mandated timeliness. Appeal and grievance data is reported on the company compliance dashboard and offers ongoing monitoring to rapidly identify variances and address the variances in a timely manner.

G&A Clinical Specialist conducted expedited review for any imminent and severe threat to health including but not limited severe pain, or potential loss of life, limb, or major body function for Medi-Cal.

5,234 grievances and appeals received in 2020, including 1225 grievance and 827 appeals from Cal MediConnect and 2037 grievance and 1145 appeals from Medi-Cal. The cases are classified among these 3 categories Access, Quality of Care and Quality of Service.

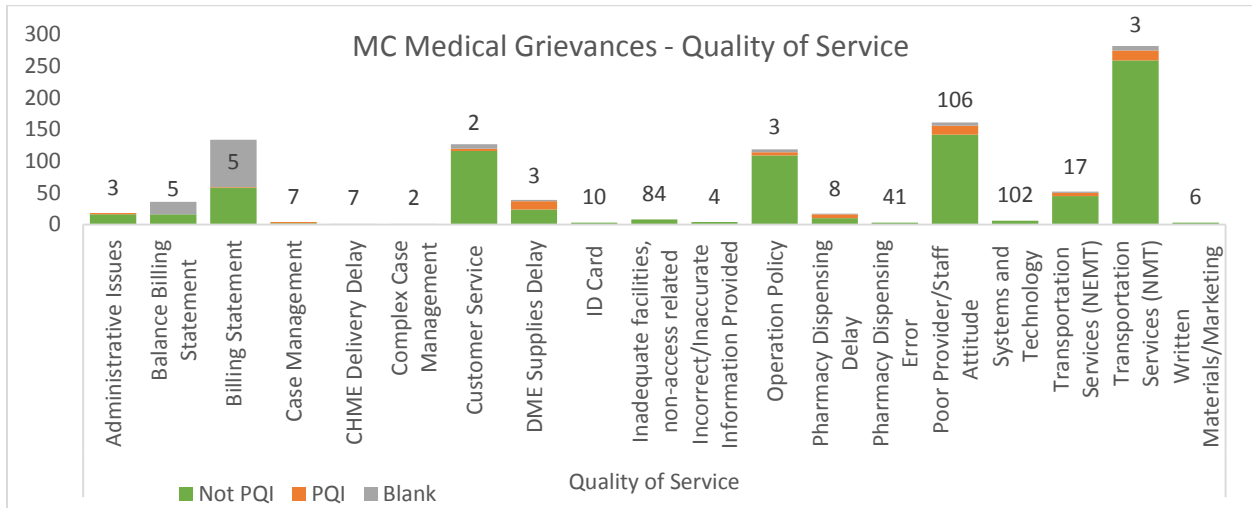
2020 showed an improved compliance rate of 98.0% for standard grievances and appeals resolved in the mandated time frames. This was an improvement of over 1.0 % from the prior year's rate of 97.0%. Improvement opportunity was found for the performing metric related to expedited grievances and appeals.

### Medi-Cal

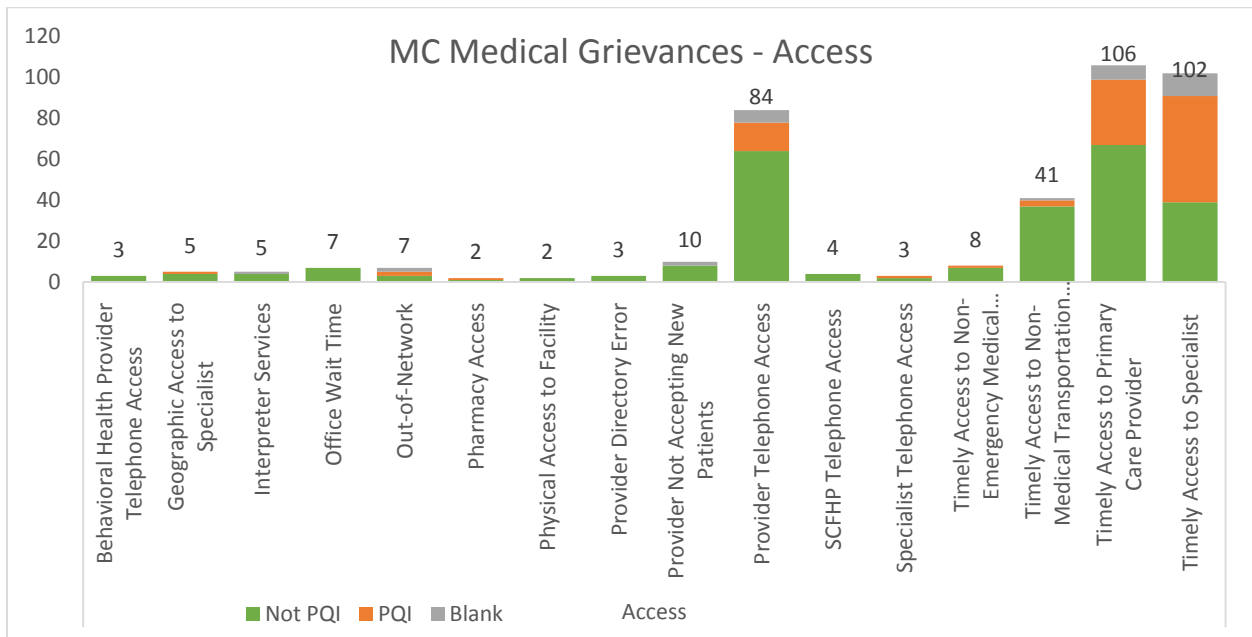
SCFHP monitored Medi-Cal grievances by category and subcategory from medical and pharmacy grievances.

Medi-Cal Grievance Category	Medical Grievance	Pharmacy Grievance	Total	Percentage
Quality of Service	1018	26	1044	51.25%
Access	392	5	397	19.49%
Quality of Care	349	17	366	17.97%
Referral	86	2	88	4.32%
Enrollment/Disenrollment	41	1	42	2.06%
Plan Benefits	39	2	41	2.01%
Other	29	1	30	1.47%
Compliance	26	2	28	1.37%
Marketing	1	0	1	0.05%
Grand Total	1981	56	2037	100%

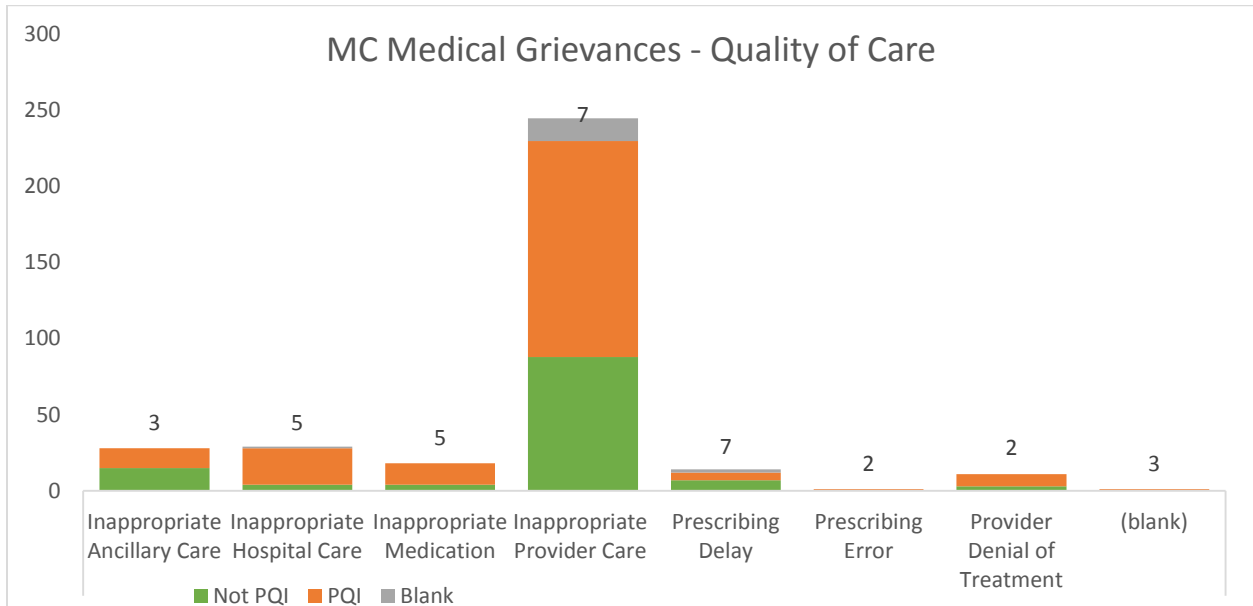
Transportation service (NMT) was the top subcategory for all medical grievances under quality of service in which comprised of 14% (282 cases). It is consistently the highest subcategory. SCFHP met with the transportation vendor regularly to determine the specific solutions to decrease overall grievances.



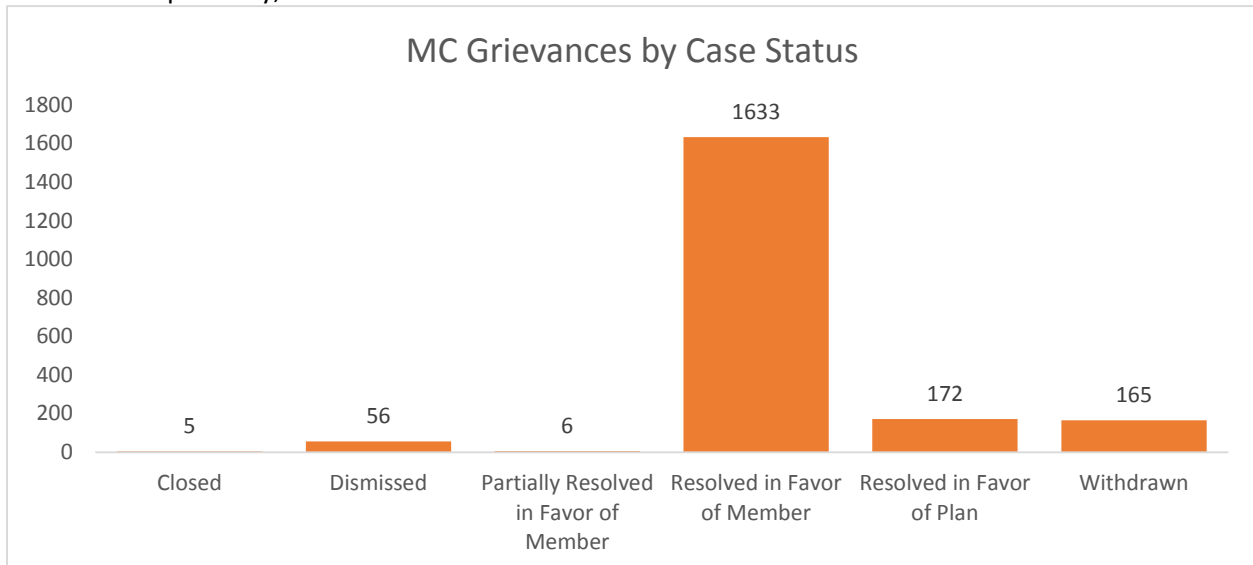
Timely access to primary care provider and specialist were the highest in Access category with 106 cases and 102 cases respectively. In 2020, appointment availability and timely access was due to the COVID-19 pandemic.



Third top category of medical grievances quality of care received the most grievance on inappropriate provider care which comprised of 12% of all grievances (245 cases). This was also the most referred cases for PQI.



All cases are reviewed and determined whether they required Potential Quality of Care review. Some cases could be withdrawn or had one or more related cases which PQI was reviewed on the “mother case”. 1,633 cases (80.17%) were resolved in favor member and 6 cases were partially resolved in favor of member. 172 cases were resolved in favor of plan. 165 cases and 56 cases were withdrawn and dismissed respectively, and 5 cases were closed.

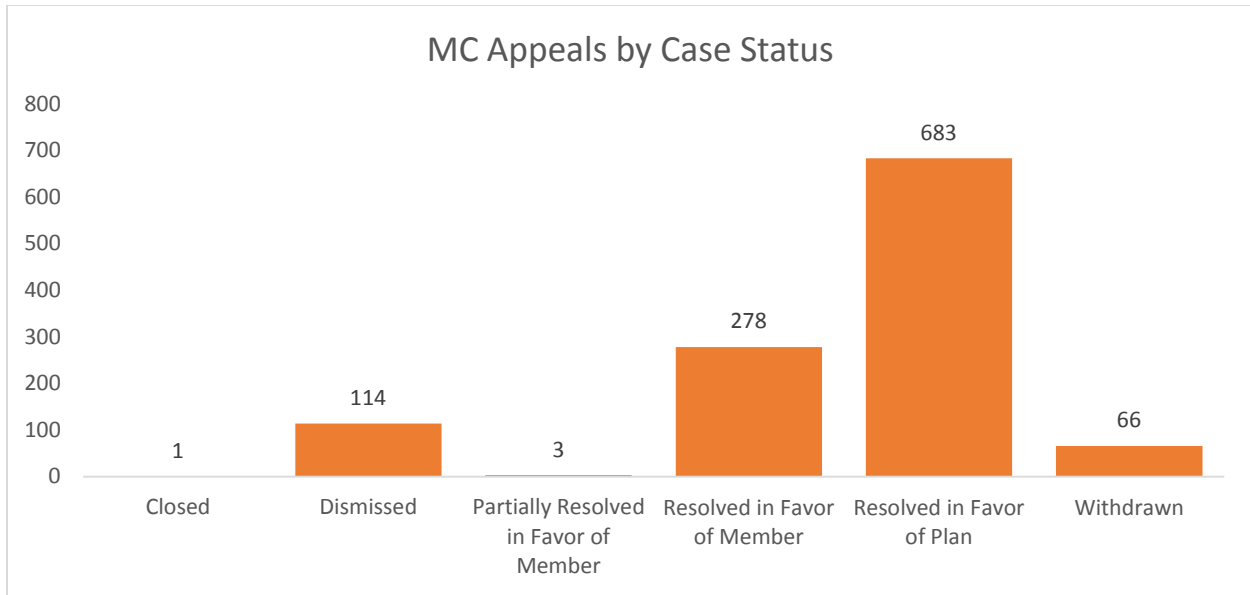


SCFHP tracks and trends all member appeals for each of the five categories: including. Authorization – covered service, Authorization – medical necessity, Continuity of Care, Covered Service, and Medical Necessity. The data below representative of total 1145 member appeals in 2020.

Case Type	Category Name	Grand Total
Medi-Cal Pre Service Pharmacy Appeal	Authorization (Medical Necessity)	538
	Authorization (Covered Service)	33
<b><i>Pre Service Pharmacy Appeal</i></b>		<b>571</b>
Medi-Cal Pre Service Medical Appeal	Authorization (Medical Necessity)	317
	Authorization (Covered Service)	196
	Continuity of Care	8
<b><i>Pre Service Medical Appeal</i></b>		<b>521</b>
Medi-Cal Post Service Medical Appeal	Medical Necessity	33
	Covered Service	15
<b><i>Post Service Medical Appeal</i></b>		<b>48</b>
Medi-Cal Post Service Pharmacy Appeal	Medical Necessity	4
	Covered Service	1
<b><i>Post Service Pharmacy Appeal</i></b>		<b>5</b>
<b>Grand Total</b>		<b>1145</b>

262 cases were overturned, 8 were partially favorable, 691 were upheld and 15 were withdrawn by the Plan/Medical Direction Disposition.

Case Status Name	Overturn	Partially Favorable	Uphold	Withdrawn	Other	Grand Total
Resolved in Favor of Plan	2		680		1	683
Resolved in Favor of Member	259	5	8		6	278
Dismissed	1		1		112	114
Withdrawn			2	15	49	66
Partially Resolved in Favor of Member		3				3
Closed					1	1
<b>Grand Total</b>	<b>262</b>	<b>8</b>	<b>691</b>	<b>15</b>	<b>169</b>	<b>1145</b>

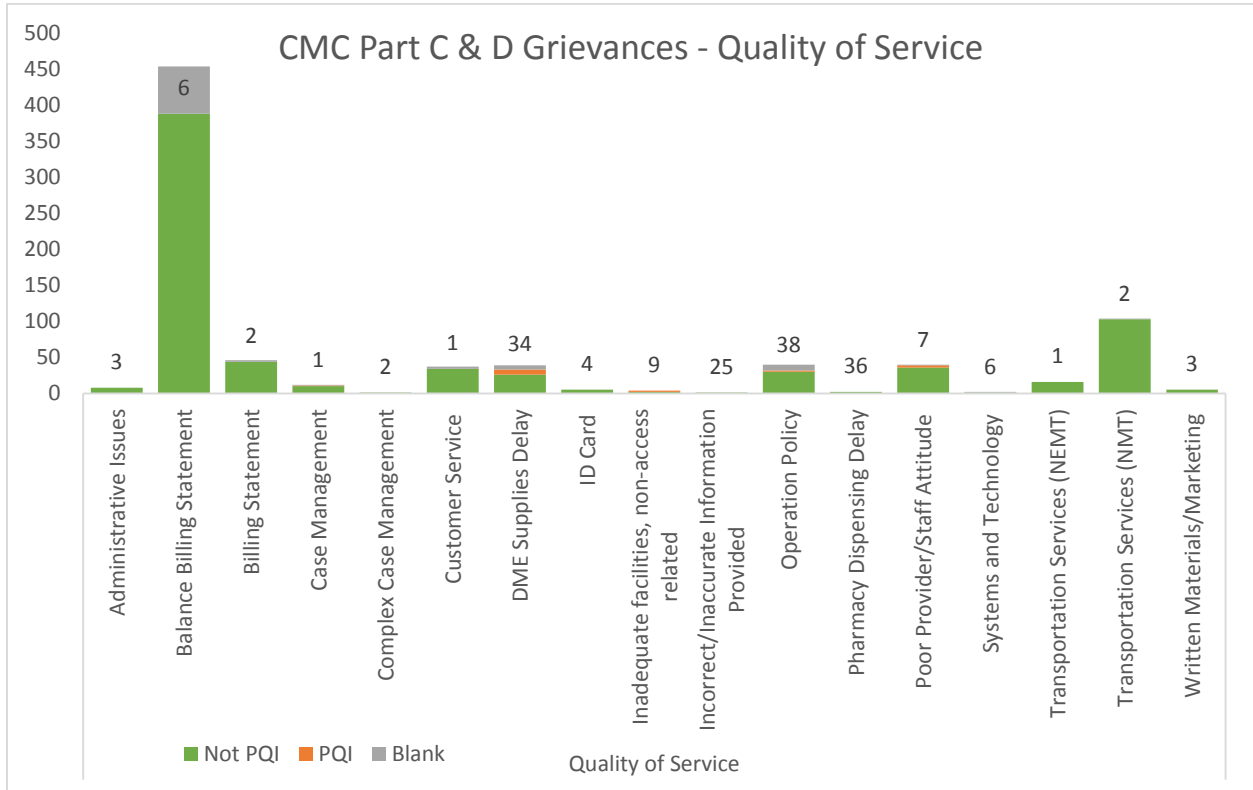


### Cal MediConnect

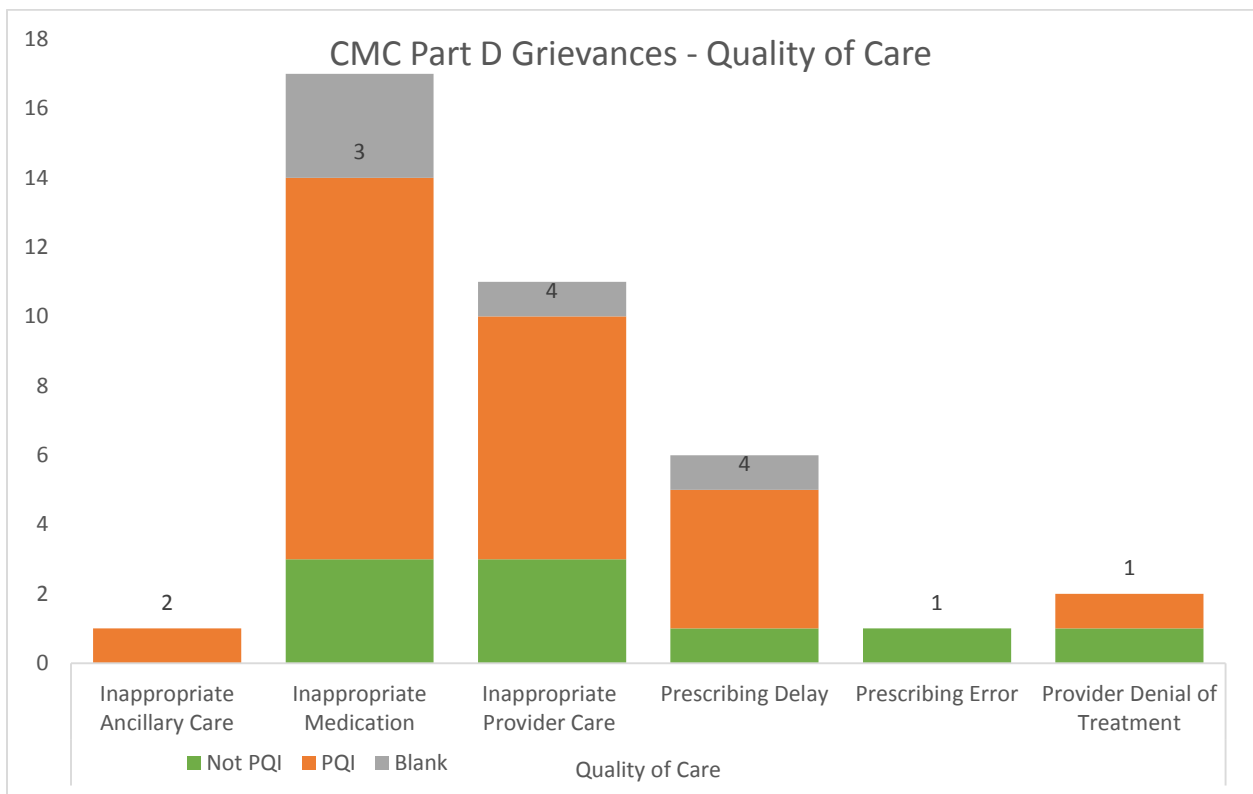
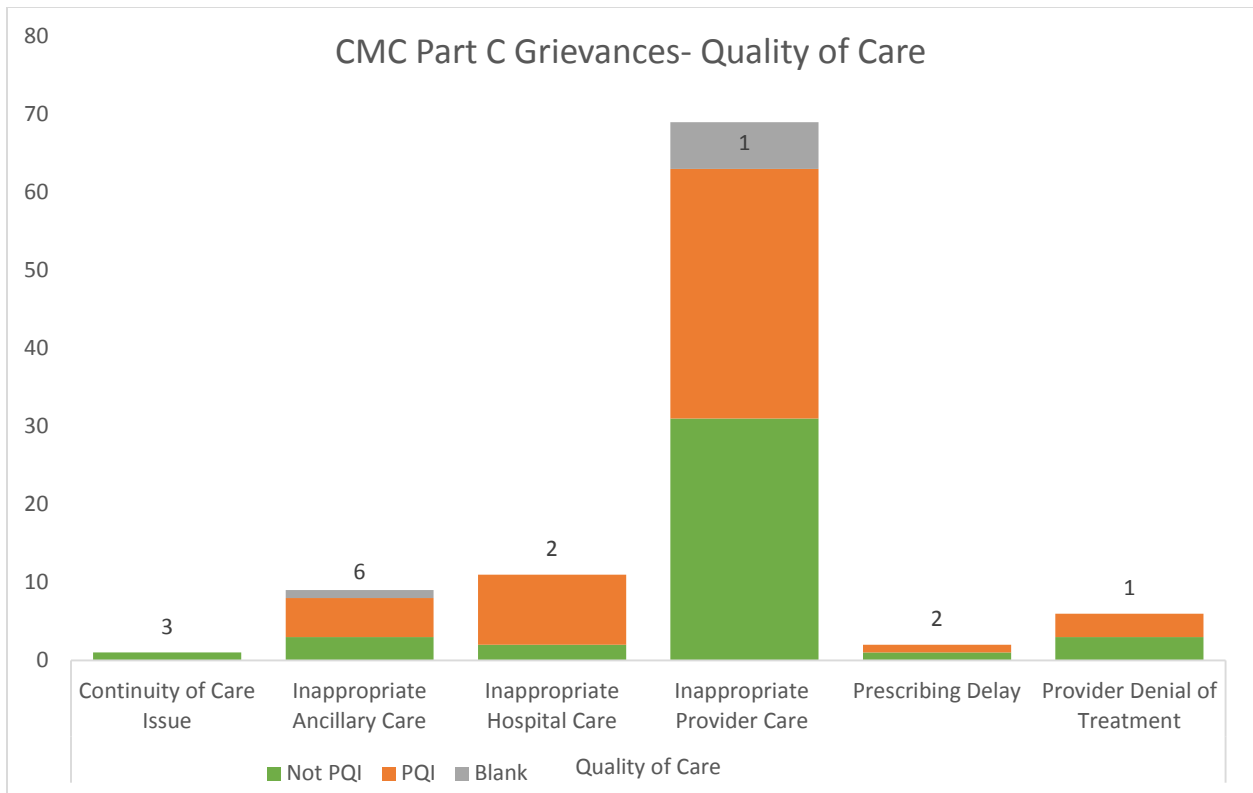
SCFHP monitored Cal MediConnect grievances by category and subcategory from Part C and Part D grievances.

Cal MediConnect Grievance Category	Part C	Part D	Grand Total	Percentage
Quality of Service	816	37	853	69.63%
Quality of Care	98	38	136	11.10%
Access	125	5	130	10.61%
Compliance	43	4	47	3.84%
Plan Benefits	6	12	18	1.47%
Service Authorization and Plan Level Appeals Process	18	0	18	1.47%
Enrollment/Disenrollment	7	2	9	0.73%
Coverage Determination/Redetermination Process	0	5	5	0.41%
Other	3	0	3	0.24%
Expedited	2	1	3	0.24%
Marketing	3	0	3	0.24%
<b>Grand Total</b>	<b>1121</b>	<b>104</b>	<b>1225</b>	<b>100%</b>

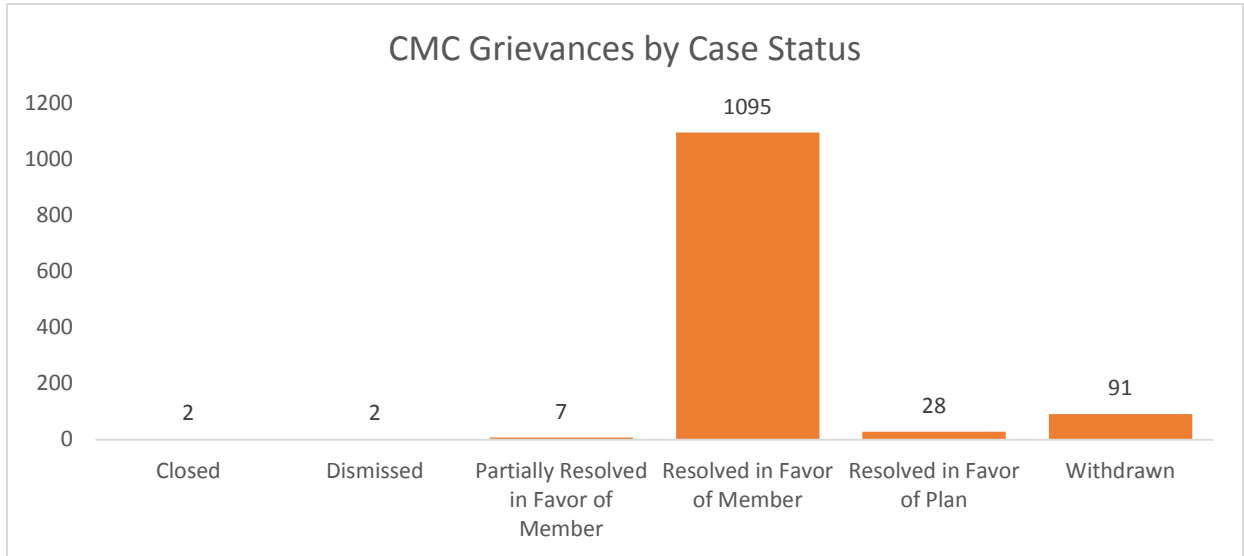
Balance Billing Statement was the top subcategory for all Part C & D grievances under quality of service in which comprised of 37.06% (454 cases). Same as Medi-Cal, Transportation service (NMT) was also on the top subcategory for Part C & D grievances under quality of service in which comprised of 8.49% (104 cases).



The third top subcategory was Inappropriate Provider Care under the category of Quality of Care. There were total 80 cases, 69 from Part C and 11 from Part D.



All cases are reviewed and determined whether they required Potential Quality of Care review. 1095 cases (89.39%) were resolved in favor member and 7 cases were partially resolved in favor of member. 28 cases were resolved in favor of Plan. 91 cases and 2 cases were withdrawn and dismissed respectively. And 2 cases were closed.



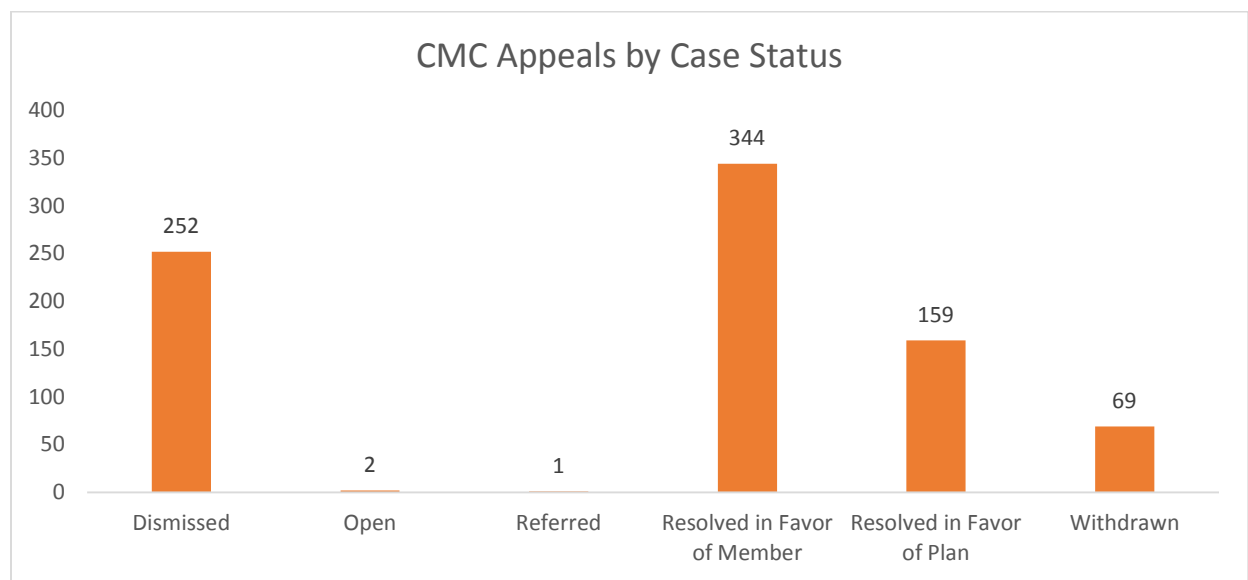
SCFHP tracks and trends all member appeals for each of the five categories: including Post Services and Pre-Services for Part B, C and D. The data below representative of total 827 member appeals in 2020.

Appeal Case Type	Category Name	Grand Total
<b>Cal Medi-Connect Post Service Part C</b>		<b>500</b>
	Post-Service Reconsideration (Claims)	500
<b>Cal MediConnect Post Service Part D</b>		<b>10</b>
	Direct Member Reimbursement Redetermination	4
	Post-Service Redetermination (Claim)	6
<b>Cal MediConnect Pre-Service Part B</b>		<b>2</b>
	Expedited	1
	Pre-Service Reconsideration (Authorization)	1
<b>Cal MediConnect Pre-Service Part C</b>		<b>157</b>
	Expedited	20
	Pre-Service Reconsideration (Authorization)	137
<b>Cal MediConnect Pre-Service Part D</b>		<b>5</b>
	Expedited	41
	Pre-Service Reconsideration (Authorization)	117
<b>Grand Total</b>		<b>827</b>



350 cases were overturned, and 165 were upheld and 15 were upheld by the Plan/Medical Direction Disposition.

Case Status	Overturn	Uphold	Other	Grand Total
Resolved in Favor of Member	343		1	344
Dismissed	1	2	249	252
Resolved in Favor of Plan		159		159
Withdrawn	5	3	61	69
Open	1		1	2
Referred		1		1
<b>Grand Total</b>	<b>350</b>	<b>165</b>	<b>312</b>	<b>827</b>



G&A management provides daily review of oversight monitoring reports to flag staff for potentially untimely cases, regular monitoring of company holiday schedule and to ensure proper holiday coverage, and provides reminders to staff about the upcoming holiday. G&A management also promotes compliance on their cases prior to departing for the scheduled holidays. Refresher training is provided to staff on notification requirements for expedited grievance and appeal cases.

SCFHP identified opportunities to enhance member experience by identifying sources of abrasion and resolves the grievances and appeals in a timely manner.

## VI. CONCLUSION

In summary, SCFHP was able to complete Quality Improvement Interventions as planned in the Quality Improvement Work Plan.

The COVID-19 pandemic has reflected a number of strengths of the plan. The collaboration efforts and dedication of leaders by the Quality Department and other departments, including but not limited to: Grievance & Appeals, Pharmacy, Case Management, Provider Network Operations continued to focus on providing best possible quality clinical care and safety of care services to our Medi-Cal and Cal Medi-Connect members in Santa Clara County. SCFHP values its strong relationships with provider networks to maintain coordination of care and enhance data collection and the data sharing process. The Plan continues to strive and minimize the impact of our quality services in 2021.

SCFHP will follow the analysis, identified barriers, and tracked and trended data in 2020 to develop our 2021 Quality Improvement Work Plan and seek approval from the Quality Improvement Committee in April 2021.

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	<u>QI Program Evaluation</u>	QI Program Annual Evaluation	CMC 2.16.3.3.4 NCQA 2018 QII Elements A and B	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives - trending of measures to assess performance in the quality and safety of clinical care and quality of service - analysis and evaluation of the overall effectiveness of the QI Program and of its progress toward influencing network-wide safe clinical practices	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annually	May 2020	Yes	Approved by QIC: 04/08/2020 Adopted by Board: 06/25/2020  <b>Assessment/Monitoring of Previous Issues:</b> Significant improvement in the Cervical Cancer Screenings (>5%) from 2018 to 2019. In the CMC line of business, there was a significant improvement (>10%) in the 30 Day Follow-Up after Hospitalization for Mental Illness measure from 2018 to 2019
Member Experience	<u>NCQA Health Plan Accreditation</u>	SCFHP provides members with the information they need to understand and use their pharmacy benefit.	NCQA 2020 ME 5 - Pharmacy Benefit Information	Ensure pharmacy benefit information provided to members on an ongoing basis is accurate	- The Pharmacy Department and Customer Service will collect data and review for accuracy and ensure quality of information being provided to members	- Annually the Pharmacy Department will report -data collection -assessment -actions	100%  <b>Update:</b> Quality: 100% Accuracy: 100%	Pharmacy Manager and Customer Service Director	Annually	Third quarter Quality Improvement Committee [Update: Q4 QIC]	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020  <b>Assessment/Monitoring of Issues:</b> Did not meet one measure for Accuracy (providing member with accurate turnaround time for exceptions) and two measures for Quality (Exceptions process and determining availability of generic substitutions). All other 100%. Refresher trainings scheduled for 12/18/2020.
Member Experience	<u>NCQA Health Plan Accreditation</u>	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2020 ME 6 - Personalized Information on Health Plan Services	Ensure members can use personalized information to navigate health plan services effectively	- The Customer Service Department will collect data on the quality and accuracy provided, compare information against goals, and determine deficiencies in delivery of information act to improve deficiencies identified	- Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions to improve data	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee [Update: Q4 QIC]	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020  <b>Assessment/Findings:</b> All established measures applied to the website and telephone met the goal of 100% on accuracy and quality. No deficiencies were identified for this audit period.
Member Experience	<u>NCQA Health Plan Accreditation</u>	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2020 - ME 6 Element D	Ensure quality and timely email communication to members is happening on an ongoing basis	- The Customer Service Department will collect data email responses to members is happening on an ongoing basis in a timely manner	Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions of email responses to members	100%  <b>Update:</b> Timeliness: 100% Quality: 100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 08/12/2020 Adopted by Board:  <b>Assessment/Findings:</b> Did not meet goal for timeliness: responding comprehensively and taking action. Scored 89%. Interventions conducted to provide staff re-trainings.
Member Experience	<u>NCQA Health Plan Accreditation</u>	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element A	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- SCFHP assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	Analysis of cultural, ethnic, racial and linguistic needs of it's members relative to the provider network	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 04/08/2020 Adopted by Board: 06/25/2020  <b>Assessment/Findings and Monitoring of Issues:</b> Confirmed highest number of interpreter requests were for Spanish, Vietnamese and Chinese. Over 50% of SCFHP speak non-English language at home. Continue to outreach to contract with providers with diverse background and language skills.
Quality of Service	<u>NCQA Health Plan Accreditation</u>	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element B	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Analyze performance against primary care availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> Overall, SCFHP is able to demonstrate that member cultural and linguistic needs are met. • Provider to member ratios and maximum time and distance standards were met at 100%.
Quality of Service	<u>NCQA Health Plan Accreditation</u>	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element C	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high-volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	Analyze performance against specialists (including high volume and high impact) availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> Overall, SCFHP is able to demonstrate that member cultural and linguistic needs are met. • Provider to member ratios and maximum time and distance standards were met at 100%.

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Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Service	<u>NCQA Health Plan Accreditation</u>	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element D	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	Analysis of behavioral health care practitioners access standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021 <b>Assessment/Findings:</b> The assessment showed that provider to member ratios were met at 100%. • Year to year comparisons indicate that provider to member ratios remain steady. • The assessment showed that maximum time and distance standards were met at 100%. • Time and distance goals were exceeded at 93.3% (lowest) and 99.9% (highest).
Quality of Service	<u>NCQA Health Plan Accreditation</u>	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services	NCQA 2020 NET 2 Elements A-C	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services.	Collect and perform analysis of data for primary care, specialty, and behavioral health 1. Regular and routine care appointments. 2. Urgent care appointments. 3. After-hours care	Analysis and report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021 <b>Assessment/Findings:</b> The assessment showed that over a 3-year period specific provider types remain steady below goal on urgent appointment access. • While appointment access surveys may show appointment access issues with specific provider types, other access assessments (listed below) were conducted and no trending against specific provider types were identified: <input type="checkbox"/> Review of letter of agreements <input type="checkbox"/> Member complaints/appeals <input type="checkbox"/> Percentage of providers open for new referrals <input type="checkbox"/> Member out of network requests
Quality of Service	<u>NCQA Health Plan Accreditation</u>	SCFHP monitors access to healthcare services and takes action to improve it	NCQA 2020 NET3 Elements A-C	SCFHP provides members adequate network access for needed healthcare services.	- SCFHP annually: 1. Analyzes data from member experience, complaints and appeals about network adequacy for non-behavioral healthcare, behavioral, and overall services 2. Analyzes data from member experience, complaints and appeals about network adequacy for behavioral healthcare services, behavioral, and overall services 3. Compiles and analyzes requests for and utilization of out-of-network services. 4. Prioritizes opportunities for improvement identified, 5. implements intervention 6. measure effectiveness of interventions	Annual report - Annual Assessment of Network Adequacy	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021 <b>Assessment/Findings:</b> Member complaints on transportation was identified as a potential issue. No member appeals were filed. Member out-of-network requests appeared to be within normal limits and no trending was identified. Focus area: <input type="checkbox"/> Transportation complaints *Transportation issues are currently being addressed by customer service and provider relations.
Health Plan Accreditation	<u>NCQA Health Plan Accreditation</u>	SCFHP systematically collects, integrates and assesses member data to inform its population health management programs	NCQA 2020 PHM 2 Element B	SCFHP assesses the needs of its population and determines actionable categories for appropriate intervention.	- SCFHP annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Assesses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI)	Annual report	N/A	Health Educator	Annually	First quarter Quality Improvement Committee	Yes	Approved by QIC: 02/12/2020 Adopted by Board: 03/26/2020 <b>Assessment/Findings:</b> An average of 29.8% CMC respondents of the Health Risk Assessment (2019) reported they run out of money to pay for food, rent, bills, or medicine. Respondents experiencing problems writing checks or keeping track of money had a higher than average percentile rate in Long Term Care (LTC), Serious Mental Illness (SMI), and Long Term Services and Support (LTSS) members. Improvements to the social determinants of health (SDOH) indicators such as education, employment, and income are needed.
Member Experience	<u>NCQA Health Plan Accreditation</u>	SCFHP has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement	NCQA 2020 PHM 6 Element A	- Quantitative results for relevant clinical, cost/utilization and experience measures -Comparison of results with a benchmark or goal. -Interpretation of results	-collect data on relevant cost, utilization and experience measures	Annual report	100% [Update: - Reduce # of members with multiple unmanaged conditions who also have 3 or more ED visits in the past year by 10 percentage pts - Increase HbA1c control rate by 2 percentage points - Reach 5% increase in number of CMC members with annual wellness check]	Case Management Manager	Annually	First quarter Quality Improvement Committee	Yes	Approved by QIC: 08/12/2020 Adopted by Board: 09/24/2020 <b>Assessment/Findings/Monitoring of Previous Issues:</b> All goals met except for HbA1c (did not increase control rate by 2 percentage pts). Barriers identified include lack of reporting on Diabetic Health Ed classes, med adherence and members not remembering to get HbA1c tested. Currently implementing new reporting, training for care managers and gift card incentives for HbA1c testing.

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Member Experience	<u>NCOA Health Plan Accreditation</u>	SCFHP implements mechanisms to assess and improve member experience	NCQA 2020 ME 7 Elements C-D	To assess member experience with its services, the organization annually evaluates member complaints and appeals and member survey data (i.e. CAHPS), and identified opportunities for improvement	Collect valid measurement data for each of the following categories -quality of care -access -attitude and service -billing and financial issues -quality of practitioner office site  Analyze and identify opportunities for improvement from the following sources -Member complaint and appeal data -CAHPS survey	Annual report	100%	Director, Customer Service	Annually	Fourth quarter Quality Improvement Committee	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020  <b>Assessment/Findings:</b> All established measures applied to the website and telephone met the goal of 100% on accuracy and quality. No deficiencies were identified for this audit period.
Member Experience	<u>NCOA Health Plan Accreditation</u>	SCFHP implements mechanisms to assess and improve member experience	NCQA 2020 ME 7 Elements E-F	Assess member experience with Behavioral Health services Evaluate and identify opportunities for improvement	-Evaluate member complaints and appeals -conduct member survey -Improve members experience with behavioral healthcare and service -Assess data from complaints and appeals or from member experience surveys -Identifying opportunities for improvement -implementing interventions -measuring effectiveness of interventions	Annual report	100%	Behavioral Health Manager	Annually	Fourth quarter Quality Improvement Committee	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> Overall, the majority of members reported positive or neutral experiences through their use of behavioral health care providers and services, and showed more positive responses than in 2019.
Quality of Care	<u>QI Program</u>	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4.7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2019 QI Evaluation and 2020 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annually	May 2020	Yes	Approved by QIC: 04/09/2020 Adopted by Board: 06/25/2020 (Work Plan)
Quality and Safety of Clinical Care	<u>NCOA Health Plan Accreditation</u>	SCFHP monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.	NCQA 2020 QI 3 Elements A-C	SCFHP annually identifies opportunities to improve coordination of medical care, act on opportunities identified, measuring effectiveness of improvement actions taken	A. Collect 1. Collect data on member movement between practitioners 2. Collect data on member movement across settings 3. Conduct quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting four opportunities for improvement B. Act Annually act to improve coordination of care activities identified in the Collect phase C. Measure Annually measure the effectiveness of improvement actions taken in the Act phase	Quantitative and qualitative analysis with identification of four opportunities for improvement documented in a report	100%	Health Services Director [Update: Quality Nurse]	Annually	Third quarter Quality Improvement Committee  [Update: Fourth quarter Quality Improvement Committee]	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020  <b>Assessment/Findings:</b> Four (4) measures were reviewed: Transition of Care – Medication Reconciliation, Comprehensive Diabetes Care (CDC) Eye Exam Rate, PCP Follow-up After 30 Days of Discharge, and Plan All-Cause Readmissions (PCR). Ms. Patel noted all measures compared measurement year 2019 with the baseline data from 2017 and 2018. A cross-functional work group comprised of representatives from Case Management (CM), Utilization Management (UM), Behavioral Health (BH), Long Term Services and Support (LTSS), and Quality Improvement (QI) Departments reviewed the barriers analysis of each measure. The recommendation to maintain performance goals that were met was due to the impact COVID-19 is expected to have on the metrics in 2020. Many members have postponed preventive services and the impact to the hospitals and readmissions is of concern.
Medi-Cal and CMC	<u>UM Program</u>	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annually	September 2020	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021
Quality of Service	<u>CAHPS</u>	Annual Oversight of CAHPS Survey and Work Plan		Complete annual survey, analyze results, identify opportunities for improvement and implement interventions	Develop improvement plans and other interventions based on results	Areas for improvement identified in the CAHPS 2020 survey	Annual recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee	Yes	Approved by QIC: 10/21/2020 Adopted by Board: 11/30/2020  <b>Assessment/Findings:</b> The following areas were identified as areas for improvement: • Rating of Healthcare Quality • Rating of Personal Doctor • Customer Service • Getting Needed Care, Getting Appointments and Care Quickly SCFHP will develop working groups increase ratings in customer service by streamlining the AOR process and getting needed care/getting appointments and care quickly by providing educational materials to providers

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Quality of Service	<u>HOS</u>	Annual Oversight of HOS Survey and Work Plan		Complete annual survey, analyze results, identify opportunities for improvement and implement interventions	Develop improvement plans and other interventions based on results	Areas for improvement identified in the HOS survey	Annual recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee	Yes	Presented to QIC: 4/17/2021  <b>Assessment/Findings:</b> Physical Health Results: Cohort 20 scored slightly lower than Cohort 19. Performance are as expected when compared to national average. Mental Health Results: Cohort 20 scored slightly higher than Cohort 19. Cohort 20 performed as expected as national average and cohort 19 score performed better than national average.
Quality of Service	<u>NCOA Plan Ratings</u>	Annual Oversight of NCQA Plan Ratings and Work plan		Analyze Results	Develop Improvement Plans based on results	Areas for improvement identified in results	Annual recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee	On Hold	Not published due to COVID-19
Timely Access	<u>Access/Availability</u>	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1	Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hours 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity	Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hours 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity	Annual Report - Provider Accessibility Report	97%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> • The assessment showed that over a 3-year period specific provider types remain steady below goal on urgent appointment access. • While appointment access surveys may show appointment access issues with specific provider types, other access assessments (listed below) were conducted and no trending against specific provider types were identified: <input type="checkbox"/> Review of letter of agreements <input type="checkbox"/> Member complaints/appeals <input type="checkbox"/> Percentage of providers open for new referrals <input type="checkbox"/> Member out of network requests • It is important to note that the Provider Appointment Availability survey does not take into account other access opportunities such as other providers within a group and/or urgent care facilities that are available to see a patient within access standards.

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Safety of Clinical Care	<u>Access/Availability</u>	Credentialing program activities monitored	CMC 2.10.5 (CR 5)	Credentialing file reviews New applicants processed within 180 calendar days of receipt of application	Credentialing file reviews New applicants processed within 180 calendar days of receipt of application	Report	100%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020
Safety of Clinical Care	<u>Access/Availability</u>	Credentialing program activities monitored	CMC 2.10.5 (CR 5)	Credentialing file reviews Recredentialing is processed within 36 months	Credentialing file reviews Recredentialing is processed within 36 months	Report	100%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020	Yes	Approved by QIC: 12/09/2020 Adopted by Board: 12/17/2020
Quality of Service	<u>Access/Availability</u>	Availability of Practitioners	CMC 2.11.2.1	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Annual Network Availability Analysis	90%	Provider Services Director or Designee	Annually	August 2020	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> • Provider networks have made progress in meeting after-hours access and timeliness in the past 2-years. The provider (including BH) network met and exceeded the "access" standard for the first time in 2020. • While survey results indicate that the provider network may be unaware of the "timeliness" standard (call back within 30min), this standard is difficult to assess. For example, provider's are marked as noncompliant if the after-hours message does not state that a call back will occur within 30-minutes, and while the after-hours message machines may not state the provider will call back within this timeframe, the majority of network providers are likely meeting this standard.
Quality of Service	<u>Access/Availability</u>	Availability of Practitioners	CMC 2.11.2.1	Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution	Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution	Annual Network Availability Analysis	90%	Provider Services Director or Designee	Annually	August 2020	Yes	Approved by QIC: 02/09/2021 Adopted by Board: 03/26/2021  <b>Assessment/Findings:</b> The assessment showed that provider to member ratios were met at 100%. • Year to year comparisons indicate that provider to member ratios remain steady. • The assessment showed that maximum time and distance standards were met at 100%. • Time and distance goals were exceeded at 93.3% (lowest) and 99.9% (highest).
Medi-Cal and CMC	<u>Case Management</u>	CM Program Annual Evaluation	NCQA 2020 PHM 6	Assess the impact of the goals set by the population health management strategy.	CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis	Annual Population Health Management Impact Analysis	Annual Evaluation	CM Manager	Annually	6/1/2020 [Update: August QIC]	Yes	Approved by QIC: 08/12/2020 Adopted by Board: 09/24/2020  <b>Assessment/Findings:</b> - Managing Multiple Chronic Illnesses: 2020 PHM strategy will reflect that this focus area goal will not change but will continue to be evaluated during this next year. - Managing Members with Emerging Risk: No change to focus area goal; however additional process improvements will be implemented specific to referral management reporting, additional outreach, and additional staff education in-service training opportunities which will be provided to continue to help improve member outcomes. - Keeping Members Healthy: 2020 PHM strategy will reflect a new Focus Area goal to achieve an IHA notification rate of 90% - Patient Safety or Outcomes Across Settings: No change to focus area goal; however, additional planned process improvements and reporting functionality will be developed and implemented by

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Medi-Cal and CMC	HEDIS Reporting	Report HEDIS successfully by 6/15/2020	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 15, 2020 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/1/2020 - 54 Medi-Cal HEDIS 2020 measures below the Medicaid Minimum Performance Level - CMC Composite HEDIS 2020 Average at 60%	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV	Submission of the IDSS to NCQA by 6/15/2020	Annual Submission	HEDIS Project Manager	Annually	June 2020	Yes	Approved by QIC: 08/12/2020 Adopted by Board: 09/24/2020  Findings: It was a challenge transitioning over because of workflow and data mapping changes using new HEDIS engine vendor. The same vendor of medical record software tool was not used making it difficult to ensure that Admin and Medical records vendors synced up. Had difficulty getting access to medical records because of COVID causing provider offices closing or having limited hours because of COVID. Able to contact the doctor's offices and worked out a process to retrieve the records. Successful implementation with three vendors: Citius Tech, CareSeed, & Guardian Angel, and incorporated 13 new supplemental data sources. 100% of Valley Medical Center's cases was abstracted. Next steps to improve measures under MPL: Asthma Medication Ratio, Comprehensive Diabetes Care, Cervical Cancer Screening, and Adolescent Well Care
Quality of Clinical Care	Statewide Disparity Performance Improvement Projects	Increase rate of adolescent well care visits	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	5.8% percent increase in adolescent well care rate over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement and use member incentive to improve rates	DHCS Modules 1 through 4	5.8% increase over baseline rate of 16.7% for Network 20	Process Improvement Project Manager	Quarterly	30th June, 2021	Completed Modules 1 & 2 Due to pandemic, DHCS paused PIP	AWC is now an internal PIP and will not be reported to DHCS/HISAG. Next PIP cycle, which is due March 2021.
Quality of Clinical Care	Statewide Child and Adolescent Performance Improvement Projects	Increase rate of well child visits for children turning 15 months	Medi-Cal Exhibit A, Attachment 4.9.C.b	26.43% increase in W15 rate over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement and use member incentive to improve rates	DHCS Modules 1 through 4	26.43% increase over baseline rate of 35.11% for Network 50	Process Improvement Project Manager	Quarterly	December 31st, 2020	Completed Modules 1 & 2 Due to pandemic, DHCS paused PIP	W15 started out as a PIP. PIP was cancelled by DHCS. W15 was combined into our regular incentive program.
Quality of Clinical Care	Internal Performance Improvement Projects Medi-Cal	Comprehensive Diabetes Care - Poor Control	Medi-Cal Exhibit A Attachment 4.9.C.a	5% decrease in CDC-Poor Control rate over the life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement	Report	By December 31, 2020, decrease by 5% from baseline rate of 46.04%	Process Improvement Project Manager	Annually	December 31st, 2020	In progress - carry over to 2021	Due to issues with the vendor and DHCS Rx rollout, implementation timeline is stalled and will be revised based on new vendor contract
Quality of Service	Internal Performance Improvement Projects CMC	Increase number of members with an ICP and discussion of care goals	CMC 2.16.4.3.1.2.1	Increase the percentage of members with an ICP completed and percentage of members with documented discussion of care goals	- Plan will further develop and implement new processes and training materials to improve consistency of documentation within SCFHP's case management software program	Annual Submission	By December 31st 2020, increase by 5% from baseline in all three submeasures	Health Services Director	Annually	December 31st, 2020	All modules are completed and validated	Assessment/Findings: Percentage Score of Evaluation Elements Met* 71% Percentage Score of Critical Elements Met** 64% Validation Status - Partially Met - High risk members with an ICP completed (Study indicator 1) 2nd yr. re-measurement 57.83% Goal 68% - Low risk members with an ICP completed (Study indicator 2) 2nd yr. re-measurement 55.97% Goal 66.8% - Total number of Cal MediConnect members with at least one documented discussion of care goals in the initial ICP (Study indicator 3) 2nd yr. re-measurement 100% Goal 65%
Quality of Clinical Care	Chronic Clinical Performance Improvement Projects CMC	Target Chronic Condition: Behavioral Health Condition - Mental Illness	CMC	Increase the number of follow up visits for members with a discharge from the Emergency Department with a diagnosis of mental illness	Plan will develop and implement a 3 year project to increase the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow up visit with a mental health practitioner within 30 days of discharge.	Annual Submission	By December 31, 2021, increase measure rate from 43.18% to 53.18%.	Behavioral Health Manager and Process Improvement Project Manager	Annually	December 31, 2019 December 31, 2020 December 31, 2021	In progress	Assessment/Findings and Monitoring: - Implemented new questions in Easette to be completed by staff during TOC - Complete internal audit (CCIP-FUII) - Data collection is ongoing, BH staff received training
Quality of Clinical Care	Project: Prevention and Screening	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 50th percentile (60.65%) - 61.07% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	In progress	Implemented incentive program mailing and conducted outreach calls to members.
Quality of Clinical Care	Project: Prevention and Screening	HEDIS Measure: Childhood Immunization Status (CIS) - Combination 3	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 10	- Develop and implement interventions based on a barrier analysis for CIS Combo 10	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 10 rate over the Medicaid 50th Percentile (34.79%) - 49.39% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	CANCELLED	Canceled due to COVID
Quality of Clinical Care	Project: Diabetes	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 50th percentile (88.55%) - 89.78% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	In progress	Implemented incentive program mailing and conducted outreach calls to members. New end date changed to 12/31/2020
Quality of Clinical Care	Project: Cardiovascular Conditions	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (61.04%) - 56.93% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	In progress	Conducted outreach calls to members and included measure in COVID QIP in Oct. New end date changed to 01/31/2021
Quality of Clinical Care	Project: Access & Availability of Care	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (83.76%) - 86.86% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	In progress	Developed Healthy Moms Healthy Babies program for 2020.



2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	<u>Project: Utilization</u>	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2020 Managed Care Accountability Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder letters for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (83.85%) - 76.16% HEDIS 2019	QI Manager or designee	Quarterly	October 2021	In progress	Canceled due to COVID
Quality of Service	<u>Project: 120 Initial Health Assessment</u>	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations	- Medicaid rate 80%	QI Manager or designee	Quarterly	December 2020	Yes	<b>Approved by QIC:</b> 2/09/2021 <b>Adopted by Board:</b> 03/26/2021  <b>Assessment/Findings:</b> all IHA element scores were above 50%, with the exception of the Staying Healthy Assessment (SHA) Questionnaire.
Health Plan Accreditation	<u>NCQA Accreditation</u>	NCQA Accreditation of the CMC line of business	CMC	Maintain accreditation status for CMC line of business	- Ensure all business units are completing required activities, analyses and interventions per the annual NCQA work plan	- all required evidence collected for 2020 by December 31, 2020	Maintain accreditation	Process Improvement Manager	Annually	12/31/2020	In Progress	Plan is on 2nd year of first accreditation. Continuing to address previously identified issues in First Survey and complete all required accreditation activities.
Safety of Clinical Care	<u>Facility Site Review</u>	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow-up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis	100%	QI Nurse	Ongoing	Ongoing - Monthly	On Hold	FSRs were not conducted due to the COVID-19 situation. Extensions have been approved by DHCS. DHCS has temporarily suspended the requirement to conduct FSRs until the COVID-19 emergency declaration is rescinded. The FSRs will have to be completed once this emergency is over. There were no FSRs due in October 2020. Virtual FSRs will be soon introduced for new sites.
Safety of Clinical Care	<u>Quality of Care</u>	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQIs originating from Grievance and Appeals within 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQIs - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	90% of PQIs closed within 60 days	QI Nurse	Ongoing	Ongoing - Monthly	Yes	<b>Approved by QIC:</b> 12/09/2020 <b>Adopted by Board:</b> 12/17/2020  <b>Assessment/Findings:</b> SCFHP investigated total 657 PQI cases in 2020. Of those 657 closed cases, 18, 511, 23,102, 3 were level 0, 1, 1A, 2 and 3, respectively. Total 3 CAPs were issued, monitored, validated, and closed in 2020. Out of 3, 1 was against a provider, 1 against a pharmacy, and 1 against Skilled Nursing Facility (SNF).
Quality and Safety of Clinical Care	<u>NCQA Health Plan Accreditation</u>	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2020 Q14 Elements A-C	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually collects data about opportunities for collaboration between medical care and behavioral healthcare and conducts activities to improve coordination, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identify and selecting two opportunities for improvement, implement interventions and measure the effectiveness of the interventions.	Aggregate available data	100%	Behavioral Health Manager	Annually	Third quarter Quality Improvement Committee	Yes	<b>Approved by QIC:</b> 12/09/2020 <b>Adopted by Board:</b> 12/17/2020  <b>Assessment/Findings:</b> The report measures 6 areas of collaboration between medical and behavioral health providers. Interventions were identified and discussed in the BH Workgroup for Factor 4 and Factor 6. Two (2) interventions were implemented for Factor 4. Management of Co-Existing Medical and Behavioral Disorders. The first was a letter to providers, followed by (three) 3 outgoing calls to members to remind them of the need for an AIC test. At this time, it is inconclusive as to whether or not the implemented interventions were effective. Although no effectiveness could be identified during analysis extending specifically from these interventions, SCFHP plans to improve timing of data collection and implementation of interventions.

Laurie Nakahira, DO  
Chief Medical Officer  
Santa Clara Family Health Plan

Date

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work Plan	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Members' Experience	CAHPS	CAHPS Survey and Work Plan	Develop Improvement Plans based on results areas for improvement identified in the CAHPS 2021 survey	Process Improvement Manager or Designee	August 2021	- low response rate	Annual Completion		
Members' Experience	HOS	HOS Survey and Work Plan	Develop Improvement Plans based on results areas for improvement identified in the HOS 2021 survey	Process Improvement Manager or Designee	Third quarter Quality Improvement Committee	N/A - only completed every 2 years	Annual Completion		
Quality of Clinical Care	Health Education	Health Education Work Plan and Evaluation	Development of a HE Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	- limited availability of classes	Expansion of virtual classes		X
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work Plan and Evaluation	Development of a C&L Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	N/A	Annual Completion		
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2021	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.		X
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2021	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.		
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2021 April 2021 August 2021 December 2021	N/A	100%		
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2020	QI & Health Education Manager	June 2021	N/A	Annual Submission		X
Quality of Clinical Care	Quality Measures	Quality Measures Intervention Workbook	Report on MMP, Star Rating and Accreditation Measures	QI & Health Education Manager	April 2021	N/A	Annual Submission		
Quality of Clinical Care	Chronic Clinical Performance Improvement Projects (CCIP) CMC	PDSA Modules	Target Chronic Condition: Behavioral Health Condition - Mental Illness	Behavioral Health Manager	February 2022	There is no required submission deadline. SCFHP internally tracks the project. Third year cycle ends on February 2022	Plan will develop and implement a 3 year project to increase the percentage of members who had a follow-up visit with a mental health practitioner within 30 days of discharge, specifically from an acute psychiatric facility and for members age of 21 and older, who were hospitalized for treatment of mental illness. Targeting members who are discharged home and from Valley Medical Center.	By December 31, 2021, increase measure rate from 43.18 % to 53.18%.	
Safety of Clinical Care	Facility Site Review	FSR/MMR	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	QI Nurse	Ongoing - Monthly	COVID-19 has prevented completion	N/A		X
Safety of Clinical Care	Potential Quality Issues	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	- Close 80% cases with in 60 days - Review PQI referral with in 5 calendar days from a day referral was received		
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	April 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within		
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2021 December 2021	N/A	Annual Completion		

## 2021 CMC Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work Plan	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Members' Experience	CAHPS	CAHPS Survey Results Report	Develop Improvement Plans based on results areas for improvement identified in the CAHPS 2021 survey	Process Improvement Manager or Designee	October 2021 (report is provided by DHCS)	N/A	Annual Completion		
Quality of Clinical Care	Health Education	Health Education Work Plan and Evaluation	Development of a HE Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	- limited availability of classes	Expansin of virtual classes		X
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work Plan and Evaluation	Development of a C&L Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	N/A	Annual Completion		
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2021	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.		
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2021	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.		
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2021 April 2021 August 2021 December 2021	N/A	100%		
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2020	QI & Health Education Manager	June 2021	N/A	Annual Completion		
Quality of Clinical Care	Quality (MCAS/HEDIS) Measures	Quality Measures Intervention Workbook	Report on specific HEDIS and CMS core set measures	QI & Health Education Manager	June 2021 December 2021	N/A	Annual Completion		
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	PDSA Cycle - Quality Improvement Plan	QI & Health Education Manager	December 2021	N/A	Submit by deadline indicated by DHCS		
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	COVID-19 Quality Improvement Plan	QI & Health Education Manager	December 2021	N/A	Submit by deadline indicated by DHCS		
Quality of Clinical Care	Statewide Disparity Performance Improvement Projects	DHCS Modules	Increase rate of adolescent well care visits	Process Improvement Project Manager	Module 1 Due Date: March 1, 2021		5.8% increase over baseline rate of 16.7% for Network 20		X
Quality of Clinical Care	Statewide Child and Adolescent Performance Improvement Projects	DHCS Modules	Blood lead screening in children	Process Improvement Project Manager	Status: Submitted, pending validation	Children under the age of 3 need blood lead screening completed	8% increase over baseline rate of 65.14% for all target population (goal: 73.13%)		X
Safety of Clinical Care	Project: 120 Initial Health Assessment	IHA Report	Initial Health Assessment and Staying Health Assessment	QI Manager or designee	February 2021 December 2021	Low compliance rate	100%		
Safety of Clinical Care	Facility Site Review	FSR/MMR Report	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	QI Nurse	Ongoing - Monthly	COVID-19 has prevented completion	N/A		X
Safety of Clinical Care	Quality of Care	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	- Close 80% cases with in 60 days - Review PQI referral with in 5 calendar days from a day referral was recieved		
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	May 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within mandated timelines.		
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2021 December 2021	N/A	Annual Completion		

## 2021 Medi-Cal Quality Improvement Work Plan

## POLICY

<b>Policy Title:</b>	<b>Distribution of Quality Improvement Information</b>	<b>Policy No.:</b>	QI.03
<b>Replaces Policy Title (if applicable):</b>	Dissemination of Approved Information Following Quality Improvement Committee	<b>Replaces Policy No. (if applicable):</b>	QM007_01
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

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

### III. Responsibilities



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

### IV. References

NCQA, 2018

# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 04/08/2020		Title 04/08/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Reviewed	Quality Improvement	Approve 04/08/2020	
V1	Reviewed	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Peer Review Process</b>	<b>Policy No.:</b>	QI.04
<b>Replaces Policy Title (if applicable):</b>	Peer Review Process	<b>Replaces Policy No. (if applicable):</b>	QM009_02
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) Quality Improvement Program provides methods to continuously monitor and evaluate the quality of care and services delivered by the contracted network of practitioners and providers.
- B. The Chief Medical Officer (CMO) overseeing the QI Program activities is responsible for oversight of peer review activities. Peer Review is coordinated through the Quality Improvement (QI) Department and communicated to the Credentialing Department. Credentialing and Peer Review Committee is a subcommittee of the Quality Improvement Committee (QIC).

### III. Responsibilities



QI Continuously monitors, evaluates, and develops plans to improve upon Potential Quality Issues (PQI). QI, Health Services, Customer Service, IT, Grievances & Appeals, and Credentialing monitor for PQIs. The QI Department tracks and trends valuable data which can identify PQIs. All PQIs have the potential for peer review.

### IV. References

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

# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 04/08/2020		Title 04/08/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Reviewed	Quality Improvement	Approve 04/08/2020	
V1	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Quality Improvement Study Design/Performance Improvement Program Reporting</b>		<b>Policy No.:</b>	QI.06
<b>Replaces Policy Title (if applicable):</b>	Quality Improvement Study Design/Performance Improvement Program Reporting		<b>Replaces Policy No. (if applicable):</b>	QM005_02
<b>Issuing Department:</b>	Quality Improvement		<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal			<input checked="" type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) continuously monitors and develops ways to improve quality of care for plan members. This is achieved through a variety of measures including, quality of clinical care, safety in clinical care, quality of service, members' experience, trends in potential quality of care issues, chronic care improvement projects, and quality improvement activities.
- B. SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document QI.06.01 Quality Improvement Study Design/Performance Improvement Program Reporting.

### III. Responsibilities

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



### IV. References

**The Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual Chapter 5, Quality Assessment**  
**The National Committee for Quality Assurance (NCQA), 2018 NCQA HEDIS Specifications, 2018**



# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 04/08/2020		Title 04/08/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Reviewed	Quality Improvement	Approve 04/08/2020	
V1	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Cultural and Linguistically Competent Services</b>	<b>Policy No.:</b>	QI.08
<b>Replaces Policy Title (if applicable):</b>	Cultural and Linguistic Services Program Policy	<b>Replaces Policy No. (if applicable):</b>	CU 002_02
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

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

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

See associated procedures Cultural and Linguistically Competent Services, Language Assistance Program, Member Document Translations, Standing Requests for member Materials in Alternate Formats, and Ad Hoc Requests for Member Materials in Alternate Format for detailed process for meeting these objectives.

### III. Responsibilities


- i. DHCS updates threshold language data at least once every three years to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal Managed Care counties. Quality Improvement complies with the update requirements within three months of the publication of the update.
- ii. Quality Improvement and Provider Network Management, ensure Health Plan Staff and Providers are adequately trained, have access to resources, and provide culturally competent services to all Plan members.
- iii. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages, which is reviewed and updated as needed based on member assessment needs, but no later than every five years based on the results of the GNA survey.

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

**IV. References**

CMS.gov; Managed Care Manual, Chapter 13 NCQA  
 2018  
 California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C) DHCS  
 Contract  
 Title 22 CCR Section 53876  
 Title 22 CCR 53853 (c)  
 CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5) Section  
 1367.04(h)(1)  
 Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80) PL – 99-  
 003  
 APL 99-005  
 APL 17-011  
 CFR 42 § 440.262

**V. Approval/Revision History**

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, DO		
Name Director of Quality and Pharmacy		Name Chief Medical Officer		
Title 04/10/2019		Title 04/10/2019		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement	Approved 06/06/2018	
V1	Reviewed	Quality Improvement	Approved 04/10/2019	
V2	Revised	Quality Improvement	Approved 04/08/2020	
V2	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Health Education Program and Delivery System</b>	<b>Policy No.:</b>	QI.09
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

The purpose of this policy is to describe Santa Clara Family Health Plan's (SCFHP) Health Education Program and its functions. Health Education at SCFHP is operationalized within the Quality Improvement Department.

### II. Policy

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

- A. The Health Education Program will provide classes and/or materials free of charge to beneficiaries including, but not limited to, the following topics:
  - a. Nutrition
  - b. Healthy weight maintenance and physical activity
  - c. Individual and group counseling and support services
  - d. Parenting
  - e. Smoking and tobacco use cessation
  - f. Alcohol and drug use
  - g. Injury prevention
  - h. Prevention of sexually transmitted diseases, HIV, and unintended pregnancy
  - i. Chronic disease management, including asthma, diabetes, and hypertension
  - j. Pregnancy care
- B. SCFHP also offers self-management tools through the Member Portal.
- C. All SCFHP members are eligible to receive Health Education classes through SCFHP.

### III. Responsibilities

The Quality Department and Health Educator will do the following:

- A. Ensure all programs and services are provided at no cost to members.
- B. Ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health.
- C. Ensure that health education materials are written at the sixth grade reading level and are



culturally and linguistically appropriate for the intended audience.

- D. Maintain a program that provides educational interventions addressing the topics listed above.
- E. Ensure that members receive point of service education as part of preventive and primary health care visits. Health Education shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for members.
- F. Maintain policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and monitor the performance of providers that are contracted to deliver health education services to ensure effectiveness.
- G. Periodically review the health education program to ensure appropriate allocation of health education resources and maintain documentation that demonstrates effective implementation of the health education requirements.

**IV. References**

- Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with the California Department of Health Care Services and Santa Clara County Health Authority.
- NCQA 2018 Health Plan Accreditation Requirements PHM 4A-K (Wellness and Prevention), PHM 1B (Informing Members)

**V. Approval/Revision History**

First Level Approval			Second Level Approval	
				
<b>Signatur</b> Johanna Liu, PharmD			<b>Signature</b> Laurie Nakahira, DO	
<b>Name</b> Director of Quality and Pharmacy			<b>Name</b> Chief Medical Officer	
<b>Title</b> 04/10/2019			<b>Title</b> 04/10/2019	
<b>Date</b>			<b>Date</b>	
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	Revised	Quality Improvement	Approve 06/06/2018	
V2	Reviewed	Quality Improvement	Approve 04/10/2019	
V2	Reviewed	Quality Improvement	Approve 04/08/2020	
V2	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Member Non-Monetary Incentives</b>	<b>Policy No.:</b>	QI.11
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

To establish guidelines for the administration of rewarding members who demonstrate effort and success in adopting health-promoting behaviors.

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) may utilize non-monetary incentives to reward members who demonstrate effort and success in adopting health-promoting behaviors or changing health risk behaviors.
- B. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
- C. SCFHP will submit annual updates to justify the continuation of an ongoing member incentive (MI) program and an end of program evaluation to describe whether or not the MI program was successful.
- D. For Focus Group Incentives (FGIs), SCFHP submits an evaluation that includes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives, SCFHP will submit a copy of the survey, along with an evaluation that includes finding and recommendations.
- E. 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 Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 04/08/2020		Title 04/08/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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V1	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Misuse of Alcohol</b>	<b>Policy No.:</b>	QI.12
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) will support the contracted network in the use and administration of SBIRT when indicated during administration of the Staying Health Assessment (SHA) or at any time the PCP identifies a potential alcohol misuse problem.
- B. SCFHP will meet the Department of Health Care Services (DHCS) contractual requirements for identification, referral, and coordination of care for members requiring alcohol abuse treatment services.

### III. Responsibilities

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

### IV. References

DHCS All Plan Letter 14-004: Screening Brief Intervention, and Referral to Treatment for Misuse of Alcohol  
DHCS Contract Exhibit A, Attachment 11, Provisions 1A.

United States Preventive Task Force (USPSTF) alcohol screening recommendation



<http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>

Website for SHA Questionnaires <http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx>



# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 04/08/2020		Title 04/08/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Reviewed	Quality Improvement	Approve 04/08/2020	
V1	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Comprehensive Case Management</b>	<b>Policy No.:</b>	QI.13
<b>Replaces Policy Title (if applicable):</b>	Case Management	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan’s consistent processes for providing access to appropriate and coordinated services for members through identification of care needs and promote optimal health and functionality for positive member outcomes.

### II. Policy

- A. The Comprehensive Case Management program is established to provide case management processes and procedures that help members with multiple or complex conditions obtain access to care and services, and the coordination of appropriate care, services, and resources. The structure of Comprehensive Case Management program is organized to promote quality case management, member 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.
- B. The fundamental components of the SCFHP Case Management program include:
  - Initial assessment of members’ health status, including condition specific issues
  - Documentation of clinical history, including medications
  - Initial assessment of the activities of daily living
  - Initial assessment of behavioral health status, including cognitive functions
  - Initial assessment of social determinants of health
  - Initial assessment of life-planning activities
  - Evaluation of cultural and linguistic needs, preferences or limitations
  - Evaluation of visual and hearing need, preferences or limitations
  - Evaluation of caregiver resources and involvement
  - Evaluation of available benefits
  - Evaluation of community resources
  - Provider engagement
- C. Referrals to the Comprehensive Case Management program are accepted from members or their caregivers, practitioners or other external providers, hospital discharge planners, SCFHP internal staff (including customer service and utilization management) and/or community partners. All referrals will initially be assessed by care coordination staff for the appropriate level of case management support needed to coordinate care and services for medical, behavioral health and other non-medical risk factors. Successful completion of an initial assessment will determine a member’s placement in the most appropriate Population Health Management case management tier for ongoing support.

## POLICY

- D. A Case Management referral form is available on SCFHP's public website and can be completed and submitted directly to the Case Management department via mail delivery, fax, or secure email. Case Management referrals may also be requested verbally through telephonic interaction by calling SCFHP's Customer Service department at 1-877-723-4795 for Cal MediConnect members or 1-800-260-2055 for Medi-Cal members and requesting case management support. Members can also call the Case Management Department directly at 1-877-590-8999. All Case Management referrals will receive an initial review within 72 business hours of receipt.
- E. SCFHP's 2021 Population Health Management Strategy description defines the process of how SCFHP coordinates services for the highest risk members with complex conditions and helps them access needed resources through intensive and comprehensive interactions. This includes addressing members with Severe Mental Illness (SMI), homelessness, and members receiving Long Term Services and Supports (LTSS).

### III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

### IV. References

- Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019).
- Medicare and Medicaid Services and Core Reporting Requirements 2021.
- NCQA Health Plan Accreditation Guidelines 2021 - Population Health (PHM) Element 5
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 16-002: Continuity of Care
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
- Department of Health Care Services (DHCS) All Plan Letter (DPL) 17-012: Care Coordination Requirements for Managed Long - Term Services and Supports
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities

**POLICY**

**V. Approval/Revision History**

First Level Approval	Second Level Approval
<hr/> Angela Chen, RN Interim Director, Case Management	<hr/> Laurie Nakahira, D.O. Chief Medical Officer
<hr/> Date	<hr/> Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve	08/05/2016
V1	Reviewed	Quality Improvement	Approve	08/09/2017
V1	Reviewed	Quality Improvement	Approve	06/06/2018
V2	Revised	Quality Improvement		

## POLICY

<b>Policy Title:</b>	<b>Transitions of Care</b>	<b>Policy No.:</b>	QI.15
<b>Replaces Policy Title (if applicable):</b>	n/a	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan’s process for managing Cal Medi-Connect (CMC) and non-delegated Medi-Cal High Risk Seniors and Persons with Disabilities (SPD) members at risk for planned and unplanned transitions across the care continuum.

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) supports and promotes appropriate transitions between care settings which is critical to improving member quality of care and health outcomes.
- B. SCFHP’s Transitions of Care program is focused on identifying members at risk for transitions and facilitating the transitions between settings to the most appropriate and safe level of care for that member. This includes, but is not limited to:
  - a. Acute hospitals;
  - b. Inpatient psychiatric hospitals;
  - c. Skilled Nursing Facilities (SNFs);
  - d. Assisted living and residential care facilities;
  - e. Rehabilitation facilities; and
  - f. Member’s home
- C. SCFHP will implement evidence-based interventions to ensure safe and coordinated care across the Care Continuum and to prevent readmissions.
- D. SCFHP will ensure members are in the least restrictive and most appropriate setting that meets the members’ health care needs
- E. The Transition of Care program is the combined responsibility of SCFHP and the member’s assigned Primary Care Provider (PCP).
- F. The Transition of Care program consists of, but is not limited to:
  - a. Identification and management of members at risk for planned and unplanned transitions;
  - b. Communication with the member and/or the member’s authorized representative, PCPs, and specialists, if appropriate;
  - c. Reduction of unplanned transitions;
  - d. Support member preferences and choice through the ICP process;
  - e. Promote the exchange of information across care settings; and
  - f. Analyzing and monitoring data for process improvement

## POLICY

- G. SCFHP implements processes that coordinate services and care needed for members including, but not limited to, ensuring access to necessary medical and behavioral health care, medications, durable medical equipment, supplies, transportation, Long Term Support Services (LTSS) benefits, and community based resources.

### III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

### IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)  
 Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 16-002: Continuity of Care  
 Department of Health Care Services (DHCS) Duals Plan Letter (APL) 16-003: Discharge Planning for Cal MediConnect  
 National Committee on Quality Assurance: Population Health Management (2021)

### V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Interim Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
<b>Date</b>	<b>Date</b>

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve	08/05/2016
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V1	Reviewed	Quality Improvement	Approve	06/06/2018
V2	Revised	Quality Improvement		

## POLICY

<b>Policy Title:</b>	<b>Long Term Services and Supports (LTSS) Care Coordination</b>	<b>Policy No.:</b>	QI.16
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

This policy defines how SCFHP shall provide and manage Long Term Services and Supports (LTSS) so that its members receive coordinated care across a continuum of benefits and services that includes medical, behavioral health, LTSS and community resources.

The Plan promotes coordination of LTSS 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. SCFHP shall maintain an LTSS program that coordinates and monitors access, availability, and continuity for Long Term Services and Supports (LTSS) for members. SCFHP, in partnership with members, providers, advocates and other community stakeholders shall support a person-driven long-term continuum of care where members with disabilities and chronic conditions have choice and access to an array of quality services. LTSS shall provide an alternative to institutional placement and be available to members who meet eligibility criteria.
- B. SCFHP maintains LTSS Program procedures as well as Case Management and Utilization Management procedures that apply.

LTSS Program Procedures include:

- 1. LTSS Coordination of Services
- 2. In-Home Supportive Services Referrals and Coordination Community Based Adult Services (CBAS): Eligibility/Determination and Coordination, Referrals
- 3. Multipurpose Senior Services Program (MSSP) Referrals and Coordination
- 4. LTC Case Management and Care Transitions
- 5. Care Plan Options and Home and Community Services (HCBS) Coordination

### III. Responsibilities

SCFHP Health Services integrates LTSS with internal departments to inform and identify members receiving or requesting LTSS, to coordinate services and to meet the following requirements:



- A. Support coordinated care delivered by an appropriate network of providers
- B. Support a comprehensive initial and annual health assessment of each member's physical, behavioral, psychosocial, functional and social support needs;
- C. Support and participate in a members' interdisciplinary Care Team (ICT), as appropriate;
- D. Facilitate the development of an individual care plan in consultation with the member that identifies goals, interventions, services and benefits to be provided

# POLICY

## IV. References

- NCQA 2019 Health Plan Accreditation Standards Population Health Management
- APL 17-012 Care Coordination Requirements for Managed Long Term Services and Supports
- APL 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
- DPL 15-001 Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
- DPL 16-002 Continuity of Care
- DPL 16-003 Discharge Planning for Cal MediConnect
- DPL 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect

## V. Approval/Revision History

First Level Approval		Second Level Approval		
 Signature Lori Andersen Name Director, Long Term Services and Support Title 04/08/2020 Date		 Signature Laurie Nakahira, D.O. Name Chief Medical Officer Title 04/08/2020 Date		
Version Number	Change (Original/Reviewed/Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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V1	Review	Quality Improvement	04/14/2021	



## POLICY

<b>Policy Title:</b>	<b>Care Coordination Staff Education and Training</b>	<b>Policy No.:</b>	QI.19
<b>Replaces Policy Title (if applicable):</b>	Care Coordination Staff Training	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan’s consistent processes for providing initial and ongoing education and training to all Care Coordination staff who have responsibilities related to serving members and the skills to meet member needs related to care coordination principles.

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) Care Coordination staff will receive initial and on-going education and training to provide members with access to quality health care that is delivered in a cost-effective and compassionate manner
- B. Training will be provided in a variety of educational formats including, but not limited to, the distribution of documents, classroom, informational sessions, and virtual learning modules as appropriate
- C. Care Coordination Staff training includes, but is not limited to, the following:
  1. Overview of regulatory and contractual requirements
  2. Organizational objectives
  3. SCFHP policies and procedures
  4. Member eligibility and benefits
  5. Member rights and responsibilities
  6. Health Insurance Portability and Accountability Act (HIPAA)
  7. Seniors and Persons with Disabilities (SPD)
  8. Disability Awareness and Sensitivity
  9. Population Health Management
  10. Interdisciplinary Care Teams (ICTs) role and responsibilities
  11. Long Term Services and Supports (LTSS) eligibility, referrals and operations
  12. Behavioral Health services and coordination
  13. Grievance and appeals process
  14. Pharmacy management
  15. Care Coordination and care transitions
  16. Cultural Competency and available Cultural and Linguistic Services
  17. Community resources and services
  18. Person centered planning process
  19. Wellness principles

## POLICY

### 20. Understanding Dementia

- D. Training content is reviewed and updated as needed to meet state and federal regulatory requirements as well as other best practices. Staff training is completed upon hire, reviewed annually and as needed.

### III. Responsibilities

Health Services management works with internal departments, external partners and providers to provide staff training to prepare Care Coordination to best assist and support our members.

### IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)  
 Department of Health Care Services (DHCS) All Plan Letter (APL) 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities  
 Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

### V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Interim Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
Date	Date

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V1	Original	Quality Improvement	Approve	08/05/2016
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V2	Revised	Quality Improvement		

## POLICY

<b>Policy Title:</b>	<b>Health Homes Program</b>	<b>Policy No.:</b>	QI.28
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Quality Improvement	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

### II. Policy

- A. SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:
1. Comprehensive Care Management
  2. Care Coordination
  3. Health Promotion
  4. Comprehensive Transitional Care
  5. Individual and Family Support Services
  6. Referral to Community and Social Supports
  7. Housing Navigation

### III. Responsibilities

- A. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified.
- B. SCFHP members are assigned to CB-CMEs based on the following factors:
1. PCP Assignment

## POLICY

2. Geographic Location of the Member
3. Behavioral Health Needs
4. CB-CME's Experience with Certain Populations (homelessness, Language, Demographic, etc.)
- C. SCFHP will utilize Model 1
  1. CB-CMEs contracted for HHP embeds care coordinators on-site in the community provider offices
    - i. CB-CMEs will employ staff that meet the care coordination ration of 1:60 over two years
- D. Delegation will occur when applicable
  1. Delegated entity will use Model I or Model II
  2. Delegated entity will oversee Health Home responsibilities with their subcontracted CB-CMEs
    - i. Delegated entity and their CB-CMEs will follow the same HHP policies and procedures set forth by SCFHP
    - ii. To ensure consistency among all CB-CMEs under SCFHP and delegated entities, SCFHP will approve all CB-CME sites and contracts
  3. Delegated entity will be responsible for capturing data and reporting on the measures for each CB-CME they subcontract with.
  4. Delegated entity will be responsible for meeting all reporting deadlines set forth by SCFHP
- E. SCFHP is responsible for selecting, and overseeing the implementation of a shared HIT platform that will assist in data collection and reporting
- F. Ensure that the CM-CME have the capacity to provide assigned HHP members with a multi-disciplinary care team.
  1. This is completed through site reviews prior to the initial launch date of HHP and during quarterly auditing reviews.
- G. SCFHP will provide outreach to provider networks and hospital systems to strengthen multi-disciplinary participation from non-participating CB-CMEs
  1. Site visits, marketing materials, and ongoing informational webinars will be utilized to disseminate information (See Outreach Procedure)
- H. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
  1. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
  2. SCFHP will share each member's health history with assigned CB-CMEs
  3. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process.
- I. Identify, review, and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
  1. Identify members through the DHVS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
  2. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed
- J. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g. Whole Person Care)
- K. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP
- L. Develop and administer payment structure for CB-CMEs
  1. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding
- M. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

### CM-CME Responsibilities

- A. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
  1. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide
- B. Complete a readiness assessment as developed by SCFHP

# POLICY

1. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps to enrolling members
- C. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements
- D. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
- E. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
- F. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination
- G. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools
- H. Maintain a multi-disciplinary care team to provide the 7 core services
- I. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
- J. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP
- K. Utilize existing health information technology (HIT) to collect and share data to SCFHP
  1. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes
- L. CB-CME will attend required trainings for the HHP

## IV. References

Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide*. Sacramento, CA

Department of Health Care Services. (2018). *All Plan Letter 18-012*. Sacramento, CA: Managed Care Quality and Monitoring Division.

Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions*. Sacramento, CA: Marjorie Swartz.

## V. Approval/Revision History

First Level Approval			Second Level Approval	
				
Signature Johanna Liu, PharmD			Signature Laurie Nakahira, D.O.	
Name Director, Quality and Process Improvement			Name Chief Medical Officer	
Title 04/08/2020			Title 04/08/2020	
Date			Date	
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 02/13/2019	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Reviewed	Quality Improvement	Approve 04/08/2020	
V1	Review	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Health Risk Assessment</b>	<b>Policy No.:</b>	QI.30
<b>Replaces Policy Title (if applicable):</b>	n/a	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan’s process for identifying potential health risks of Cal MediConnect (CMC) and Medi-Cal only Seniors and Persons with Disabilities (SPD) members based on the responses provided by the member in the Health Risk Assessment (HRA) that is to be used for development of a member’s Individualized Care Plan (ICP).

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) shall identify the health risk of each newly enrolled CMC and Medi-Cal only SPD members using a proprietary Risk Stratification Algorithm to identify members who have High Risk and more complex health needs and those who have Low Risk.
- B. The Risk Stratification Algorithm shall incorporate member-specific utilization data for the most recent 12 months to identify members who are High Risk and have more complex healthcare needs. These data sources may include, but not limited to:
  - a. Medicare Parts A, B, and D;
  - b. Medi-Cal FFS;
  - c. Medi-Cal In Home Supportive Services (IHSS);
  - d. Multipurpose Senior Services Program (MSSP);
  - e. Skilled Nursing Facility (SNF);
  - f. Behavioral health pharmacy;
  - g. Outpatient, inpatient, emergency department, pharmacy, and ancillary services; and
  - h. Results of previously administered assessments
- C. SCFHP identifies higher risk members for meeting any one of the following criteria:
  - a. Has been on oxygen within the past 90 days;
  - b. Has been hospitalized within the last 90 days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
  - c. 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);
  - d. Has IHSS greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
  - e. Is enrolled in MSSP;
  - f. Is receiving Community Based Adult Services;

## POLICY

- g. Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
  - h. Has cancer and is currently being treated;
  - i. Has been prescribed anti-psychotic medication within the past 90 days;
  - j. Has been prescribed 15 or more medications in the past 90 days; or
  - k. Has other conditions as determined by the MMP, based on local resources.
- D. Members stratified as High Risk shall be assessed using the HRA within forty-five (45) days of enrollment with SCFHP.
- E. Members stratified as Low Risk shall be assessed using the HRA within ninety (90) days of enrollment with SCFHP.
- F. All communications, whether by phone, mail, or in-person, shall be provided in a linguistically and culturally appropriate manner.
- G. SCFHP shall use the completed HRA to develop an ICP to meet the member's medical, functional, cognitive, psychosocial, social support, and access to care needs as appropriate.
- H. Members shall be reassessed, using the HRA, as appropriate, as follows:
- a. Annually, for all active members, within twelve (12) months of completing the last HRA, or before the enrollment anniversary date of the member if no HRA was obtained in the prior measurement year, or
  - b. As often as the medical, functional, cognitive, psychosocial, and social needs of the member requires based on clinical review of the SCFHP Care Coordination staff
- I. SCFHP shall ensure a process for incorporating member and stakeholder input in the development and update of the HRA for the CMC population that includes, but is not limited to, reviewing the tool and process at:
- a. Member Advisory Committee (MAC) meeting or other member events
  - b. Quality Improvement Committee (QIC) meeting, and
  - c. Provider Advisory Committee (PAC) meeting

### III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

### IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect  
Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect  
Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans  
Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements (2018)  
Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (2021)



**POLICY**

Department of Health Care Services (DHCS) All Plan Letter (APL) 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities (2017)

**V. Approval/Revision History**

First Level Approval	Second Level Approval
<hr/> Angela Chen Interim Director, Case Management	<hr/> Laurie Nakahira, D.O. Chief Medical Officer
<hr/> <b>Date</b>	<hr/> <b>Date</b>

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	04/14/2021	



## POLICY

<b>Policy Title:</b>	<b>Individual Care Plan</b>	<b>Policy No.:</b>	QI.31
<b>Replaces Policy Title (if applicable):</b>	n/a	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan’s consistent process for development of an Individual Care Plan (ICP) with and for Cal Medi-Connect (CMC) and Medi-Cal only High Risk Seniors and Persons with Disabilities (SPD) members, as well as the process for monitoring timeliness and quality of ICPs.

### II. Policy

- A. Upon completion of a Health Risk Assessment (HRA) or through another method to identify the need for care coordination, SCFHP Care Coordination staff will develop an ICP with and for the member in the member’s preferred language within thirty (30) working days of the completion of the HRA.
- B. ICPs will be developed for each member and include individualized goals according to the members needs and preferences.
- C. ICPs will be prioritized with target dates and include measureable objectives to meet medical, behavioral, social and Long Term Services and Supports (LTSS) needs.
- D. The ICP will be sent to the member and the member’s Primary Care Physician (PCP) for review to elicit feedback.
- E. ICPs will be monitored for quality and timeliness.
- F. ICPs will be updated as needed to incorporate member-prioritized goals and, at a minimum, on an annual basis.

### III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

### IV. References

- Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)
- Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
- Department of Health Care Services (DHCS) All Plan Letter (APL) 17-012: Individual Care Plan for Medi-Cal Only Seniors and Persons with Disabilities (2017)

**POLICY**

**V. Approval/Revision History**

First Level Approval	Second Level Approval
<hr/> Angela Chen, RN Interim Director, Case Management	<hr/> Laurie Nakahira, D.O. Chief Medical Officer
<hr/> Date	<hr/> Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	04/14/2021	

## POLICY

<b>Policy Title:</b>	<b>Interdisciplinary Care Team</b>	<b>Policy No.:</b>	QI.32
<b>Replaces Policy Title (if applicable):</b>	n/a	<b>Replaces Policy No. (if applicable):</b>	n/a
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annual
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> CMC		

### I. Purpose

To outline Santa Clara Family Health Plan's process for the development of Cal Medi-Connect (CMC) and Medi-Cal only High Risk Seniors and Persons with Disabilities (SPD) members' Interdisciplinary Care Team (ICT) and the functions of the ICT.

### II. Policy

- A. Santa Clara Family Health Plan (SCFHP) Care Coordination staff will offer to develop the member's Interdisciplinary Care Team (ICT) when a need is demonstrated or as requested by the member or the member's authorized representative.
- B. ICTs are comprised of professionals appropriate for the needs, preferences, and abilities of the member and will integrate the member's medical care, Long Term Services and Supports (LTSS) needs, and behavioral health services as appropriate in collaboration with the member to develop, implement, and maintain the Individual Care Plan (ICP).
- C. The members' ICT will be led by professionally knowledgeable and credentialed personnel that will include, at a minimum:
  - a. The member;
  - b. Family member and/or caregiver, as approved by the member;
  - c. If receiving In-Home Supportive Services (IHSS), the County IHSS social worker;
  - d. A licensed SCFHP Care Coordination staff member
  - e. Primary Care Provider (PCP)
- D. The ICT must include the individuals listed above and will also include individuals or providers who are actively involved in the care of the member, if approved by the member, and when appropriate including:
  - a. Hospital discharge planner;
  - b. Nurse;
  - c. Social worker;
  - d. Nursing facility representative;
  - e. Specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists;
  - f. If receiving IHSS, the IHSS provider
  - g. If participating in Community-Based Adult Services (CBAS), the CBAS provider;

## POLICY

- h. If enrolled in the Multipurpose Senior Services Program (MSSP) waiver program, the MSSP care manager;
  - i. Behavioral health service provider; and/or
  - j. Other professionals, as appropriate
- E. The ICT will facilitate care management, including completing Health Risk Assessment (HRA), care planning, authorization of services, and transitional care issues.
- F. The ICT collaborates with the member to stabilize medical conditions, increase compliance with the Individual Care Plan (ICP), and meet ICP goals for optimal health and functional status.
- G. SCFHP will provide training for ICT individuals prior to their participation on a care team and on an annual basis on the following topics:
  - a. Person-centered planning processes;
  - b. Cultural competence;
  - c. Accessibility and accommodations;
  - d. Independent living and recovery and wellness principles; and
  - e. LTSS programs, eligibility for these services, and program limitations
- H. Members are not required to participate on their ICT and may opt-out of participating at any time and the ICT will continue its operations.
- I. Members who refuse to develop an ICT will be provided the contact information of the SCFHP Care Coordination staff who will re-visit the refusal at the time of reassessment, or if the member's PCP changes
- J. Meetings with a member's ICT will be offered and conducted periodically as needed for the member's care or if requested by the member

### III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

### IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)  
Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans (2017)  
Department of Health Care Services (DHCS) All Plan Letter (APL) 17-012: Interdisciplinary Care Team for Medi-Cal Only Seniors and Persons with Disabilities (2017)

**POLICY**

**V. Approval/Revision History**

First Level Approval	Second Level Approval
<p>Angela Chen Interim Director, Case Management</p>	<p>Laurie Nakahira, D.O. Chief Medical Officer</p>
<b>Date</b>	<b>Date</b>

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Created	Quality Improvement	04/14/2021	

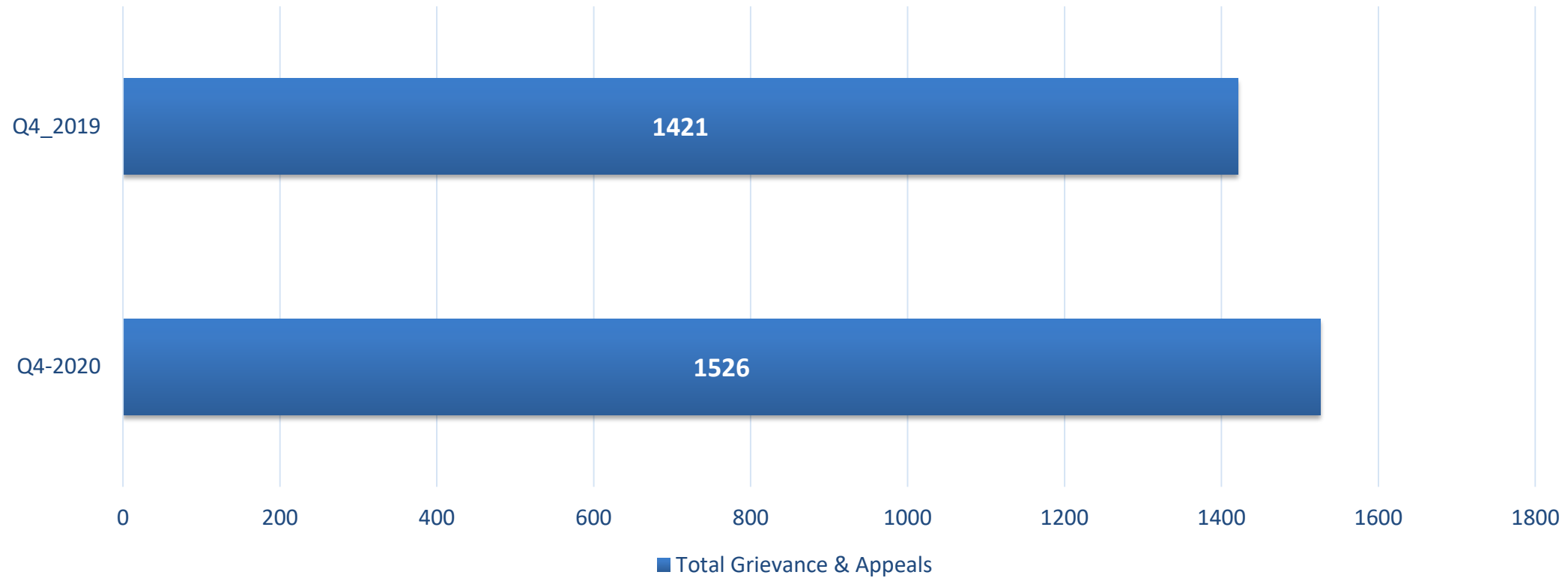


**Santa Clara Family  
Health Plan™**

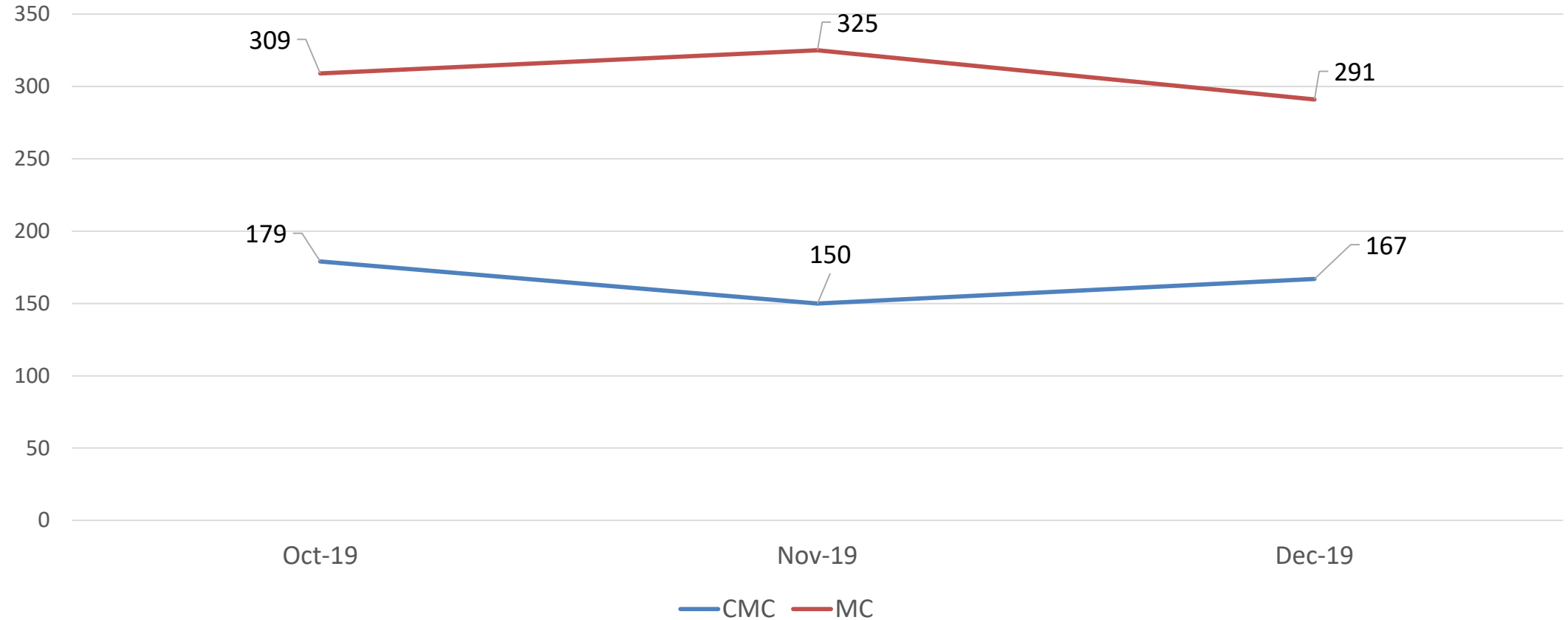
## Quality Improvement Committee

Q4 2020 Grievance & Appeals Data

# Total Grievance & Appeal Cases Received (All LOB)

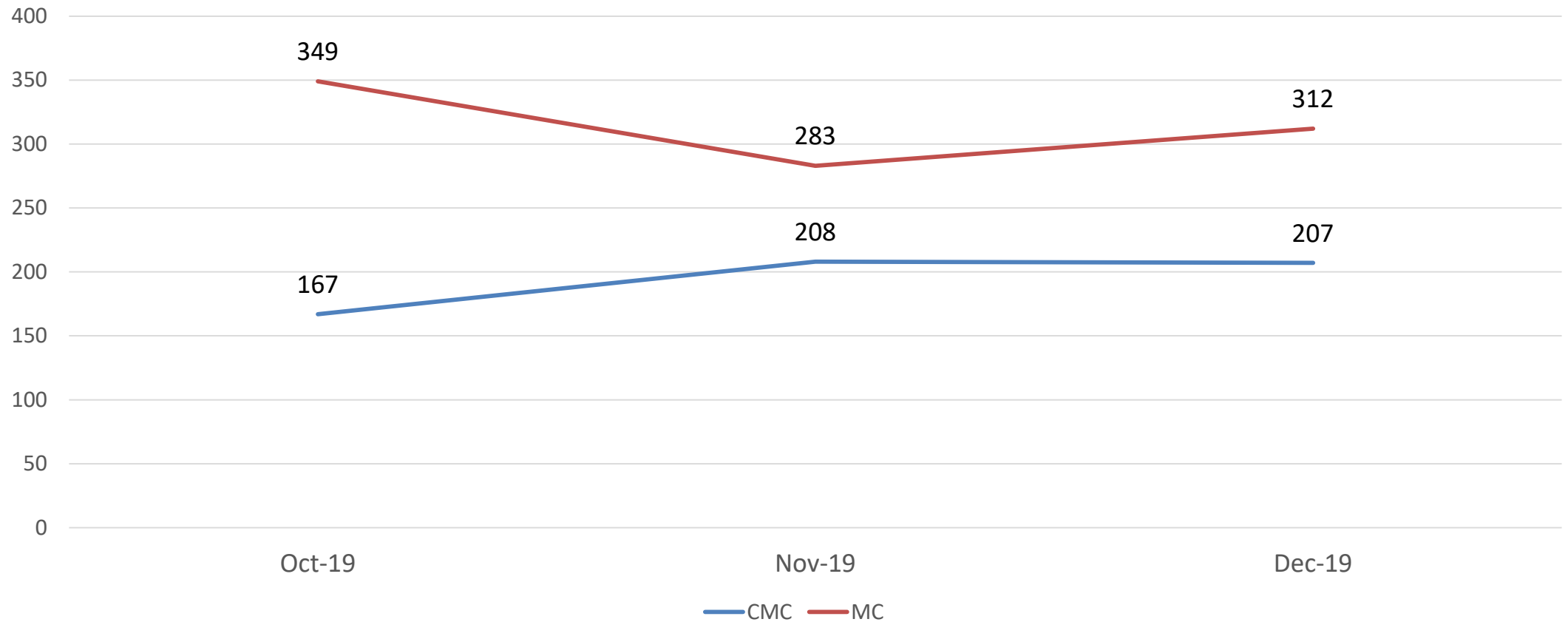


# Q4 2019 Total Grievance & Appeal Cases Received (All LOB)





# Q4 2020 Total Grievance & Appeal Cases Received( All LOB)



# CalMediConnect Grievance & Appeals (Rate per 1000 Members)

	Oct-19	Nov-19	Dec-19	Oct-20	Nov-20	Dec-20
<b>Total Appeals</b>	87	62	69	75	95	94
<b>CMC Total Membership</b>	<b>8,233</b>	<b>8,289</b>	<b>8,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>
<b>Rate per 1,000</b>	10.5672	7.4798	8.1870	7.8370	9.8151	9.5723
<b>Total Grievances</b>						
<b>Total Grievances</b>	92	88	98	101	131	133
<b>CMC Total Membership</b>	<b>8,233</b>	<b>8,289</b>	<b>8,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>
<b>Rate per 1,000</b>	11.1745	10.6165	11.6279	10.5538	13.5345	13.5438

# Medi-Cal Grievance & Appeals (Rate per 1000 Members)

	Oct-19	Nov-19	Dec-19	Oct-20	Nov-20	Dec-20
<b>Total Appeals</b>	113	112	121	138	96	114
<b>MC Total Membership</b>	<b>237,095</b>	<b>235,350</b>	<b>233,995</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>
<b>Rate per 1,000</b>	0.4766	0.4759	0.5171	0.5380	0.3704	0.4363
<b>Total Grievances</b>						
<b>Total Grievances</b>	209	215	185	274	258	254
<b>MC Total Membership</b>	<b>237,095</b>	<b>235,350</b>	<b>233,995</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>
<b>Rate per 1,000</b>	0.8815	0.9135	0.7906	1.0683	0.9954	0.9721

# Medi-Cal

January							February							March						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
1	2	3	4	5	6	7	1	2	3	4									1	2
8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
15	16	17	18	19	20	21	12	13	14	15	16	17	18	10	11	12	13	14	15	16
22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
29	30	31					26	27	28	29	30			24	25	26	27	28	29	30

April							May							June						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
1	2	3	4	5	6	7				1	2	3	4						1	2
8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
15	16	17	18	19	20	21	12	13	14	15	16	17	18	10	11	12	13	14	15	16
22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
29	30	31					26	27	28	29	30			24	25	26	27	28	29	30 <b>W</b>

July							August							September						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
1	2	3	4	5	6	7				1	2	3	4						1	2
8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
15	16	17	18	19	20	21	12	13	14	15	16	17	18	10	11	12	13	14	15	16
22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
29	30	31					26	27	28	29	30			24	25	26	27	28	29	30

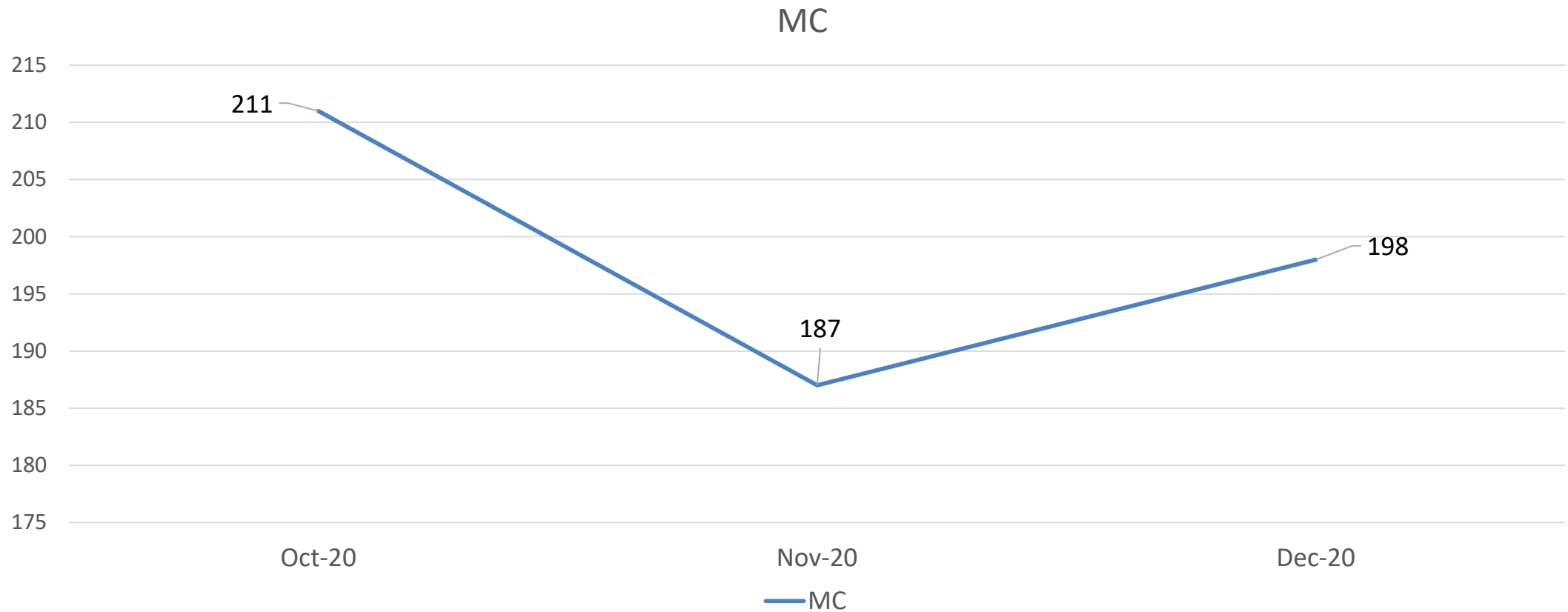
  

October							November							December						
S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
1	2	3	4	5	6	7				1	2	3	4						1	2
8	9	10	11	12	13	14	5	6	7	8	9	10	11	3	4	5	6	7	8	9
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22	23	24	25	26	27	28	19	20	21	22	23	24	25	17	18	19	20	21	22	23
29	30	31					26	27	28	29	30			24	25	26	27	28	29	30 <b>W</b>



**Q4 2020**

# Q4 2020 Total Medi-Cal Grievance Cases Received

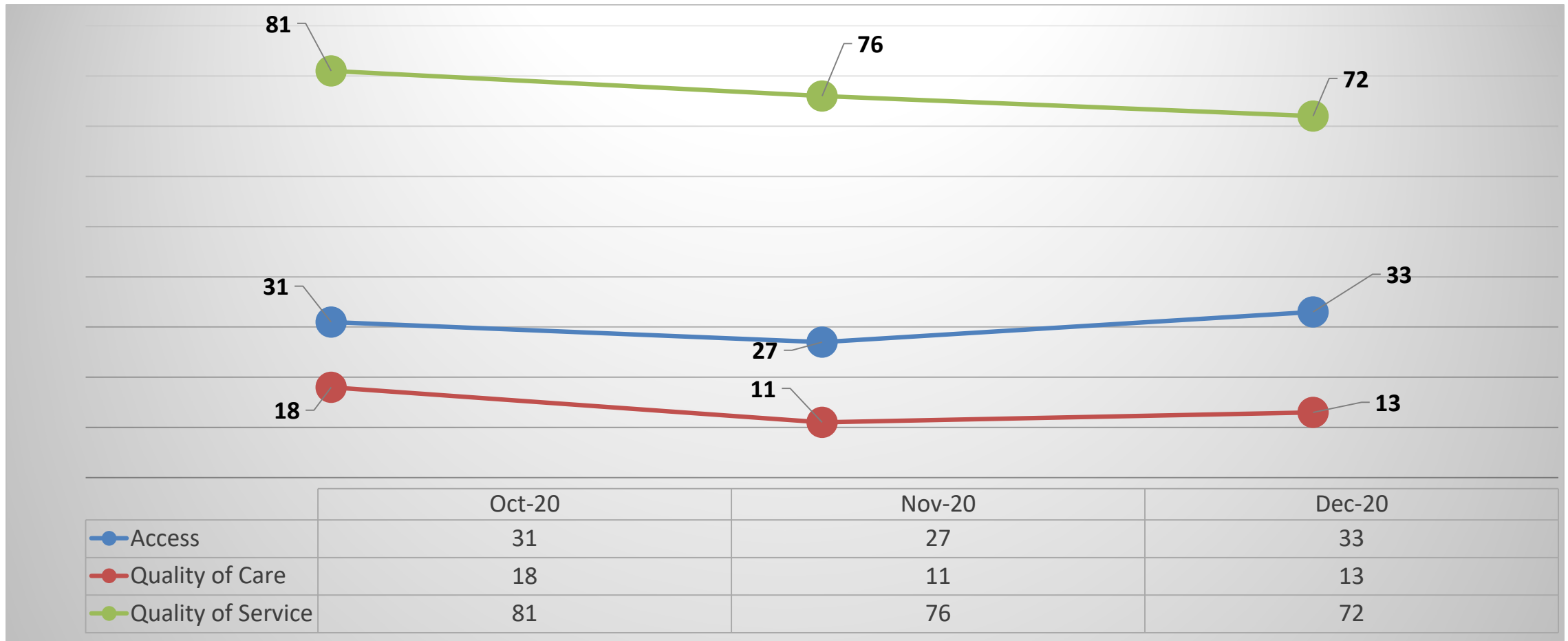


# Q4 2020 Medi-Cal Grievances by Network

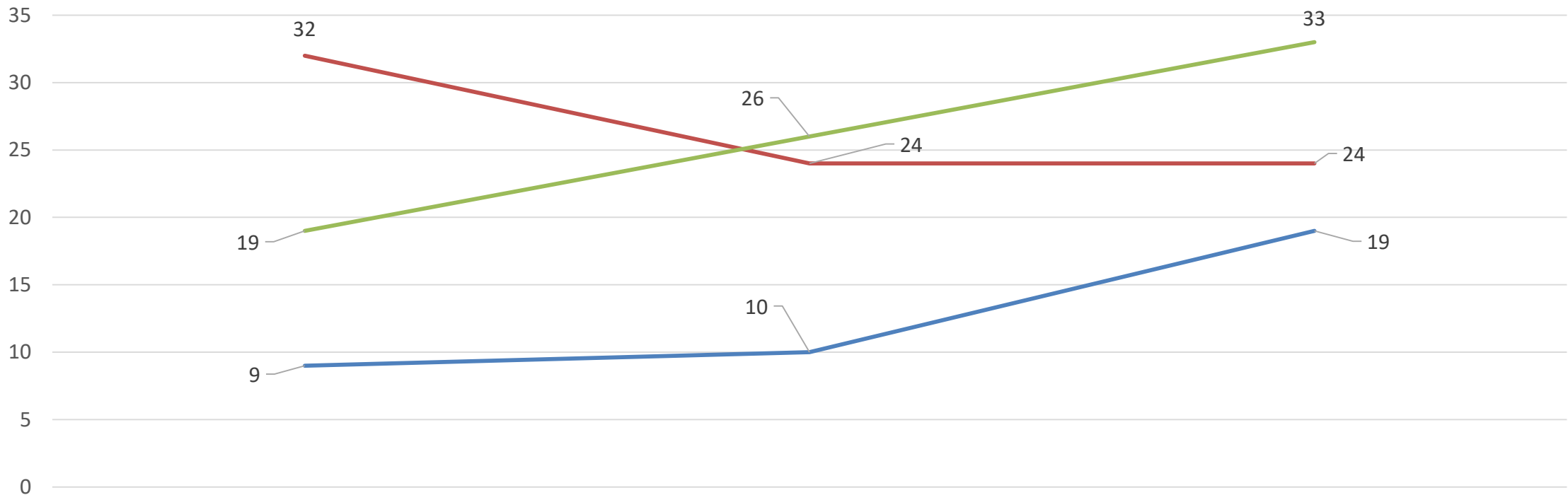
*(Rate per 1000 Members)*

Network	Oct-20	Nov-20	Dec-20	Total Grievance Q4 by Network	Rate per 1,000
INDEPENDENT PHYSICIANS	16,627	16,829	16,938	94	5.55
MEDICARE PRIMARY	15,742	15,830	16,002	28	1.75
PALO ALTO MEDICAL FOUNDATION	6,935	6,985	7,010	29	4.14
PHYSICIANS MEDICAL GROUP	44,223	44,560	44,861	94	2.10
PREMIER CARE	15,473	15,593	15,646	22	1.41
VHP NETWORK	128,622	130,068	131,124	318	2.43

# Q4 2020: Top 3 MC Grievance Categories



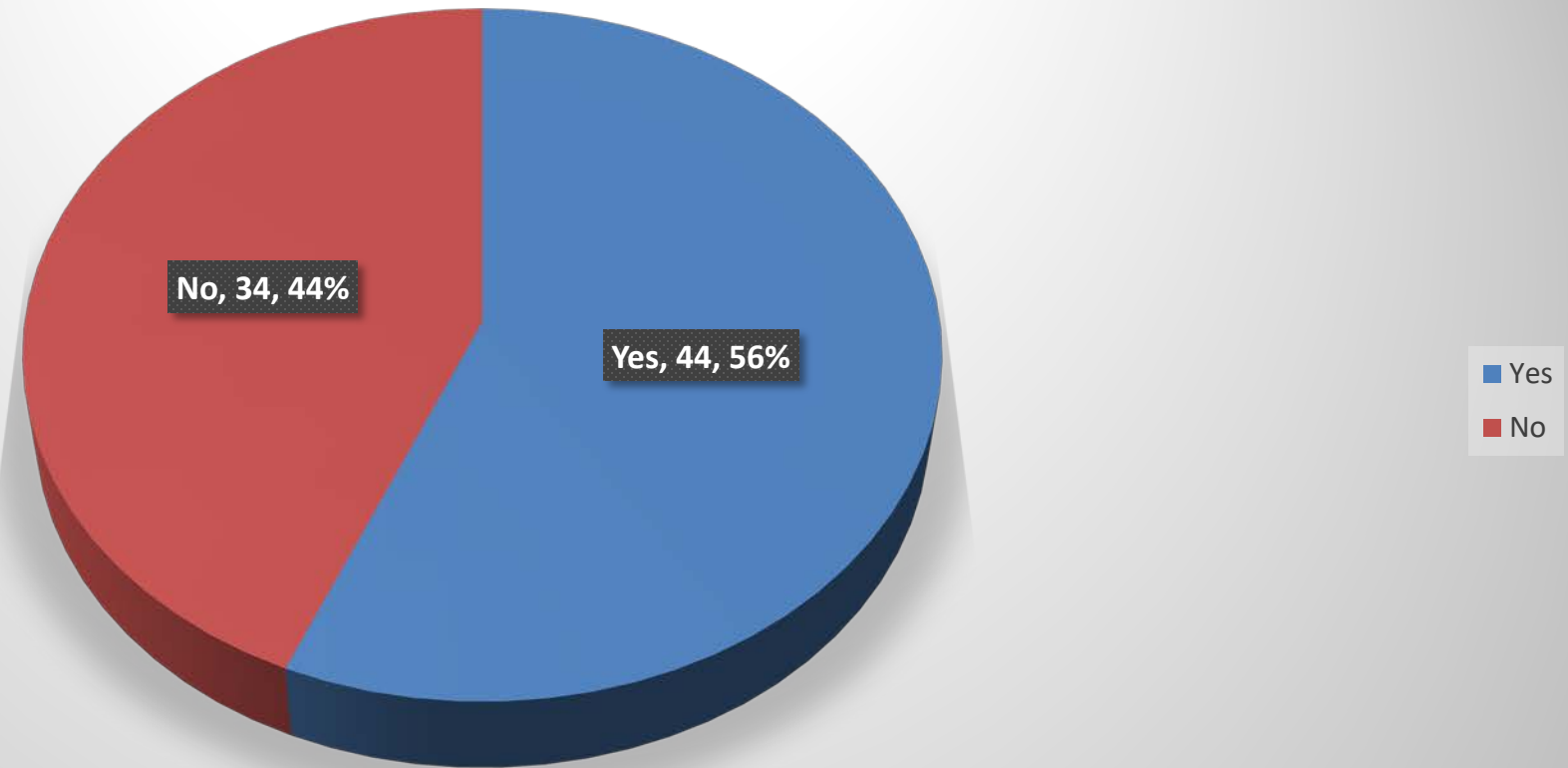
# Q4 2020: Top 3 MC Grievance Subcategories



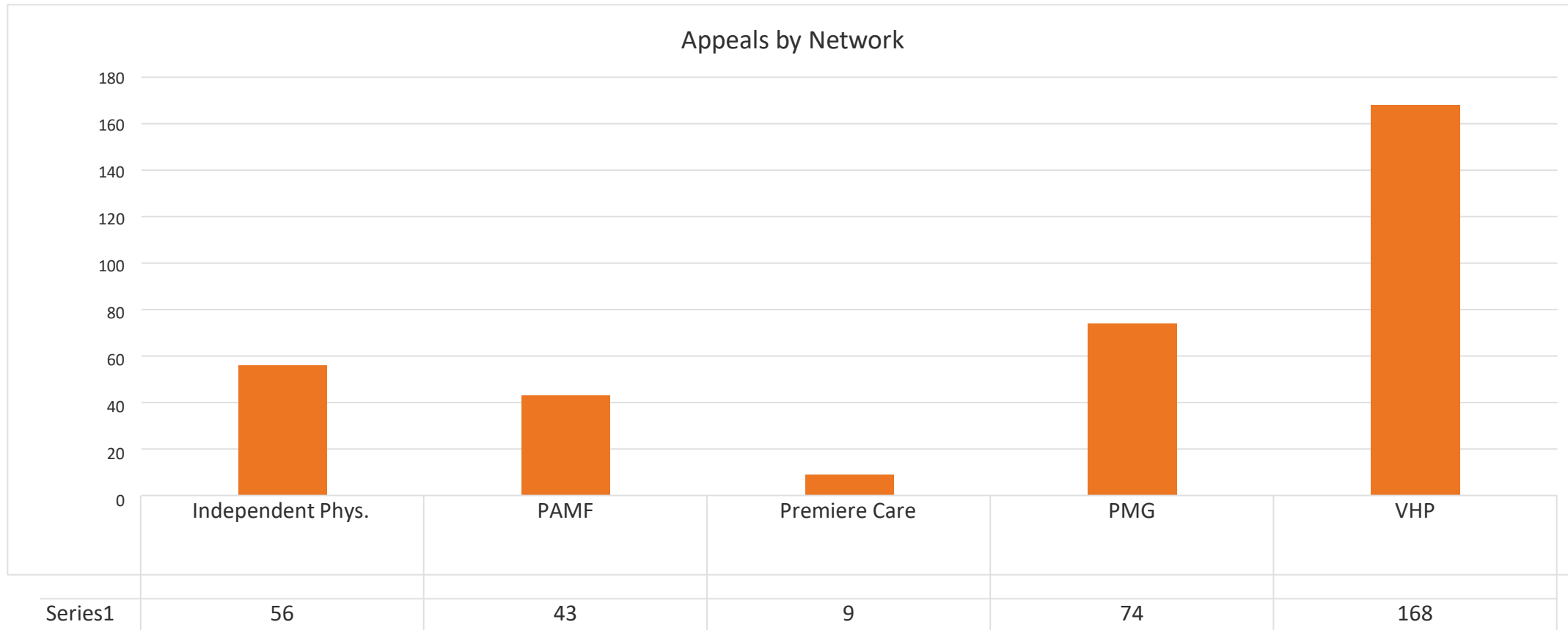
	Oct-20	Nov-20	Dec-20
Access-Provider Telephone Access	9	10	19
QOC-Inappropriate Provider Care	32	24	24
QOS-Inappropriate Billing	19	26	33



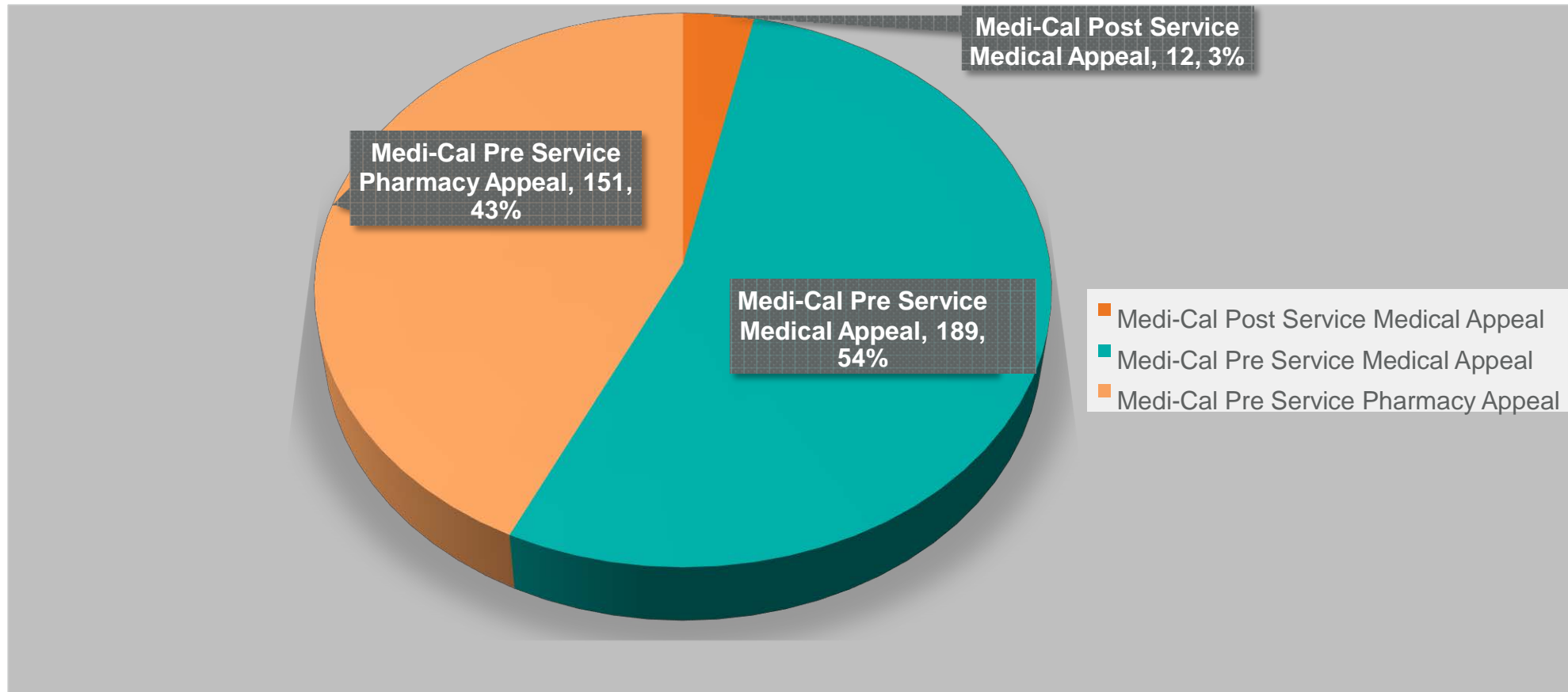
# Q4 2020 MC Inappropriate Provider Care PQI Issues Flag



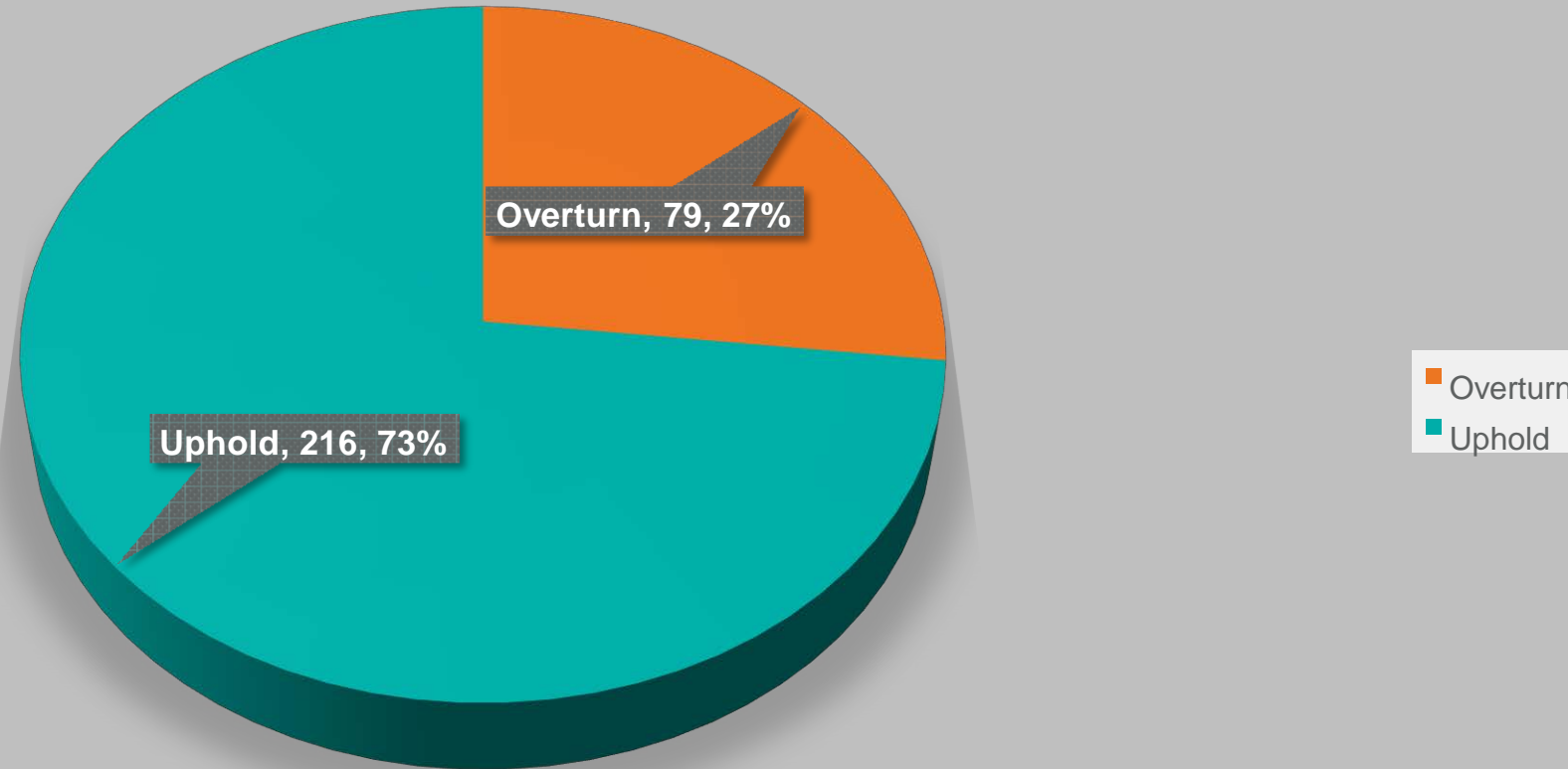
# Q4\_2020 Appeals by Network



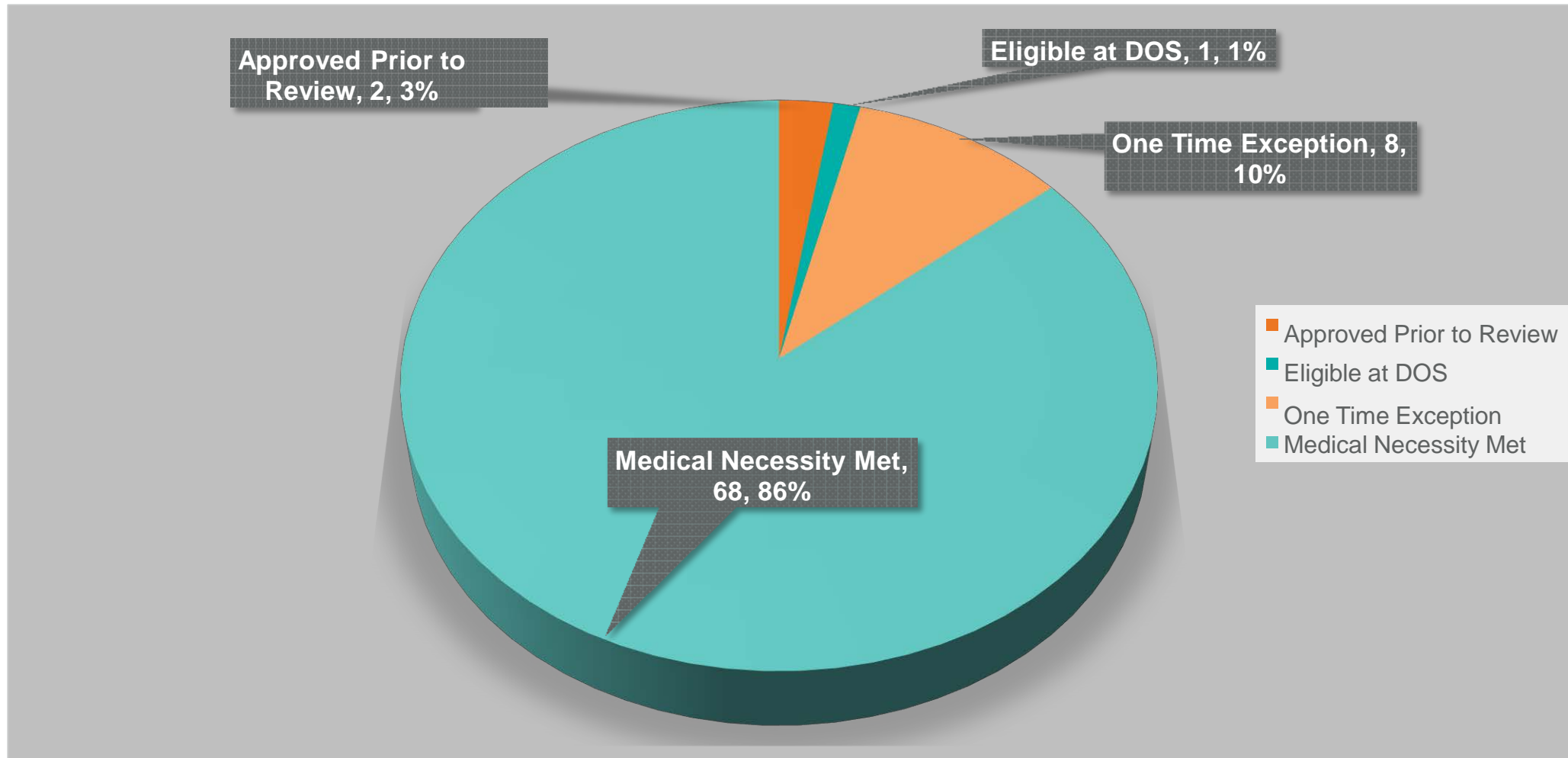
# Q4 2020 Medi-Cal Appeals by Case Type



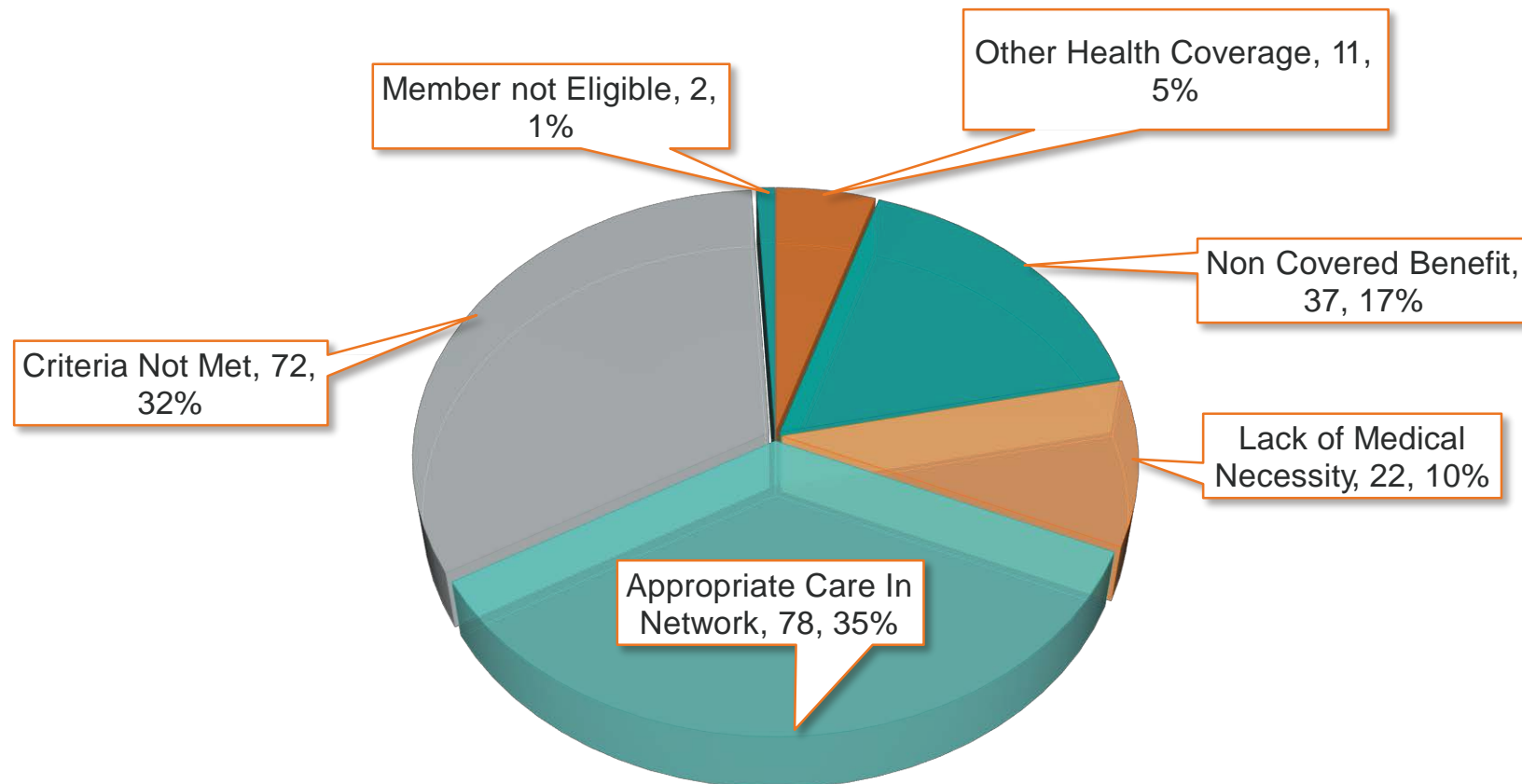
# Q4 2020 MC Appeals by Disposition



# Q4 2020 MC Appeals: Overturn Rationale



# Q4 2020 MC Appeals: Uphold Rationale



# Cal MediConnect

January						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
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29	30	31				

February						
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				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
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March						
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April						
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29	30	31				

May						
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June						
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16	17	18	19	20	21	22
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July						
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August						
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September						
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October						
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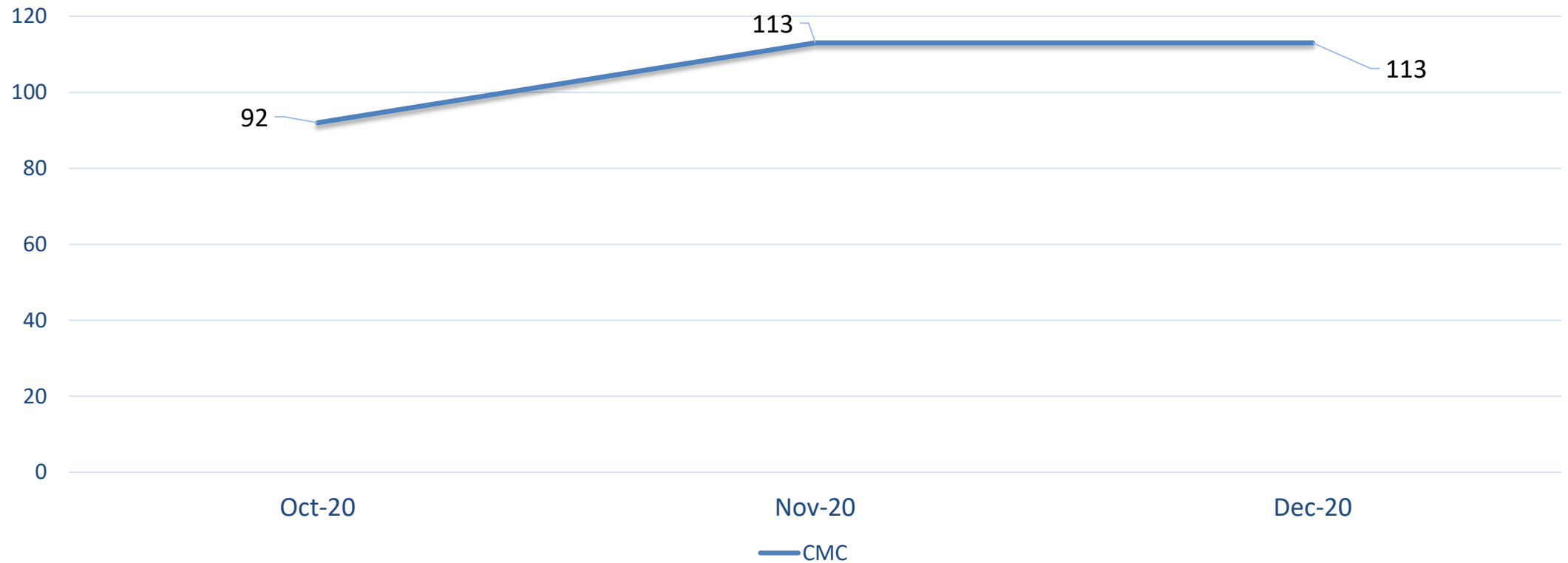
November						
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December						
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					



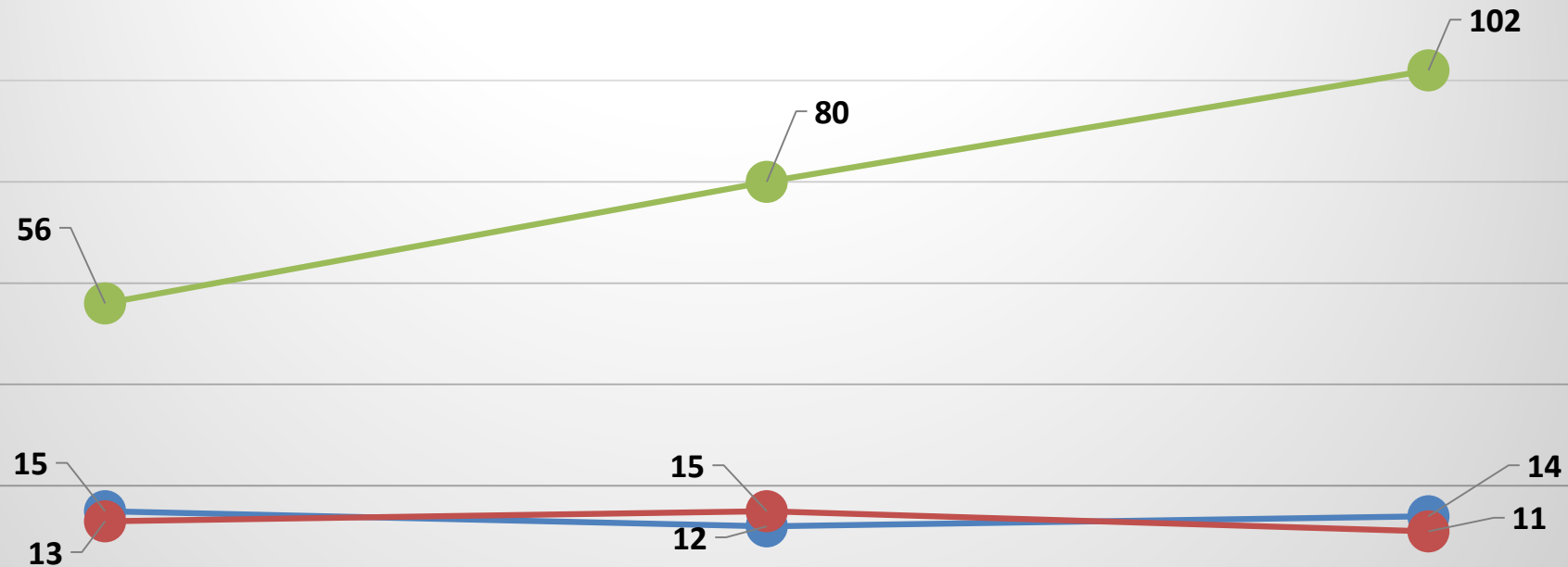
Q4 2020

# Q4 2020 Total CMC Grievance Cases Received



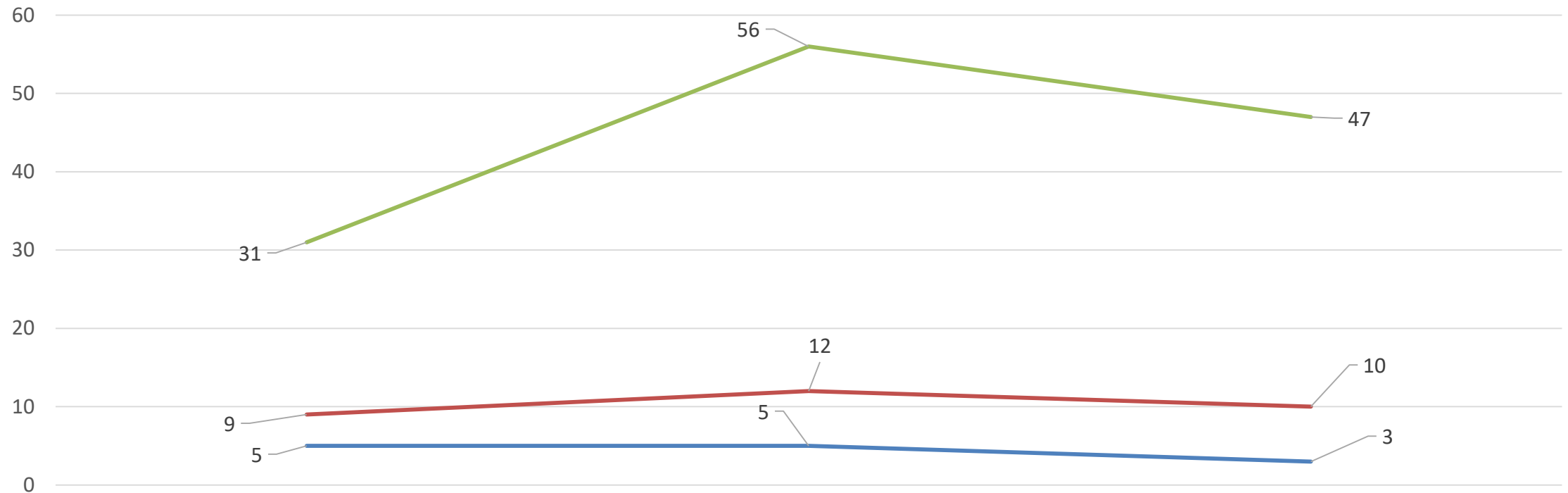


# Q4 2020: Top 3 CMC Grievance Categories



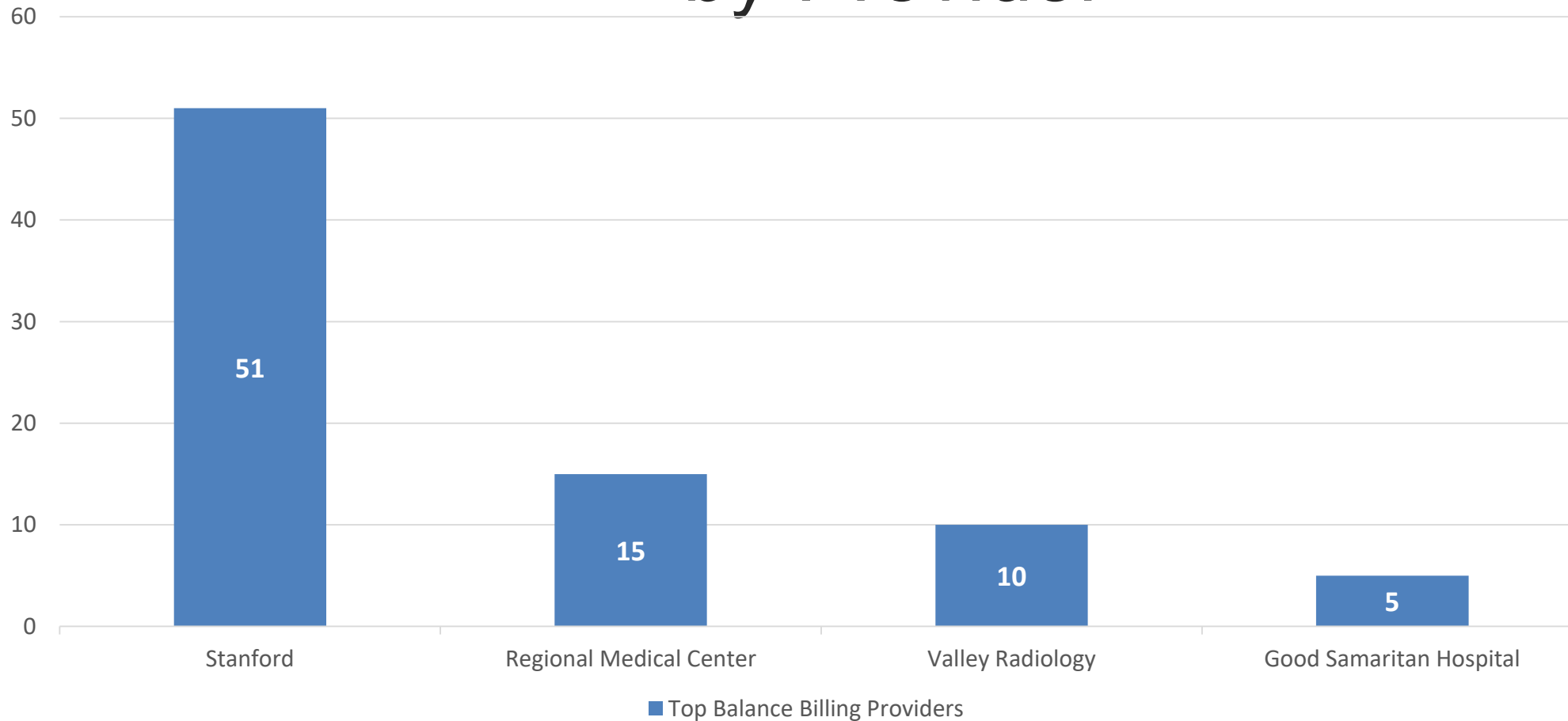
	Oct-20	Nov-20	Dec-20
● Access	15	12	14
● Quality of Care	13	15	11
● Quality of Service	56	80	102

# Q4 2020: Top 3 CMC Grievance Subcategories

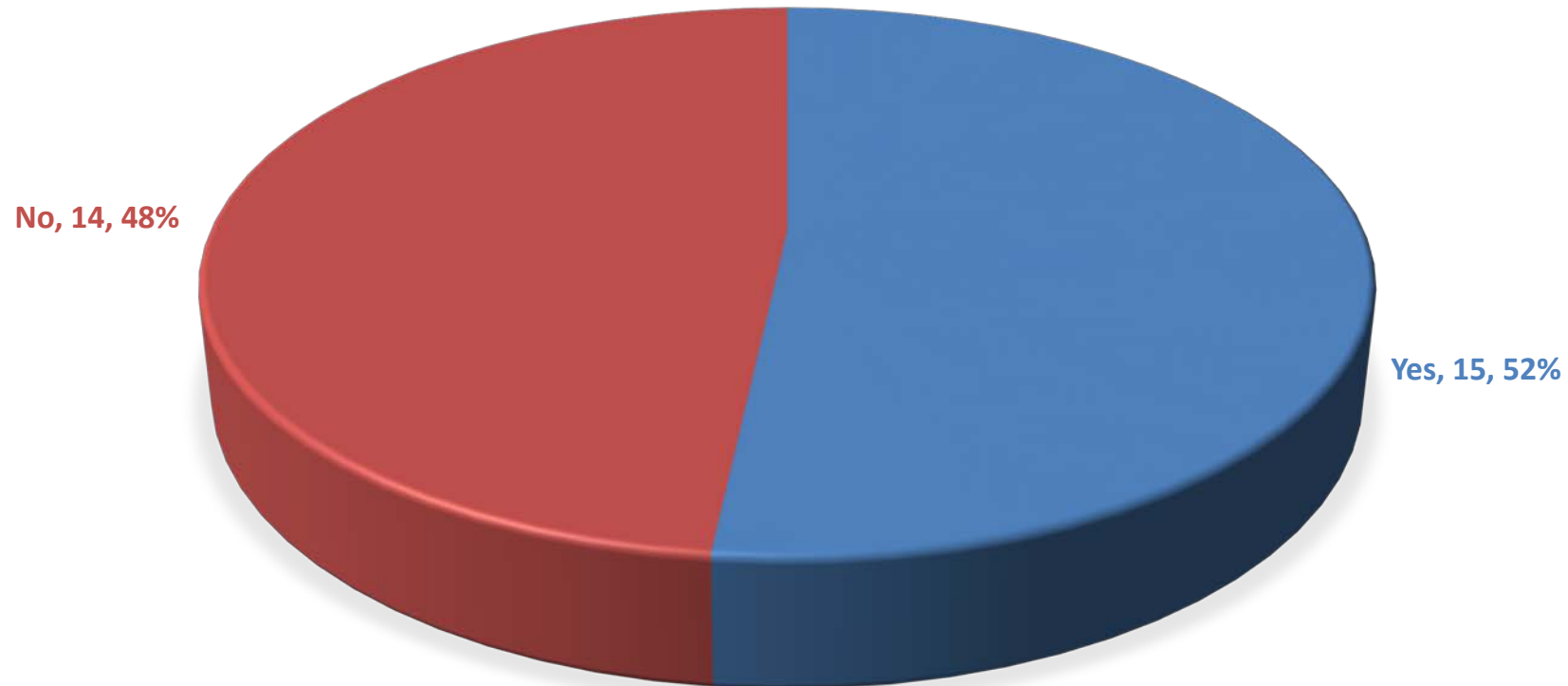


	Oct-20	Nov-20	Dec-20
— Access-Timely Access to Specialist	5	5	3
— QOC-Inappropriate Provider Care	9	12	10
— QOS-Billing/Balance Billing	31	56	47

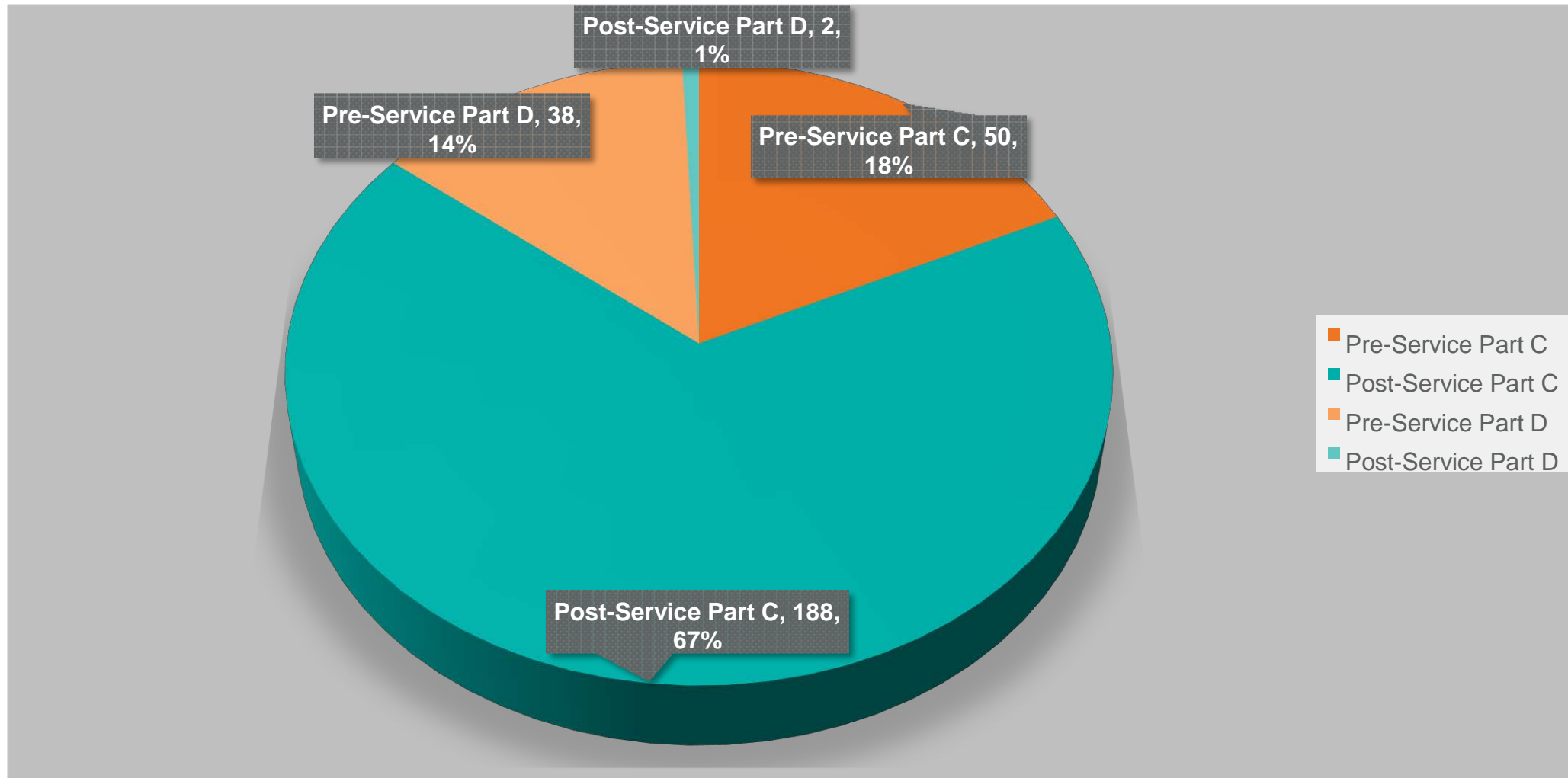
# Q4 2020 CMC Balance Billing Grievances by Provider



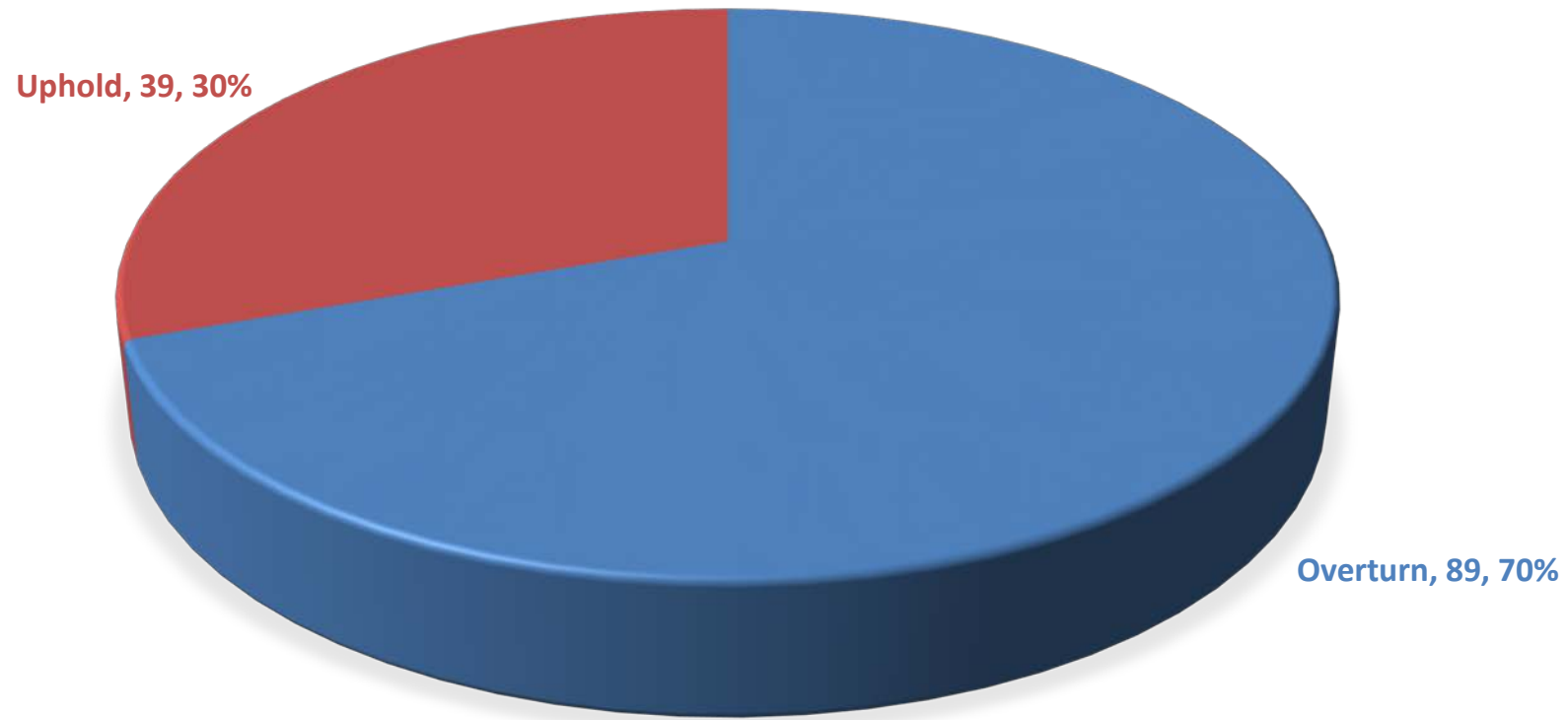
# Q4 2020 CMC Inappropriate Provider Care PQI Issues Flag



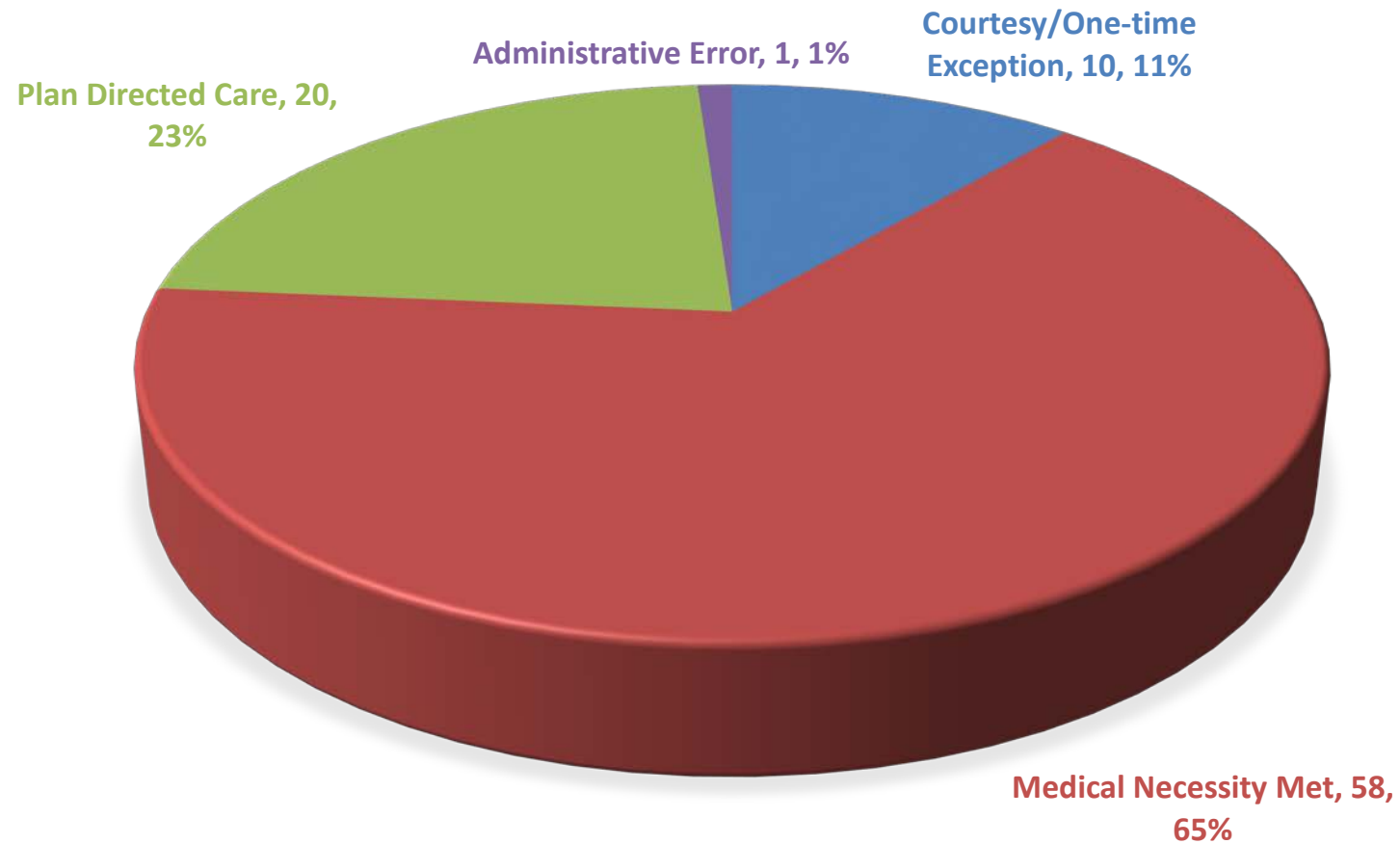
# Q4 2020 CMC Appeals by Case Type



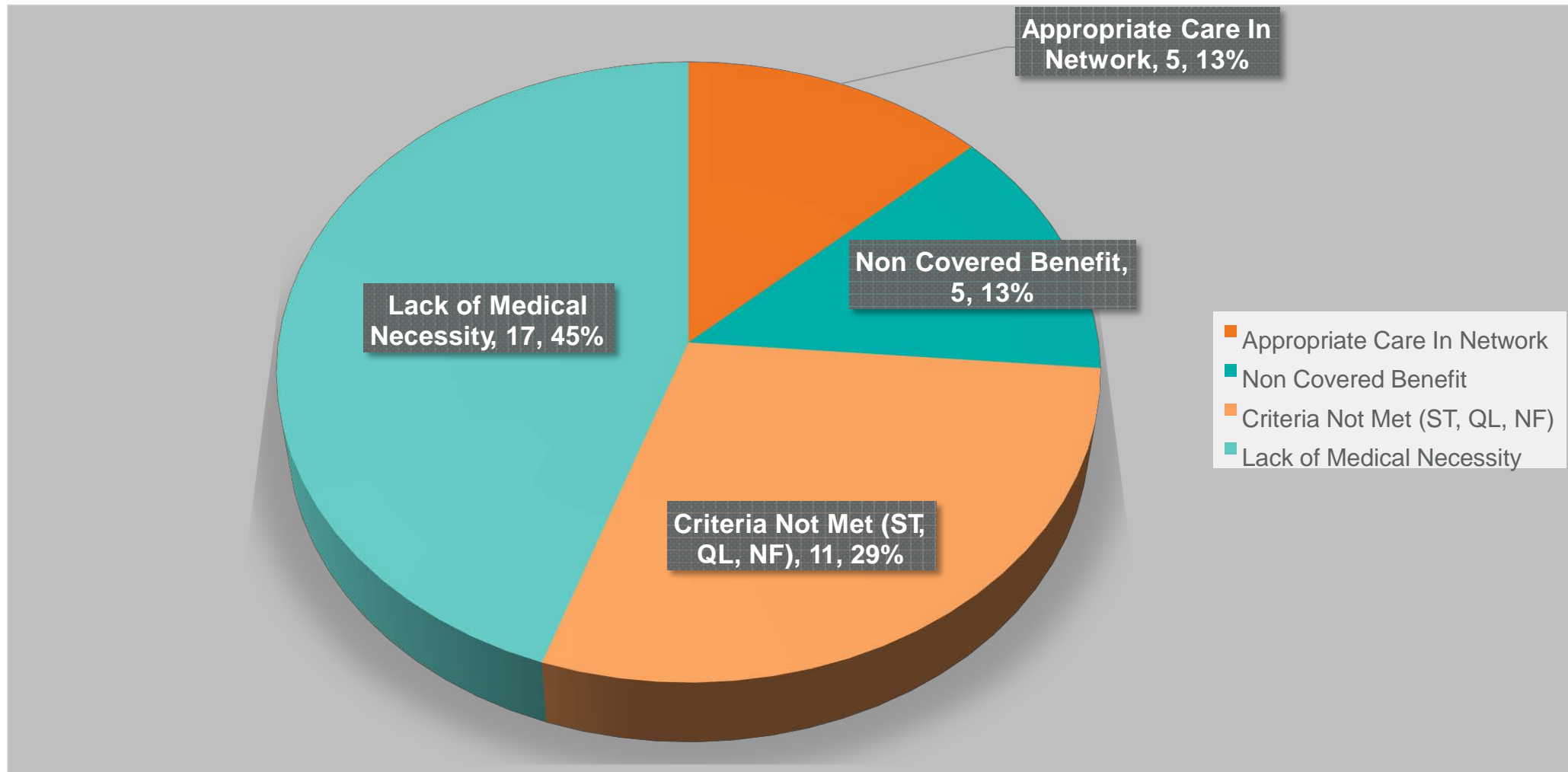
# Q4\_2020 CMC Appeals by Disposition



# Q4\_2020 CMC Appeals: Overturn Rationale



# Q4\_2020 CMC Appeals: Uphold Rationale





Regular Meeting of the  
**Santa Clara County Health Authority**  
**Utilization Management Committee**

Wednesday, January 20, 2021 6:00 – 7:30 PM  
Santa Clara Family Health Plan  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes - DRAFT

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### Members Present

Jimmy Lin, M.D., Internal Medicine, Chair  
Ali Alkoraishi, M.D., Psychiatry  
Laurie Nakahira, D.O., Chief Medical Officer  
Habib Tobbagi, PCP, Nephrology  
Indira Vemuri, Pediatric Specialist

### Members Absent

Dung Van Cai, D.O., Head & Neck  
Ngon Hoang Dinh, OB/GYN

### Staff Present

Christine Tomcala, Chief Executive Officer  
Dang Huynh, PharmD, Director, Utilization  
Management & Pharmacy  
Raman Singh, Director, Case Management  
Lily Boris, M.D., Medical Director  
Angela Chen, Manager, Utilization  
Management  
Natalie McKelvey, Manager, Behavioral  
Health  
Luis Perez, Supervisor, Utilization  
Management  
Amy O'Brien, Administrative Assistant

#### 1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:08 p.m. Roll call was taken and a quorum was established.

#### 2. Public Comment

There were no public comments.

#### 3. Meeting Minutes

The minutes of the October 14, 2020 Utilization Management Committee (UMC) meeting were reviewed.

**It was moved, seconded, and the minutes of the October 14, 2020 UMC meeting were unanimously approved.**

**Motion:** Dr. Lin

**Seconded:** Dr. Vemuri

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Vemuri

**Absent:** Dr. Cai, Dr. Dinh

**Abstain:** Dr. Tobbagi

#### 4. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, provided a brief update, which included SCFHP's participation in calls with the Public Health department. There are some challenges with the vaccine rollout. Southern California has received the majority of the vaccines, as they have more COVID cases, and their demand is greater than Santa Clara County. The state is working on streamlining the tiers for reopening, and ensuring there are more mass vaccination sites available.

## 5. Chief Medical Officer Update

### a. General Update

Dr. Laurie Nakahira began with an update on SCFHP'S participation in Santa Clara County's and the state's vaccine distribution plan. The staff of SCFHP do not yet qualify for the vaccine, as we are not considered frontline health care workers. Currently, the county is concluding vaccine administration for those who qualify based on the 1A guidelines, and they are moving into vaccine administration for those who qualify based on the 1B criteria. Eligibility under the 1B guidelines includes those who are greater than 65 years of age and those with comorbidities. Dr. Nakahira gave an overview of the federal and state vaccination distribution plan. The SCFHP website includes a link to the Santa Clara Public Health site where members can sign up to schedule their vaccinations. Members with Kaiser, PAMF, and Stanford are encouraged to schedule their vaccinations directly with these facilities. Kaiser also offers vaccinations to non-members. Dr. Lin stated that one of his patients, who is not a Kaiser member, tried to sign up for a vaccination, but Kaiser turned them down. Dr. Nakahira stated that she was on the Kaiser website, and there is a toll-free number to call which will give you information on how to complete the online form and schedule your appointment. Dr. Boris explained that patients must go through Member Services to obtain a Kaiser ID number, then call the toll-free number to make an appointment. Oftentimes, the recording instructs you to call tomorrow, but with continued effort it is possible to make a vaccination appointment.

Dr. Nakahira continued with an update on the status of CalAIM, which was on hold due to COVID, but now has an implementation date of January 1, 2022. SCFHP is preparing for this implementation date. The Plan is also preparing for the DHCS and DMHC audits in March 2020.

Dr. Lin remarked that SCFHP staff members should qualify for the vaccination, as our line of business qualifies as patient care. Dr. Boris stated that, per the vaccination guidelines, SCFHP staff members do not qualify as frontline healthcare workers and are currently ineligible for the vaccination.

### b. Annual Confidentiality Agreements

This item was not addressed this evening.

## 6. UM Program Description – 2021

Dr. Boris summarized the more significant changes to the 2021 UM Program Description for the Committee. Dr. Boris advised that the majority of the changes occurred in item "G", Emergency Services and Post-Stabilization care. Dr. Boris highlighted changes in verbiage such as the fact that referrals are no longer required for emergency medical conditions, including for severe pain that a prudent layperson would consider emergent. The Program Description also now states that SCFHP does require prior authorization for post-stabilization care beyond 30 minutes. Additional verbiage states that the Plan will fully document all requests for authorizations and our responses. A bullet point was added which states that, in the event the Plan is unable to provide a determination within 30 minutes, the requested authorization is deemed approved. The Plan's annual communication to providers, which includes the 24/7 managed care website, now states the names of the on-call physicians. Dr. Boris explained that, outside of these changes, the remainder of the 2021 UM Program Description remains the same as the 2020 Program Description.

**It was moved, seconded, and the UM Program Description – 2021 was unanimously approved.**

**Motion:** Dr. Lin

**Seconded:** Dr. Tobbagi

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi, Dr. Vemuri

**Absent:** Dr. Cai, Dr. Dinh

## 7. BHT Program Description - 2021

Ms. McKelvey presented the BHT Program Description for 2021 to the Committee. It has been 2 years since the last update to the BHT program. Ms. McKelvey advised the Committee that the recent changes are made to reflect the current APL of 19014. There are no changes to the authorization process. Once the request for service is received, all other steps in the process remain the same. The CDE is given to BH from the provider, not the parent. There are no changes or updates to the treatment codes or guidelines. BH reviews all treatment plans to ensure they are based on the individual needs of the child. Ms. McKelvey advised the Committee that an update to APL 19014 is expanded to include any child with a medical necessity for BHT, not just those with an autism diagnosis.

Dr. Vemuri requested improved communication between primary care physicians and therapists. Ms. McKelvey agreed, and she explained that, prior to COVID, BH conducted meetings with ABA providers who also struggled with communication issues. One action item has been implemented which is to request parents sign a Release of Information form which authorizes ABA therapists to communicate with primary care physicians. Dr. Vemuri suggested that, every time the patient visits the therapist, the therapist sends written documentation of the visit to the primary care physician. Ms. McKelvey advised that each authorization period is 6 months, and treatment plans are received by BH and used as criteria to determine continuation of treatment and services. These treatment plans can also be used as progress notes. Dr. Vemuri confirmed this information would be beneficial. Ms. McKelvey will follow-up with the BH team to implement this process. Dr. Alkoraishi indicated that use of the electronic medical record system to send progress notes to the primary care physician would be more beneficial.

Dr. Vemuri also expressed concern with the number of requests she receives from patients for emotional support animals. Her staff forwards these requests to patients' therapists; however, she would like to have confirmation that a patient is actually receiving treatment from a therapist. Dr. Nakahira suggested that patients, providers, and parents make an appointment together to ensure all parties are on the same page in regards to the patient's treatment.

Dr. Vemuri requested Ms. McKelvey contact Community Solutions and Rebekah Childrens' Services and request better communication with physicians. Ms. McKelvey agreed that there needs to be a better communication system. She advised that, for patients under 21 years of age, the EPSDT threshold for benefit management administered by county agencies is much lower than for adults. Ms. McKelvey advised that it is easier to address communication issues with ABA providers, rather than general mental health providers. Dr. Lin advised that he has never received any feedback from private mental health providers. Dr. Lin feels it is easier to provide treatment notes within the county provider network, rather than through private physicians. Ms. McKelvey advised the Committee that she will bring this feedback to the BH provider group to incorporate and implement as much as they can to achieve better communication.

**It was moved, seconded and the BHT Program Description – 2021 was unanimously approved.**

**Motion:** Dr. Lin

**Second:** Dr. Alkoraishi

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi, Dr. Vemuri

**Absent:** Dr. Cai, Dr. Dinh

## 8. Annual Review of UM Policies

- a. HS. 01 Prior Authorization
- b. HS. 02 Medical Necessity Criteria
- c. HS.03 Appropriate Use of Professionals
- d. HS.04 Denial of Services Notification
- e. HS.05 Evaluation of New Technology
- f. HS.06 Emergency Services
- g. HS.07 Long-Term Care Utilization Review
- h. HS.08 Second Opinion

- i. HS.09 Inter-Rater Reliability
- j. HS.10 Financial Incentive
- k. HS.11 Informed Consent
- l. HS.12 Preventive Health Guidelines
- m. HS.13 Transportation Services
- n. HS.14 System Controls

Dr. Boris presented the Committee with the annual review of UM policies. Dr. Boris summarized the purpose of, and changes to, policies HS.01 through HS.06. No changes were made to policies HS.07 through HS.14. Changes may include formatting changes and streamlining of verbiage. Dr. Boris called the Committee's attention to policy HS.13 Transportation Services, as DHCS mandates which types of emergency medical transportation services require prior authorization; however, there are no changes to this policy from 2020. Dr. Boris further highlighted policy HS.14 System Controls, which is primarily required by NCQA; however, there are no changes to this policy from 2020.

**It was moved, seconded and the Annual Review of UM Policies and Procedures was unanimously approved.**

**Motion:** Dr. Tobbagi

**Second:** Dr. Alkoraishi

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi, Dr. Vemuri

**Absent:** Dr. Cai, Dr. Dinh

## 9. Reports

### a. Membership

Dr. Boris gave a brief summary of the Membership Report from January 2020 through January 2021. Cal MediConnect membership increased approximately 14% from January 2020 to January 2021. Medi-Cal membership increased approximately 10% from January 2020 through January 2021. The majority of our members remain delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Premier Care, and Kaiser Care. Ms. Tomcala reminded the Committee that the primary reason for the growth of our Medi-Cal membership is the suspension of redeterminations by the state. Our existing members continue to stay on the plan when, under normal circumstances, the Plan would lose approximately 4,000 members a month due to redeterminations. This trend will continue through the public health emergency. Once COVID is under control, the state will resume redeterminations, and the Plan may see a significant drop in our Medi-Cal membership rolls.

### b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the calendar year 2020. Dr. Boris also summarized the 2020 results of the Cal MediConnect line of business. The average length of stay for our Medi-Cal SPD population is approximately 5 days, with Q1 slightly higher due to flu season. Our Q1 discharges per thousand is also higher due to flu season. Otherwise, the numbers remain fairly stable. The average length of stay for our non-SPD Medi-Cal population was approximately 4 days, with the number of discharges per thousand slightly lower than for our Medi-Cal SPD population.

The average length of stay for our Cal MediConnect population is 5.85 days, and this, along with the number of discharges per thousand, is typically higher than our Medi-Cal SPD and non-SPD populations due to higher utilization levels and increases in co-morbidities. Ms. Tomcala requested the UM team compare these numbers to 2019 to see the impact of COVID. Dr. Boris concurred and will bring these results to the April 2021 meeting.

Dr. Boris next summarized the results for Medi-Cal and Cal MediConnect inpatient readmissions, from January through December 2020. The Medi-Cal readmission rate is 17.71%; however, the goal was closer to 10%. The report may not have been run to exclude outliers, which has potentially impacted this number. The Plan's usual readmission rate is closer to 20%. The Cal MediConnect readmission rate is 15.99% which is below the NCQA 50<sup>th</sup> percentile. Ms. Tomcala remarked that the formula for the metric of the HEDIS PCR measure changed from 2019 to 2020. The goals should have been set, and this data pulled, based on the current 2020 metric. Dr. Boris agreed that the data should be rerun either based on the current metric, or with the outliers omitted. Dr. Lin remarked that he would expect the numbers to be 10-15% less due to COVID. Dr. Boris concurred, and this decrease is reflected in the number of outgoing calls.

Dr. Boris concluded with a summary of the ADHD Medi-Cal BH metrics.

#### c. Dashboard Metrics

- Turn-Around Time – Q4 2020

Mr. Perez summarized the Cal MediConnect Turn-Around Time metrics for Q4 2020. The turn-around times for determinations is compliant at 99% or better. The turn-around time for expedited Part C prior authorization requests was compliant for October and November, but decreased in December. The percentages for expedited initial determination notifications also decreased. In the categories of Part B determinations and prior authorization requests, there is some room for improvement; however, the range of percentages still remains at 90% or better.

Mr. Perez next summarized the Turn-Around times for Medi-Cal authorizations for Q4 2020. The turn-around times for authorizations is compliant at 97% or better. In other areas of authorization requests, the percentages decreased; however, the range of percentages remains at 97% or better.

#### d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q4 2020

Ms. Chen summarized the data from the Q4 2020 Cal MediConnect and Medi-Cal Quarterly Referral Tracking reports for the Committee. Ms. Chen explained that the UM team tracks the cycle of prior authorizations from the time the prior authorization is issued through to claims payment. The average claims cycle is 90 days. Some of the more high volume requests include outpatient hospital services, DME requests, and home healthcare, and include the highest number of unpaid services. The results for Q4 2020 are consistent with the results for Q3 2020.

#### e. Cal MediConnect and Medi-Cal Annual Referral Tracking – Q4 2020

Ms. Chen summarized the data from the Q4 2020 Cal MediConnect and Medi-Cal Annual Referral Tracking reports for the Committee. There were 22, 819 authorizations for both the Cal MediConnect and Medi-Cal lines of business. The Medi-Cal line of business typically has a higher volume than the Cal MediConnect line of business. On average, this accounts for approximately 1,900 authorizations per month on average. Even with the suspension of prior authorization requirements for all covered services and medications in March and April, there is not a large difference between the Q3 2020 and Q4 2020 results. Compared to 2019 data, there was a higher percentage of services rendered within 90 days, and a lower percentage of services not rendered at all. During COVID, the same volume of authorizations were approved and more people received requested services than prior to COVID. Ms. Chen summarized the results of the outreach calls that were made to our Cal MediConnect and Medi-Cal members. Ms. Chen further summarized the results of the data used to track claims mismatch.

#### f. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q4 2020

Ms. Chen summarized the results of the Q4 2020 Quality Monitoring of Plan Authorizations and Denial Letters for the Committee. Ms. Chen reported that the UM department received a 100% score in virtually all categories, with the exception of a small handful of written notifications that were untimely. As a result,

work flows have been updated to include daily reports, and UM leadership will continue to take an active role in QA oversight.

**g. Inter-Rater Reliability (IRR) Report BH – 2021**

Ms. McKelvey presented the results of the 2021 BH IRR report to the Committee. Of the 4 staff members who provided authorizations and completed the IRR, 3 achieved a 100% score, and 1 achieved a 90% score. All staff members passed and are cleared to continue with the authorizations.

**h. Annual Physician Peer-to-Peer (HS.02.02) – 2020**

Dr. Boris presented the purpose and goals of the Annual Physician Peer-to-Peer program for 2020. Dr. Boris summarized the results for the Committee.

**i. Behavioral Health UM**

Ms. McKelvey summarized the Behavioral Health Treatment utilization for the Committee. Ms. McKelvey highlighted the 2 new ABA providers under contract as of Q4 2020. Ms. McKelvey also highlighted the fact that Array Telehealth was just signed as a new provider for our Medi-Cal line of business. There were 8,027 developmental screenings completed in 2020. The majority of these were completed by VHP. There were 3,221 trauma screenings completed in 2020. The BH work group continues its efforts to raise the level of developmental and trauma screenings.

Dr. Boris asked if members can specifically request the services of Array Telehealth. Ms. McKelvey confirmed members can either access Array directly, or request the BH team connect them to services. Training on Array Telehealth's scheduling app will soon be conducted. Array is the first mild-to-moderate psychiatric services provider for the Plan's adult population.

**10. Adjournment**

The meeting adjourned at 7:10 p.m. The next meeting of the Utilization Management Commitment is on April 21, 2021 at 6:00 p.m.

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Jimmy Lin, M.D, Chair  
Utilization Management Committee

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Date



Regular Meeting of the  
**Santa Clara County Health Authority**  
**Cal MediConnect Consumer Advisory Board**

Thursday, March 4, 2021 11:30 AM – 1:00 PM  
 Santa Clara Family Health Plan – via Zoom  
 6201 San Ignacio Ave., San Jose, CA 95119

## MINUTES - Draft

<p><b><u>Members Present</u></b>          Laurie Nakahira, DO, Chief Medical Officer, Chair          Luis Gova Gonzalez          Tiffany Huyenh-Cho, Ombudsman, Staff Attorney,          Bay Area Legal Aid          Narendra Pathak</p> <p><b><u>Members Absent</u></b>          Charles Hanks          Verna Sarte          Dennis Schneider</p>	<p><b><u>Staff Present</u></b>          Laura Watkins, Vice President, Marketing and          Enrollment          Chelsea Byom, Director, Marketing and          Communications          Dang Huynh, Director, Pharmacy and Utilization          Management          Johanna Liu, Director, Quality and Process          Improvement          Lucille Baxter, Manager, Quality and Health          Education          Mike Gonzalez, Manager, Community Resource          Center          Thien Ly, Manager, Medicare Outreach          Theresa Zhang, Manager, Communications          Byron Lu, Process Improvement Project Manager          Lynette Topacio, Marketing Project Manager          Zara Hernandez, Health Educator          Amy O'Brien, Administrative Assistant</p> <p><b><u>Others Present</u></b>          Padmaja Vasireddy, American Heart Association</p>
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### 1. Roll Call

Dr. Laurie Nakahira, Chief Medical Officer and Chair, called the meeting to order at 11:35 a.m., roll call was taken, and a quorum was established.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

The minutes of the December 3, 2020 Cal MediConnect Consumer Advisory Board (CAB) meeting were reviewed.

#### **4. Health Plan Update**

Dr. Laurie Nakahira, Chair and Chief Medical Officer, presented the enrollment update. The Plan's Cal MediConnect membership continues to grow. As of February 2021, the Plan has 9,893 Cal MediConnect members, an increase of approximately 90 members since January 2021. Compared to February 2020, Cal MediConnect membership has increased by approximately 400 members. This is attributable partially to the Medicare Outreach team's efforts to enroll member and to the pause on Medi-Cal disenrollment due to COVID-19. Dr. Nakahira advised the Advisory Board of the upcoming Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) audits March 8 through March 9, 2021. Dr. Nakahira stated that these are routine oversight audits.

#### **5. Discussion Items**

##### **a. COVID-19 Update**

Dr. Nakahira said that Santa Clara County has now progressed to the Red tier status. SCFHP encourages all members to get COVID vaccinations. Dr. Nakahira discussed the types of vaccines on the market. There are three vaccines available at this time, the Pfizer and Moderna vaccines each require 2 shots, and the Johnson and Johnson vaccine which requires only 1 shot. The Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) have no preference among the three vaccines. The single shot Johnson and Johnson vaccine is recommended for individuals 18 years of age and older. The efficacy rate is approximately 66.3%, and studies have shown it decreases the severity of the illness in those who contract COVID.

Mr. Pathak asked if children and teens 18 years of age and under are eligible for vaccination. Dr. Nakahira responded that two of the vaccines are safe and effective for individuals 18 years of age and older. Pfizer is the only vaccine approved for individuals 16 years of age and older. Further studies are needed on the Moderna and Johnson and Johnson vaccines in order for the Federal Drug Administration (FDA) to approve these vaccines for use on children and teens. Dr. Nakahira explained that the objective of "herd immunity" is to achieve a high enough level of vaccinated individuals within communities to decrease the risk of unvaccinated children and teens contracting COVID. Mr. Pathak inquired about the travel requirements for fully vaccinated individuals. Dr. Nakahira replied that travel recommendations have not been issued yet. Nevertheless, masking, social distancing, and regular hand washing are still recommended. The CDC is unclear as to whether or not fully vaccinated individuals can still be asymptomatic carriers who may transmit the virus to unvaccinated individuals. Mr. Gova Gonzalez advised that, even though he is eligible, he declines vaccination at this time. Dr. Nakahira asked him to discuss his concerns in regards to the safety of the vaccine. Mr. Gova Gonzalez advised that he is uncomfortable with the risk of death as a result of vaccination. Dr. Nakahira responded that these deaths are under investigation, and she believes that the death rate as a result of vaccination is very low. Dr. Nakahira asked if it would change his mind if, hypothetically, the death rate was found to be 1 person in 1 million, or it was determined that there is a high number of people with no adverse effects. Mr. Gova Gonzalez stated that, at this time, he chooses not to become vaccinated.

##### **b. Vaccine Outreach**

Chelsea Byom, Director, Marketing & Communications, presented the Advisory Board with an update on the Plan's key messages on COVID-19. Ms. Byom reminded the Advisory Board that SCFHP offers transportation services to and from vaccine appointments at no cost to members. Ms. Byom highlighted all the strategies the Plan has in place for COVID vaccine member outreach. The Plan continues to adapt and align their strategies with the Santa Clara County Public Health Department and the vaccine supply available in Santa Clara County. Mr. Gova Gonzalez asked if the Plan has any flyers available as handouts he can pass out within his community. Ms. Byom confirmed that Marketing will mail him a supply of flyers, and she thanked him in advance for his efforts.



## 6. Standing Items

### a. Community Resource Center (CRC)

Mike Gonzalez, Manager, Community Resource Center, presented the Advisory Board with an update on the CRC. Mr. Gonzalez highlighted the work in progress over the next few months to ensure the CRC is operational and will meet the needs of our members' and community residents. Mr. Gonzalez defined the Plan's key populations, and he discussed the mission of the CRC. Mr. Gonzalez outlined the goals of the CRC Strategic Planning process. During this strategic planning process, the CRC will have a phased opening following strict COVID guidelines. In-person services will be limited; however, virtual programming services via Zoom and social media will be available. Health and wellness classes will be offered in English and Spanish, and classes in other threshold languages will be offered in the future.

Mr. Gova Gonzalez advised that there appears to be no signage at the CRC location. Mr. Gonzalez responded that the CRC is in the same building as the old Hometown Buffet. Proper signage is in the works and should be visible within the next several weeks. The CRC is located in the courtyard between Target and Ross. Ms. Watkins clarified that the doors to the CRC are currently locked as the center is not yet open to the public during COVID.

Mr. Pathak asked if services will be offered in languages other than English and Spanish. Mr. Gonzalez affirmed that multiple cultures and languages will be represented at the CRC. The three most commonly spoken languages in the center's location are English, Spanish, and Vietnamese. Mr. Pathak also inquired about the target opening date, and whether or not transportation services will be offered. Mr. Gonzalez responded that the opening date is largely dependent upon our progress with COVID and the lifting of COVID restrictions. Mr. Gonzalez advised the Plan is building a communication plan to engage members via virtual tools. As more and more people become vaccinated and we progress through less restrictive tiers, more in-person services will become available. Mr. Gonzalez welcomes the committee's input.

### b. Member Communications

Theresa Zhang, Manager, Communications, gave an overview of the member communications completed since the December 2020 CAB meeting. Mailings included the winter newsletter, which was mailed out at the end of January, with a reminder to begin 2021 with a wellness check. The newsletter included instructional infographics with topics such as when to begin key screenings, the importance of the flu shot, when to seek urgent care versus emergency care, and a reminder that the Plan's 24/7 nurse advice line is available for members. The newsletter contained articles on anti-depressants, asthma medications, sleep, taking care of your heart, and how to sign up for the American Heart Association's Healthy Hearts program. Additional articles provided information on Alzheimer's disease, fall prevention, appointing a representative, and setting up an Advance Directive. The Plan sent two postcards requesting member participation in a quality survey. The Plan continues to mail out COVID vaccination information. Outreach to our vulnerable, high risk members to check in on their welfare and to help with vaccine appointments is still in progress. Ms. Zhang highlighted the SCFHP website which is updated with meeting materials, member materials such as the Formulary, Provider Directory, and newsletters, Coronavirus information, and a dedicated flu webpage to find flu shots near you. Ms. Zhang continued with a list of the events to which the Plan sent outreach materials since our December 2020 meeting. The Plan has not attended any events in person during the COVID restrictions.

### c. Health Education and Cultural Linguistics – Presentation by American Heart Association (AHA)

Dr. Nakahira introduced Padmaja Vasireddy from the AHA. Ms. Vasireddy gave a presentation to the Advisory Board on the mission of the AHA, with an overview of the Healthy Hearts initiative. The Healthy Hearts program is in its 5<sup>th</sup> consecutive year, and the program was expanded to include East San Jose. Ms. Vasireddy shared the strategies and goals of the Healthy Hearts initiative as well as the target audience. Ms. Vasireddy explained the elements and objectives of the Check.Change.Control program and how to register

for the program. All instructors are certified and licensed within their respective specialties. Currently, the programs are offered virtually, but will return to in person workshops post-COVID. Last year, the AHA also began free A1c screenings at various locations. Ms. Vasireddy shared the testimonials of former participants in the Healthy Hearts program.

Mr. Pathak asked how SCFHP members register for this program. Ms. Vasireddy directed Mr. Pathak to Zara Hernandez, SCFHP Health Educator, for registration assistance, or he can email Ms. Vasireddy for the registration link. Ms. Vasireddy reiterated this is a 4 month series of workshops and all 8 webinars must be attended. Mr. Pathak asked if this program is funded by El Camino Hospital, and Ms. Vasireddy affirmed this is the case. Mr. Gova Gonzalez also requested the registration link.

Dr. Nakahira advised members of the CAB that in January 2021, SCFHP called all Cal MediConnect and Medi-Cal members with high blood pressure to enroll them in the Healthy Hearts program. No Cal MediConnect members chose to enroll at that time. Ms. Baxter added that she and Mike Gonzalez are in discussion with Ms. Vasireddy as to potential sponsorship of this program by SCFHP.

Mr. Pathak inquired about stroke recovery programs, and Ms. Vasireddy replied that she will connect him with resources; however, stroke recovery is not a focus of the program. Stress management and cardiovascular health is addressed in one of their webinars. Dr. Nakahira shared that maintaining healthy blood pressure is the number one stroke prevention method.

#### **d. Cal MediConnect Ombudsman Program Updates**

Tiffany Huyenh-Cho, Ombudsman, Staff Attorney with Bay Area Legal Aid, introduced herself and gave an overview of the services offered by Bay Area Legal Aid. Their services are free and offered in the various threshold languages. Services are offered to dual eligible Cal MediConnect members, as well as Medi-Cal members. The pause on Medi-Cal redeterminations continues during COVID. Medi-Cal coverage will not be terminated during the pandemic, even if an individual no longer qualifies for Medi-Cal. At this time, Bay Area Legal Aid is focusing on educating callers and service providers as to the redetermination process and assisting individuals with completing their Medi-Cal renewal packets. Lately, Bay Area Legal Aid is receiving several calls from individuals whose surgeries are being delayed. It appears this is mostly due to a backlog in surgery appointments due to the pause on non-emergency surgeries. Bay Area Legal Aid continues to provide concerned individuals with assistance to help expedite and schedule these surgeries.

Mr. Gova Gonzalez asked how he can make an appointment to speak to an attorney. Ms. Huyenh-Cho responded that, due to the pandemic, walk-in service is not available; however, individuals are welcome to call the hotline to connect with an attorney. Ms. Huyenh-Cho provided the hotline number to the committee. Ms. Huyenh-Cho advised their services are focused on equitable access to health services and health insurance. Services do not include issues of medical malpractice, as they do not have that expertise.

#### **e. Future Agenda Items**

Dr. Nakahira solicited ideas from committee members for future agenda items. Mr. Pathak suggested additional information about the COVID vaccines as a valuable topic. Of particular interest is feedback from members who experienced complications of the COVID vaccine. Mr. Pathak also suggested recognition for Mr. Subramanian for his years of service as a CAB member.

Mr. Gova Gonzalez expressed concern with his experience with a procedure at Stanford. Dr. Nakahira responded that SCFHP is currently working to resolve this issue through our Grievances and Appeals department. Dr. Nakahira attempted to contact Mr. Gova Gonzalez to discuss the Plan's mitigation efforts; however, she was unable to reach him. Dr. Nakahira reminded committee members that this meeting is a matter of public record, so it is inadvisable to discuss personal health details. Ms. Watkins recommended that, in the future, members should call SCFHP immediately to discuss their concerns, and not wait for the quarterly CAB meeting, so SCFHP can best assist. Dr. Nakahira advised she will contact Mr. Gova Gonzalez after the meeting and connect him with our Grievances and Appeals department. Dr. Nakahira advised she believes the matter in question is in the resolution stage. Mr. Pathak agrees that privacy and confidentiality

during this meeting is paramount. Guidelines for what is considered appropriate for discussion during this meeting should be established.

**7. Member Feedback and Experience**

This item was not discussed.

**8. Adjournment**

The meeting adjourned at 12:45 p.m. The next Cal MediConnect Consumer Advisory Board meeting is scheduled for Thursday, June 3, 2021 at 11:30 a.m.

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Laurie Nakahira, DO, Chairperson  
Cal MediConnect Consumer Advisory Board

Regular Meeting of the

## Santa Clara County Health Authority Pharmacy & Therapeutics Committee

Thursday, March 18, 2020, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

### Minutes (Open) - Draft

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#### Members Present

Jimmy Lin, MD, Chair  
Ali Alkoraishi, MD  
Hao Bui, BS, RPh  
Dang Huynh, PharmD, Director of Pharmacy and UM  
Laurie Nakahira, DO, Chief Medical Officer  
Peter Nguyen, DO  
Jesse Parashar-Rokicki, MD

#### Members Absent

Xuan Cung, PharmD  
Dolly Goel, MD  
Narinder Singh, PharmD

#### Staff Present

Duyen Nguyen, PharmD, Clinical Pharmacist  
Tami Otomo, PharmD, Clinical Pharmacist  
Charlene Luong, Manager, Grievance &  
Appeals  
Nancy Aguirre, Administrative Assistant

#### Others Present

Amy McCarty, PharmD, MedImpact

#### 1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:06 pm. Roll call was taken and a quorum was established.

#### 2. Public Comment

There were no public comments.

#### 3. Meeting Minutes

The 4Q2020 P&T Committee Open meeting minutes were reviewed.

**It was moved, seconded and** the open minutes of the December 17, 2020 P&T meeting were **unanimously approved.**

**Motion:** Dr. Alkoraishi

**Second:** Dr. Nakahira

**Ayes:** Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Nguyen, Dr. Parashar-Rokicki,

**Absent:** Ms. Cung, Dr. Goel, Dr. Singh

#### 4. Standing Agenda Items

##### a. Chief Medical Officer Health Plan Updates

Laurie Nakahira, DO, Chief Medical Officer (CMO), presented the CMO Health Plan Updates. SCFHP is currently in the Department of Health Care Services (DHCS) audit, which started on March 8, 2021 and will close tomorrow.

Dr. Nakahira announced a staffing change within the Case Management (CM) department. Raman Singh resigned as CM Director on March 10, 2020. Angela Chen, Utilization Management (UM) Manager, is CM certified and on the Board of CM Association in San Jose, CA. Ms. Chen has accepted the interim CM Director role.

Dr. Nakahira reported Santa Clara County is currently in the red tier. Some indoor dining and operations are permitted. There are currently three (3) COVID-19 vaccines available: Pfizer, Moderna, and Johnson & Johnson (J&J). Discussions with the Public Health Department reveal J&J will be utilized for members who are homebound and members who have trouble accessing the second vaccine.

##### b. Annual P&T Charter Review

Dang Huynh, PharmD, Director, Pharmacy & Therapeutics and UM presented the annual P&T Charter. There were no revisions made.

**It was moved, seconded and the P&T Charter was unanimously approved.**

**Motion:** Dr. Lin

**Second:** Dr. Nguyen

**Ayes:** Dr. Alkoraishi, Ms. Bui, Dr. Huynh, Dr. Nakahira, Dr. Parashar-Rokicki,

**Absent:** Ms. Cung, Dr. Goel, Dr. Singh

##### c. Medi-Cal Rx Update

Dr. Huynh presented the Medi-Cal (MC) Rx Update. The original DHCS go-live date was April 1, but was postponed due to discussions of potential conflict of interest, as Centene purchased Magellan for 2.2 billion dollars and owns Health Net. DHCS will provide an update in May, 2021.

##### d. Grievance & Appeals Report – 4Q 2020

Charlene Luong, Manager, Grievance & Appeals (G&A) presented the G&A Report for 4Q2020. Ms. Luong reviewed the MC and Cal MediConnect (CMC) appeals by volume and disposition as well as the MC appeal overturn rationale and uphold rationale.

##### e. Annual Policy Review

Dr. Huynh reported no changes were made to the following policies:

- i. PH.01 Pharmacy and Therapeutics Committee
- ii. PH.02 Formulary Development and Guideline Management
- iii. PH.03 Prior Authorization
- iv. PH.04 Pharmacy Clinical Programs and Quality Monitoring
- v. PH.05 Continuity of Care for Pharmacy Services
- vi. PH.06 Pharmacy Communications
- vii. PH.07 Drug Recalls
- viii. PH.08 Pain Management Drugs for Terminally Ill
- ix. PH.09 Medications for Members with Behavioral Health Conditions
- x. PH.11 340B Program Compliance
- xi. PH.14 Medications for Cancer Clinical Trial

**It was moved, seconded and the policies PH.01, PH.02, PH.03, PH.04, PH.05, PH.06, PH.07, PH.08, PH.09, PH.11, and PH.14 were unanimously approved.**

**Motion:** Dr. Alkoraishi

**Second:** Dr. Nguyen

**Ayes:** Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Nakahira, Dr. Parashar-Rokicki,

**Absent:** Ms. Cung, Dr. Goel, Dr. Singh

**f. Plan/Global Medi-Cal Drug Use Review**

Tami Otomo, PharmD, Clinical Pharmacist, shared the results from SCFHP's quarterly retrospective Drug Use Evaluation (DUE) program. For Q12021, the focus was Coronary Artery Disease, specific to members with a history of an inpatient hospitalization and at least one (1) cardiovascular risk factor. SCFHP identified these members may benefit from a statin to reduce morbidity and mortality.

Dr. Otomo shared the providers of the impacted members will receive a letter in the mail regarding this program.

**g. Emergency Supply Report – 1Q 2020**

Duyen Nguyen, PharmD, Clinical Pharmacist, presented the Emergency Supply Report for 1Q2020. The approved claims for antibiotics were appropriate. For denied claims, chart notes were requested. One member had a denied claim for Cefixime 400mg capsule. This was identified as a gap and a point of sale (POS) message will be implemented for Cefdinir oral as a formulary alternative.

*Adjourned to Closed Session at 6:30 p.m.*

*Pursuant to Welfare and Institutions Code Section 14087.36 (w)*

**5. Closed Meeting Minutes**

The 4Q2020 P&T Committee Closed meeting minutes were reviewed.

**It was moved, seconded and the closed minutes of the December 17, 2020 P&T meeting were unanimously approved.**

**Motion:** Dr. Nguyen

**Second:** Dr. Nakahira

**Ayes:** Dr. Alkoraishi, Ms. Bui, Dr. Huynh, Dr. Lin, Dr. Parashar-Rokicki

**Absent:** Dr. Cung, Dr. Goel, Dr. Singh

**6. Metrics and Financial Updates**

**a. Membership Report**

Dr. Nakahira presented the Membership Report.

**b. Pharmacy Dashboard**

Dr. Otomo reviewed the Pharmacy Dashboard.

**c. Pharmacy Member Portal Stats – 2H 2020**

Dr. Huynh presented the Pharmacy Member Portal Stats.

**d. Drug Utilization & Spend – 4Q 2020**

Amy McCarty, MedImpact, presented the Drug Utilization and Spend for 4Q2020..

**7. Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria**

**a. Pharmacy Benefit Manager 4Q2020 P&T Minutes**

Dr. McCarty referenced the Pharmacy Benefit Manager 4Q2020 P&T Minutes.

**b. Pharmacy Benefit Manager 1Q2021 P&T Part D Actions**

Dr. McCarty reviewed the Pharmacy Benefit Manager 1Q2021 P&T Part D Actions.

**It was moved, seconded and the Pharmacy Benefit Manager 4Q2020 and 1Q2021 Part D Actions were unanimously approved.**



## 8. Discussion and Recommendations for Changes to SCFHP's Medi-Cal and Prior Authorization Criteria

### a. Old Business/Follow-Up

Dr. Huynh reported there were no old business items to report and/or follow-up.

### b. Formulary Modifications

Dr. Otomo presented the changes made to the Medi-Cal formulary since the last P&T Committee meeting in September 2020.

**It was moved, seconded and the Medi-Cal Formulary Modifications were unanimously approved.**

### c. Fee-for-Service Contract Drug List Comparability

Dr. McCarty reviewed the Fee-for-Service (FFS) Contract Drug List (CDL) Comparability for MC.

**It was moved, seconded and the Fee-for-Service Contract Drug List Comparability proposed actions were unanimously approved.**

### d. Prior Authorization Criteria

Dr. Nguyen reviewed the Prior Authorization Criteria.

#### i. New or Revised Criteria

1. Movantik (Naloxegol) – *added*

#### ii. Annual Review

1. Letairis (Ambrisentan) – *no changes*
2. Jadenu (Deferasirox) – *no changes*
3. Vumerity (Diroximel fumarate) – *no changes*
4. Gukenya (Fingolimod) – *no changes*
5. General utilization management – *no changes*
6. Copaxone (Glatiramer acetate) – *no changes*
7. Avonex & Rebif (Interferon beta-1a) – *no changes*
8. Savella (Milnacipran) – *no changes*
9. Opioid – Reauthorization – *no changes*
10. Oxycontin (Oxycodone) – *no changes*
11. Evista (Raloxifene) – *no changes*

***Peter Nguyen joined the meeting at approximately 7:21 p.m.***

**It was moved, seconded and the Prior Authorization Criteria was unanimously approved.**

## 9. New Drugs and Class Reviews

### a. Nexletol & Nexlizet - Hyperlipidemia

Dr. McCarty presented the new drugs and class reviews.

### b. Aducanumab – Alzheimer's Disease Review

Dr. McCarty reviewed Aducanumab – Alzheimer's Disease.

### c. COVID-19 Treatments

Dr. McCarty presented the COVID-19 treatments.

**It was moved, seconded and the recommendations for New Drugs and Class Reviews were unanimously approved.**

**d. Informational Only**

- i. Ponesimod – Multiple Sclerosis
- ii. Umbralisib – Lymphoma
- iii. Dasiglucagon – Hypoglycemia
- iv. New & Expanded Indications
- v. New Derivatives, Formulations, & Combinations

***Reconvene in Open Session at 7:37 p.m.***

**10. Discussion Items**

**a. New and Generic Pipeline**

Dr. McCarty reviewed the New and Generic Pipeline. Teplizumab (diabetes type 1 prevention) is currently under FDA review and will come to market in 3Q2021. MedImpact's projected monthly cost is approximately \$23,000 per month. Dr. Huynh will present the formulary status for MC line of business to the next P&T Committee meeting.

There were no notable generic drugs to review at this time.

***Ms. Bui announced her retirement from the P&T Committee after serving the committee since 1997. Within the 20+ years of service, Ms. Bui also served 12 years as a Board member on SCFHP's Governing Board. SCFHP thanks Ms. Bui for all her dedication and commitment to the P&T Committee, SCFHP, and the members within the community. Ms. Bui's participation is appreciated and will be missed.***

**11. Adjournment**

The meeting adjourned at 7:54 p.m. The next P&T Committee meeting will be on Thursday, June 17, 2021.

\_\_\_\_\_  
Jimmy Lin, MD, Chair

\_\_\_\_\_  
Date





Regular Meeting of the  
**Santa Clara County Health Authority**  
**Quality Improvement Committee**

Wednesday, June 9, 2021, 6:00 PM – 8:00 PM  
Santa Clara Family Health Plan, Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes - Draft

### Members Present

Ria Paul, MD, Chair  
Ali Alkoraishi, MD  
Nayyara Dawood, MD  
Jennifer Foreman, MD  
Jimmy Lin, MD  
Laurie Nakahira, D.O.,  
Chief Medical Officer  
Christine Tomcala, Chief  
Executive Officer

### Members Absent

Jeffery Arnold, MD

### Specialty

Emergency Medicine  
Adult & Child Psychiatry  
Pediatrics  
Pediatrics  
Internist

Geriatric Medicine

Pediatrics

### Staff Present

Chris Turner, Chief Operating Officer  
Laura Watkins, Vice President , Marketing and  
Enrollment  
Johanna Liu, PharmD, Director, Quality &  
Process Improvement  
Janet Gambatese, Director, Provider Network  
Operations  
Tyler Haskell, Interim Compliance Officer  
Lucile Baxter, Manager, Quality & Health  
Education  
Mike Gonzalez, Manager, Community  
Resource Center  
Natalie McKelvey, Manager, Behavioral Health  
Theresa Zhang, Manager, Communications  
Gaya Amirthavasari, Process Improvement  
Project Manager, Quality Improvement  
Victor Hernandez, Program Manager,  
Grievance and Appeals  
Kelly Davey, Supervisor, Grievance & Appeals  
Karen Fadley, Provider Database Analyst,  
Provider Network Operations  
Nancy Aguirre, Administrative Assistant  
Rita Zambrano, Administrative Assistant

### 1. Roll Call

Ria Paul, MD, Chair, called the meeting to order at 6:02 pm. Roll call was taken and quorum was established.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

Minutes of the April 14, 2021 Quality Improvement Committee (QIC) meeting were reviewed when a quorum was established.

**It was moved, seconded and the minutes of the 04/14/2021 QIC meeting were unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Alkoraishi  
**Ayes:** Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

#### 4. CEO Update

Christine Tomcala, Chief Executive Officer, reported the current Plan membership is approximately 282,670 members, reflecting an 11.3% increase over the last year, since June 2020. Of which, approximately 10,080 are Cal MediConnect (CMC) members and 272,590 are Medi-Cal (MC) members. Santa Clara Family Health Plan (SCFHP) exceeded the 10K CMC member milestone.

Ms. Tomcala announced the state will restart MC redetermination as of January 2022. A decline in membership is anticipated.

SCFHP is working on the CalAIM initiative with the county to transition their Whole Person Care (WPC) members, as well as our Home Health members, into the new ECM and ILOS programs. The deadline for the transition plan is July 1<sup>st</sup>, 2021.

Ms. Tomcala noted the Blanca Alvarado Community Resource Center (CRC) continues to host vaccination clinics and have expanded clinic hours to evenings and weekends, with no appointment necessary. Over 1,000 vaccines have been administered at the CRC. A soft opening of the CRC will begin with application assistance this month.

Dr. Lin asked where the CRC is located. Ms. Tomcala informed the committee the CRC is located on McKee Rd. and Capitol Ave, in place of the Home Town Buffet. SCFHP plans to open the CRC in September, 2021.

Dr. Paul asked which vaccine is being administered. Ms. Tomcala explained the county determines which vaccine will be administered based on availability.

#### 5. Assessment of Member Cultural and Linguistic Needs and Preferences

Janet Gambatese, Director, Provider Network Operations, presented the Assessment of Member Cultural and Linguistic Needs and Preferences. Ms. Gambatese explained SCFHP conducts this assessment on an annual basis to study the cultural, ethnic, and linguistics needs of its members.

Ms. Gambatese reviewed the Santa Clara County demographics, gathered from the US census and statistical atlas, as well as their spoken languages. SCFHP utilizes this information to develop this assessment.

Ms. Gambatese also reviewed the percentage of the SCFHP Network Providers who speak the threshold languages. Language line interpreter services, including face-to-face interpreter services, were also reviewed, as well as the member grievances for said interpreter services. The Consumer Assessment of Healthcare Provider Survey (CAHPS) results were reviewed.

In conclusion, the assessment revealed there are no significant disparities in meeting member cultural, ethnic, and linguistic preferences, which concludes member needs are being met. SCFHP will continue to seek diverse providers with the language skills needed to ensure member's needs continue to be met.

Dr. Alkoraishi pointed out the discrepancy in Ms. Gambatese's presentation, regarding the reported percentage reflecting over 100%. Ms. Gambatese explained this is due to the multiple counts of a member's ethnicity. This information is obtained through the US Census, so we may not be able to resolve this.

**It was moved, seconded and the Assessment of Member Cultural and Linguistic Needs and Preferences was unanimously approved.**

**Motion:** Dr. Alkoraishi  
**Second:** Dr. Lin  
**Ayes:** Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

## 6. 2020 Impact Analysis

Gaya Amirthavasara, Project Manager, Process Improvement, presented the 2020 Impact Analysis in place of Angela Chen, Interim Director, Case Management. The Impact Analysis is conducted on an annual basis and is based off of the goals set through the Population Health Management (PHM) Strategy, as well as NCQA requirements. The PHM group is composed of staff from the following teams: Case Management (CM), Behavioral Health (BH), Long Term Services and Support (LTSS), Quality Improvement (QI), and Health Education (HE).

Ms. Amirthavasara reviewed the goals and results of Focus Area 1: Keeping Members Healthy; Focus Area 2: Managing Members with Emerging Risk; Focus Area 3: Managing Multiple Chronic Illnesses; Focus Area 4: Patient Safety or Outcomes across Settings; and Focus Area 5: Member Experience with CM Services.

Dr. Lin inquired about incentives for providers to improve the results for the goal in Focus Area 1 (to increase the number of wellness visits of newly enrolled CMC members within their first year of membership). Johanna Liu, PharmD, Director, Quality and Process Improvement, shared the incentive opportunities SCFHP provides to its providers.

Ms. Amirthavasara reviewed the results of the Member Experience Survey for BH, specific to the CM Program, and noted this is SCFHP's first year conducting this survey. The goal was to reach 90% in each targeted area. SCFHP did not meet 4 out of 5 areas, and will continue to monitor the BH program to implement changes for improvement.

**It was moved, seconded and the 2020 Impact Analysis was unanimously approved.**

**Motion:** Dr. Nakahira  
**Second:** Dr. Lin  
**Ayes:** Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

## 7. 2021 Population Health Management (PHM) Strategy and Activities and Resources Grid

Ms. Amirthavasara presented the PHM Strategy and Activities & Resource Grid. The PHM Strategy is a document that is reviewed every year and updated if necessary. The PHM Strategy is based on the Impact Analysis as well as the PHM Assessment, and serves as a guide to the CM program.

Ms. Amirthavasara noted a change was made to include elements of our MC line of business in preparation of the MC NCQA accreditation. Similar to previous years, the PHM Strategy consists of 4 tiers. The most complex is Tier 1: Complex Case Management, followed by Tier 2: Chronic Condition Management (Uncontrolled). Tier 3 is Chronic Condition Management (Controlled), and Tier 4: Healthy Members.

Ms. Amirthavasara noted the MC line of business was added to the PHM Strategy as well as programs that align with NCQA standards.

Ms. Amirthavasara reviewed the Activities and Resources Grid, which is based on the needs results of the Population Health Assessment (PHA), to identify areas of need within the CMC line of business. Interventions, activities, and resources to address the identified needs were reviewed.

One of the activities implemented in April 2021, was to list the member's preferred spoken language to help providers identify which member's need interpreter services.

**It was moved, seconded and the 2021 PHM Strategy and Activities and Resources Grid was unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Nakahira  
**Ayes:** Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

## 8. Annual Review of QI Policies

Dr. Liu reviewed the Behavioral Health policies: QI.17, QI.18, QI.20, QI.21, QI.22, QI.23, QI.24, QI.25, and QI.27.

- a. **QI.17** – No changes made
- b. **QI.18** – No changes made
- c. **QI.20** – No changes made
- d. **QI.21** – No changes made
- e. **QI.22** – No changes made
- f. **QI.23** – No changes made
- g. **QI.24** – No changes made
- h. **QI.25** – No changes made
- i. **QI.27** – No changes made

**It was moved, seconded, and the QI Policies were unanimously approved.**

**Motion:** Dr. Lin  
**Second:** Dr. Alkoraishi  
**Ayes:** Dr. Dawood, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

## 9. Grievance and Appeals Report Q1 2021

Victor Hernandez, Quality Assurance Program Manager, Grievance and Appeals (G&A), presented the G&A Report Q1 2021.

Mr. Hernandez reviewed the grievance cases received as well as the G&A rate per 1,000 members for MC and CMC. Mr. Hernandez noted a large decrease in CMC grievances received in Q1 2021.

Also reviewed were the Q1 2021 top 3 MC Grievance Categories and the top 3 MC Grievance Subcategories, as well as the MC Appeals by Case Type, Disposition, Overturn Rationale, and Uphold Rationale.

In addition, the Top 3 CMC Grievance Categories and the top 3 CMC Grievance Subcategories were reviewed, as well as the CMC Appeals by Case Type, Disposition, Overturn Rationale, and Uphold Rationale.

Ms. Tomcala asked for an explanation of what the overturn rationale for Plan Directed Care. Mr. Hernandez reported back to Ms. Tomcala with a detailed explanation offline.

**It was moved, seconded, and the G&A Report Q1 2021 were unanimously approved.**

**Motion:** Dr. Foreman  
**Second:** Dr. Lin  
**Ayes:** Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Dr. Paul, Ms. Tomcala  
**Absent:** Dr. Arnold

## 10. Quality Dashboard

Dr. Liu reviewed the Quality Dashboard, beginning with Potential Quality of Care Issues (PQI), as well as Member Incentives. Dr. Liu noted a total of 75K mailers were mailed and 35K of gift cards have been distributed since July 2020.

Dr. Liu reviewed the Initial Health Assessment (IHA) and explained the IHA is a comprehensive assessment completed during a new MC member's initial visit with their PCP within 120 days of joining the plan. Reports indicate an increase in completion rate this year.

Dr. Liu reviewed the Outreach Call Campaign. Over the last month, over 8K calls were made, from March 2021 – May 2021, to members to help close gaps in care.

During the pandemic, SCFHP paused conducting Facility Site Reviews (FSRs) and switched to a virtual review instead. Thus far, at least 2 FSRs have been completed. SCFHP is looking forward to conducting future FSRs to expand the provider list.

#### 11. Compliance Report

Tyler Haskell, Interim Compliance Officer, reviewed the Compliance Report. SCFHP is currently undergoing the annual MC Validation Audit, required by CMS. Final results will be submitted to CMS by the end of June 2021.

Mr. Haskell reviewed the Department of Health Care Services (DHCS) MC Managed Care Audit and the Department of Managed Health Care (DMHC) MC Managed Care Audit, both of which took place in March 2021.

Mr. Haskell noted SCFHP has been working since last Fall to implement corrective actions relating to the six findings in the final 2020 DHCS audit. The corrective Action Plans (CAPs) have been implemented and are on track to be completed in June.

#### 12. UMC Minutes

Dr. Lin reviewed the draft UMC minutes for the 04/21/2021 meeting.

**It was moved, seconded, and the draft minutes of the 04/21/2021 UMC meeting were unanimously approved.**

**Motion:** Dr. Lin

**Second:** Dr. Paul

**Ayes:** Dr. Alkoraishi, Dr. Dawood, Foreman, Dr. Nakahira, Ms. Tomcala

**Absent:** Dr. Arnold

#### 13. Credentialing Committee Report

Dr. Lin reviewed the 04/07/2021 Credentialing Committee Report.

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

**Motion:** Dr. Lin

**Second:** Dr. Dawood

**Ayes:** Dr. Alkoraishi, Dr. Foreman, Dr. Nakahira, Dr. Paul, Ms. Tomcala

**Absent:** Dr. Arnold

#### 14. Adjournment

The next QIC meeting will be held on August 11, 2021. The meeting was adjourned at 7:31PM.

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Ria Paul, MD, Chair

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Date

**Santa Clara Family Health Plan  
Assessment of Member Cultural and Linguistic Needs  
and Preferences  
Reporting Year - 2020**

Cal Medi-Connect - 2021

Prepared by: Karen Fadley, Provider Network Operations Data Analyst  
For review and approval by the Quality Improvement Committee



## **INTRODUCTION**

SCFHP believes that cultural competency is a best practice for valuing diversity, practicing inclusion and creating health equity. SCFHP continues to support developmental processes to ensure awareness of cultural, ethnic/racial differences.

SCFHP is committed to providing language services at no cost and equal access to services for members with hearing or language related needs. Oral Interpreters, signers, bilingual providers and provider staff are available at all key points of contact. These services are provided in all languages spoken by SCFHP members.

SCFHP annually assesses the cultural, ethnic/racial and linguistic needs of its members relative to its provider network. Network provider characteristics (i.e., culture, ethnicity/race, spoken language) are assessed to ensure member preferences and needs are met.

## **DATA SOURCES AND COLLECTIONS**

To assess member needs, data is collected from multiple sources to include:

- 2010 US Census
- Statistical Atlas
- Data USA
- CAHPS
- APL 17-011
- Provider Language Report via eVips
- Member Ethnicity/Race and Language Report via QNXT, 834
- Language Translation Usage: January 1, 2020 – Dec 31, 2020
- Member Complaints: January 1, 2020 – Dec 31, 2020

## **METHODOLOGY**

SCFHP will use US Census, Statistical Atlas, Data USA and/or other sources to collect and examine data on the cultural ethnic/racial and linguistic composition of the population in its service area in Santa Clara County.

SCFHP extracts available enrollee demographic information from the 834 file to identify characteristics such as culture, ethnic/racial and primary language. SCFHP will extract available demographics on the same characteristics of its provider network by running reports from the eVips system. While the Plan does not have concrete data on provider ethnicity/race, conclusions are drawn from the languages spoken by network providers. For further evaluation, SCFHP also uses available publications on physician diversity in California to examine provider diversity statistics in its service area.

Santa Clara Family Health Plan and the California Department of Health Care Services (DHCS) uses the following methodology to identify enrollee threshold languages –

- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language);



- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).

The DHCS issues an all plan letter (APL 17-011) to notify the health plans of which threshold languages were identified for each county in California. SCFHP's annual cultural and linguistic assessment incorporates the threshold languages the DHCS identifies in its service area in Santa Clara County. In addition, SCFHP follows state requirements regarding translation of written informing materials for members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards.

The DHCS updates threshold language data at least once every three fiscal years, to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal managed care counties.

SCFHP cultural and linguistic assessments include PCP's, high volume/impact specialists and high volume mental/behavioral health providers. PCP provider counts include family practice and internal medicine. Family practice provider counts include geriatric and general practice providers.

## DEMOGRAPHICS

Data Source: US Census

County:	Cities:	Population
Santa Clara County	ALL	1,927,852

Data Source (Language *only*): Statistical Atlas

Santa Clara County Race and Hispanic Origin	Percentage	Language other than English spoken at Home (Top 3)	Percentage
White alone, percent (a)	52.4%	Spanish	18%
Black or African American alone (a)	2.8%	Chinese	9.4%
American Indian and Alaska Native alone (a)	1.2%	Vietnamese	6.5%
Asian alone, percent (a)	39.0%		
Native Hawaiian and Other Pacific Islander alone (a)	0.5%		
Two or More Races, percent	4.2%		
Hispanic or Latino, percent (b)	25.0%		
White alone, not Hispanic or Latino	30.6%		

(a) Includes persons reporting only one race

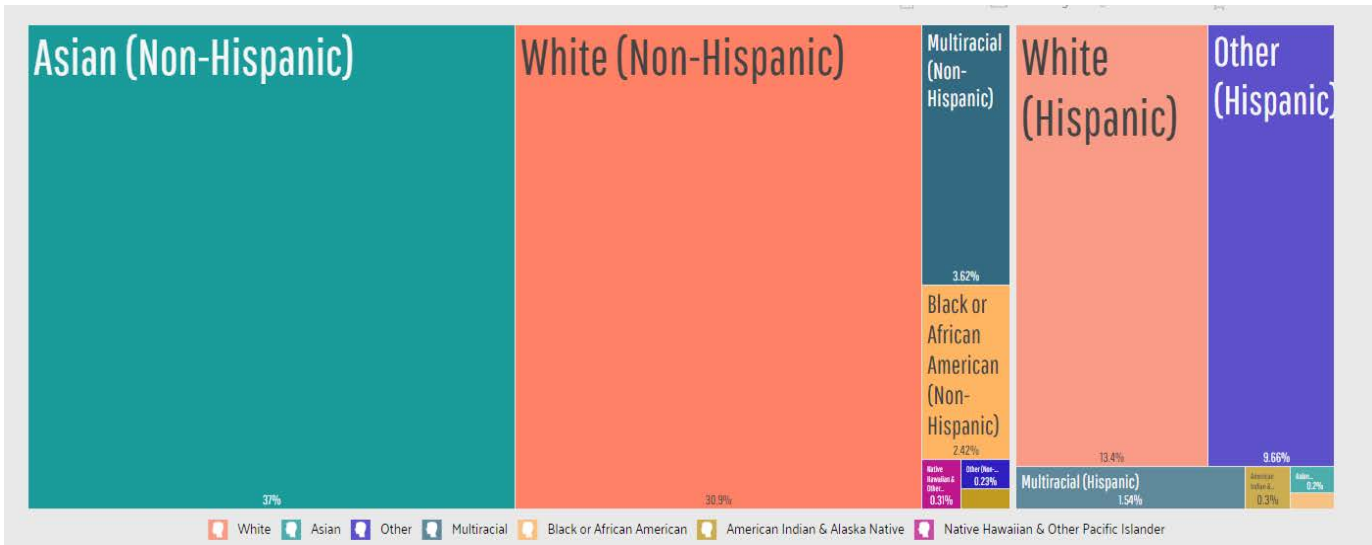
(b) Hispanics may be of any race--are included in applicable race categories

Data Source: Data USA, Censusreporter

Santa Clara County Age & Gender	Number/Percentage	Santa Clara County Health	Percentage
Persons under 5 years	5.8%	With disability, under 65	4.6%
Persons under 18 years	21.6%	Persons without Health Insurance	5.1%
Persons 65 years and over	13.9%		
Median Age	37.2%		
Female persons	49.3%		
Male persons	51.0%		

In 2018, Data USA reported that there were 1.2 times more Asian Alone residents (717k people) in Santa Clara County than any other ethnicity/race. There were 599k White Alone and 491k Hispanic or Latino residents, the second and third most common racial or ethnic groups.

To further assess and to gain a better understanding of SCFHP’s service area, a study was conducted using Data USA, which reports that 53% of Santa Clara County citizens are speakers of a non-English language, which is higher than the national average of 22%. Data USA also reports that the most common non-English language spoken in Santa Clara County is Spanish at 19%, followed by Chinese at 9% and Vietnamese at 7%. The following chart shows the races and ethnicities represented in Santa Clara County as a share of the total population.



## CAL MEDI-CONNECT ENROLLMENT COUNT

LINE OF BUSINESS	Enrollment Count
Cal MediConnect (CMC)	9,820

## DESCRIPTION OF CAL MEDI-CONNECT:

Cal Medi-Connect is a dual eligible plan for members who qualify for both Medicare and Medi-Cal. Cal Medi-Connect enrollees receives Medicare and Medi-Cal benefits from one plan, such as hospital, medical and prescription drug benefits (Medicare Parts A, B and D benefits), In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), care coordination, and nursing home care.

## MEMBER LANGUAGE and CULTURAL ASSESSMENTS

**Table I: Member Languages Spoken at Home** (N=9,820)

Language	Member Count	% of Members Speak the Language
English	4,079	42%
Spanish	1,809	18%
Vietnamese	1,492	15%
*Chinese	1,358	14%
Tagalog	345	4%
Other	737	8%

**Top 4 - Most common non-English languages spoken by CMC Members:**

- Spanish
- Vietnamese
- Chinese
- Tagalog

\*Chinese is the combined total of Chinese, Mandarin and Cantonese

As shown in Table I, SCFHP's Cal MediConnect member's most common non-English languages spoken are Spanish, Vietnamese, Chinese and Tagalog. Changes in member spoken languages from the previous year showed an increase in English at 7% a decrease in Spanish at 2%, Vietnamese decrease at 1%. Chinese remained the same, at 14% and Tagalog remained the same at 4% (no increase or decrease).

### Table II: MEMBER ETHNICITY/RACE (Top 4)

Source: 834 Enrollment File

Culture	Member Count	%
Asian	2,785	28%
Hispanic/Latino	2,413	25%
Caucasian	1,313	13%
Pacific Islanders	580	6%

As shown in Table II, the top 4 member races are Asian, Hispanic/Latino, Caucasian and Pacific Islanders. The assessment showed that the Asian descent consist of two (2) races, Vietnamese at 15% and Chinese at 13%. Pacific Islanders were of the Filipino race and the data did not show the races under the Hispanic/Latino population

External publications and studies relevant to SCFHP's service area were used to assess cultural traits on the top three member ethnicity/race (excluding Caucasian). Following is a summary of the publications and studies reviewed:

### **Vietnamese**

In 2011, the Santa Clara County Public Health Department (SCCPHD) completed the Vietnamese - American Health Assessment and reported that the Vietnamese culture, interactions and communication styles are important to adopt to meet the needs of this population. In Vietnamese culture, the traditional family is valued highly, and elders are greatly respected. For example, to show respect, elderly patients and family members should be addressed with a slight bow of the head. Certain hand gestures may be offensive to this population, such as placing your hand on your hip while speaking.

The assessment also revealed significant health disparities within the community as well as cultural and language barriers preventing access to vital services. In 2016, the city of San Jose (the largest city in SCFHP's service area), a city with one of the largest Vietnamese population in the nation, opened its first Vietnamese American Community Center; known as the Shirakawa Community Center. The center demonstrates a need in the community for a place that celebrates the Vietnamese culture and provides services for the growing demographics. Having a dedicated center for the Vietnamese community provides immigrants, refugees, youth, and seniors with a center that meets cultural needs to call their own.

The findings of the SCCPHD assessment also resulted in a recommendation by the Office of the County Executive to construct the Vietnamese - American Service Center; a health center that honors the Vietnamese culture and is expected to open its doors in summer 2021 in the city of San Jose. The service center will deliver integrated, accessible and culturally responsive social and health services to support the local community, specifically the Vietnamese - American community. Its fundamental goal is connecting the community to the County services they need, in a seamless and collaborative model. The service center model will bring key County agencies together, to work in collaboration and address the overall needs of the Vietnamese community.

### **Hispanic/Latino**

Studies showed that Hispanics/Latinos are the third largest racial/ethnic group in Santa Clara County and are projected to be the largest group by 2050. As the Latino/Hispanic population grows, the public health system in the county will continue to expand and adjust to meet changing health needs.

In 2017, at the request of the Santa Clara County Board of Supervisors, the Santa Clara County Public Health Department conducted a study on Latino/Hispanic health, with the goal of providing information that can be used to generate solutions to health issues within this population. The study showed that reliance on traditional medicine and health practices is common among Latinos/Hispanics. Culture is central in their health habits and due to the influence of traditional medical beliefs and health practices, many Latinos/Hispanics may simultaneously seek the help of both Western medicine and traditional healers.

Latinos/Hispanics have a deep rooted tradition of looking to extended family members and close family friends for emotional support and resources, which may support healthy behaviors and improve health. Family involvement in health care is common and health care providers are strongly advised to encourage such involvement and to include the family as a resource and focus of care in health planning, whether for individuals or a community. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

### **Pacific Islander**

A study by the Stanford School of Medicine reported that Pacific Islanders are a very diverse group and that it is important to avoid stereotyping. The study showed that in order for the clinical interaction to be meaningful, Pacific Islanders need to develop a sense of trust with their health care providers. They may initiate this process by trying to establish a “connection” with their physician or health care provider. This connection may involve questions to the provider regarding the community lived in, the school attended or work places. Not uncommonly, Pacific Islanders patients will start off the encounter by asking questions, trying to “find that connection”.

In 2017, the County of Santa Clara Public Health Department (CSCPHD) completed an assessment which presented both secondary data and primary health survey data on Asian/Pacific Islander communities residing in Santa Clara County. Findings from this assessment served as a building block in the county's efforts to address health disparities in the Asian/Pacific Islander community. In 2018, the CSCPHD partnered with the Asian Americans for Community Involvement (AACI) to raise awareness of the unique issues affecting health and wellbeing of this population and to establish strategies to address key areas of concern for health, mental health and social determinants of health for Asian/Pacific Islanders and identified gaps in achieving healthy communities.

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SCFHP has a provider network where members have access to medical and mental health services with providers who are sensitive to cultural diversity. For example, Gardner Health Services and Asian Americans for Community Involvement (AACI) are contracted provider groups who are dedicated to improving the health status of the communities we serve, especially the disenfranchised, disadvantaged and most vulnerable members. Gardner Health Services and AACI aligns with SCFHP's mission to provide high quality, comprehensive medical and mental health care, including prevention and education, early intervention, treatment and advocacy services which are affordable, respectful, culturally, linguistically and age appropriate..

SCFHP and its provider network recognizes that every member encounter is unique; every patient is different in age, gender, ethnicity or religion and will bring to the medical encounter their individualized perspectives and experiences. Resources to increase awareness of cultural diversity are available to SCFHP's provider network and staff and are intended to help build sensitivity to differences and styles as a goal to improve patient- provider and patient-office staff communications and to foster an environment that is non-threatening and comfortable for Plan members.

To ensure provider awareness of cultural, racial and ethnic differences, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on understanding cultural differences and how to establish effective communications with patients of all ethnic/racial and cultural backgrounds. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

**PROVIDER NETWORK THRESHOLD LANGUAGE ASSESSMENT**– Tables I - III shows the percentage of SCFHP network providers who speak threshold languages (Spanish, Vietnamese, Chinese and Tagalog).

**Table I: Primary Care Providers**

Source: eVips/ICAT

		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of	Providers-Tagalog	% of Providers
Family Practice	266	59	22%	36	14%	21	8%	6	2%
Internal Medicine	260	30	12%	31	12%	26	10%	6	2%

**Table II: Specialists - High Volume/Impact**

Source: eVips/ICAT

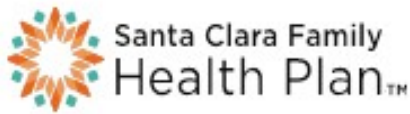
		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Cardiology	178	15	8%	8	4%	11	6%	0	0%
Ophthalmology	260	58	33%	32	18%	46	26%	2	1%
Gynecology	363	75	29%	16	6%	20	8%	0	0%
Hematology/Oncolog	221	17	13%	11	%	11	%	1	1%

**Table III: Behavioral Health Providers – High Volume**

Source: eVips/ICAT

		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Psychiatry	147	24	16%	8	5%	8	5%	0	0%
Clinical Social Worker	43	12	28%	8	19%	2	5%	0	0%
Family & Marriage Therapy	22	2	9%	0	0%	0	0%	1	.05%





As noted in the report above, SCFHP does not have concrete data on provider ethnicity/race, therefore conclusions are drawn from the languages spoken by network providers. Tables I-III shows the number of network providers who can speak the top 4 languages and meet member cultural, ethnic/racial needs. The tables do not include provider staff who may also speak the top 4 languages and who may share the same cultural, ethnic/racial characteristics of SCFHP members.

Comparison from previous year assessment shows that the number of providers that speak threshold languages remained steady.

## LANGUAGE LINE OR TRANSLATION REQUESTS

**Table I: Member Language Line Requests**

Language	Total Requests	Total Duration	% of Requests
Spanish	6,093	1,103 hrs	30%
Vietnamese	5,735	1,077 hrs	30%
Chinese	5,294	966 hrs	26%
Tagalog	1,210	159 hrs	6%

**Table II: Member Face to Face Requests**

Translation Type	Total Request	Total Duration	% of Requests
Sign Language	56	90 hrs	79%
Spanish	1	2 hrs	1%
Vietnamese	4	3 hrs	6%
Chinese	3	7 hrs	4%
Tagalog	0	0	0

In Tables I & II, it shows the language line and member face to face translation data was analyzed two different ways, one was through the frequency of language selected and second was the duration of the calls and face to face translation services.

Available access to interpreter services for members is a foundational element of Medicare - Medicaid plans. This could take the shape of telephonic or face to face interaction with a qualified interpreter. SCFHP provides this service through a vendor free of charge to its members and providers. SCFHP members have access to interpreter services 24 hours a day, 7 days a week. The plan also hires bilingual customer service representatives to further promote timely and quality access to language interpretation.

To ensure provider awareness of language assistance services and requirements, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on using interpreter services. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

To further understand membership language diversity and potential barriers to care due to language barriers, as shown above in Section F (Tables I and II), SCFHP annually reviews data from its Language Line and Face to Face interpreter services reports.

The raw data showed that thirty four (34) different languages were requested for interpreter services; some of which are not frequently seen, such as Portuguese-Creole, Swahili, and Tigrinya. While there were several other languages requested for interpreter services, it does not appear that there is a growing population outside of the threshold languages identified and spoken by SCFHP members in this report.

## MEMBER GRIEVANCES and CAHPS RESULTS

**Table I. Member Language, Ethnicity/Race Complaints**

Service Type	Language	Description	Quarter
Interpreter	Spanish	Member was dissatisfied with interpreter services in that the interpreter did not show up for the appointment, resulting in member utilizing an ipad device to communicate through.	Q1
Interpreter	Spanish	Member was dissatisfied with the quality of skills by the interpreter.	Q2
Interpreter	Spanish	Member reported no interpreter services were offered, which enabled communication that member needed to speak with Dr. due to member does not speak English.	Q4
Language Line	Spanish	Member was dissatisfied with the quality of service provided to her Grandmother. Member requested itemized statement to submit to SCFHP for reimbursement. Member speaks Spanish only and no one in the office spoke Spanish.	Q4

An assessment of member complaints against language/interpreter services and cultural/racial preferences was completed as indicated in the chart above and the resolution of those complaints are as follows:

--Language/Interpreter complaints (Q1) was reported to the Quality Cultural and Linguistics team who reported the incident to the language/interpreter vendor. The vendor indicated that the member was informed ahead of time that the interpreter was running late due to prior patient time running over, and informed member they would be using Video Remote Interpretation (VRI), the service is on an ipad and is similar to Skype as the Interpreter is live. The language line vendor assured that the complaint would be addressed with their staff and will continue to work on improving the quality of interpretation services

-- (Q2) Complaint was reported to the Quality Cultural and Linguistics team who reported the incident to the language/interpreter vendor. The language/interpreter vendor assured that the complaint would be addressed with their staff and will continue to work on improving the quality of interpretation services.

-- (Q4 – 2) the complaints were reported to the Quality Cultural and Linguistics team who reported the incidents to the language/interpreter vendor. The language/interpreter vendor assured that the complaints would be addressed with their staff and will continue to work on improving the quality of interpretation services.

The assessment on member complaints did not identify trending and the data showed complaints within acceptable limits.



**Table II: CAHPS Results – Doctors Who Communicate Well**

Question	2018	2019	2020	PY Change	Goal	Met/ Not Met
Q13. Providing clear explanation	83.50%	84.40%	85.90%	+1.50	90%	Not Met
Q14. Listening carefully	86.60%	88.00%	87.60%	-.40	90%	Not Met
Q15. Showing respect	87.90%	87.70%	90.20%	+2.50	90%	Met

As shown in Table II, the CAHPS 2020 results showed improved provider communications where Q13-providing clear explanation showed an increase in satisfaction at 1.50 percentage points, Q15-Showing respect at 2.50 percentage points, and Q14--Listening carefully at -.40 percentage points showed a slight decrease from 2019 but an increase from 2018 at 1.00 percentage points. Overall it appears that provider communications has improved.

### **Conclusion:**

SCFHP and Santa Clara County officials has a long-standing commitment to the health and well-being of all its community regardless of race, ethnicity, age or gender. SCFHP will continue to partner with community stakeholders to help improve the overall health of its diverse membership.

The assessment revealed that there are no significant disparities in meeting member cultural, ethnic/racial and linguistic preferences, which concludes that member needs are being met overall; thus, no adjustments to the provider network are necessary at this time.

While SCFHP did not identify disparities to meet language or cultural needs of its members, the Plan will continue to seek available providers with diverse backgrounds and language skills to ensure member needs continue to be met. SCFHP will also continue to evaluate the needs of its members to ensure they receive the care and services they need in a culturally sensitive manner and in their preferred language.

### **PARTICIPANTS:**

Provider Network Operations Data Analyst  
Timely Access and Availability Work Group  
Quality Improvement  
Behavioral Health  
Grievances and Appeals  
Provider Relations

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		None



**Santa Clara Family  
Health Plan™**

**2020 POPULATION HEALTH  
MANAGEMENT IMPACT ANALYSIS**

**Quality Improvement Committee  
June 9, 2021**

# PHM 6 Population Health Management Impact Report

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# PHM 6: Population Health Management Impact Analysis

## BACKGROUND/INTRODUCTION

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 residents most in need in Santa Clara County. Established in January 1997, SCFHP was created by the Santa Clara County Board of Supervisors whom elects a board of directors for residents and reflects the cultural and linguistic diversity of the community. In addition, SCFHP providers, employees, and Board of Governors live in the areas that the health plan serves.

In 2020, SCFHP provided health care coverage to over 9,800 seniors and persons with disabilities through the Cal MediConnect (CMC) program. The CMC program manages the Medicare and Medi-Cal benefits for these members. Members choose from a network of 541 Primary Care doctors, 3,091 Specialists, 9 hospitals, 30 community health centers, 239 ancillary providers and 174 pharmacies throughout Santa Clara County. Through active partnerships with healthcare providers and community partnerships, SCFHP achieved a seal of National Committee for Quality Assurance (NCQA) accreditation in 2018 and demonstrates that the managed care model can achieve the highest standard of care and successfully meets the individual needs of health plan members through the Population Health Management (PHM) Program as outlined in the Population Health Management Strategy.

## PURPOSE

Annually, SCFHP measures the effectiveness of the PHM Strategy to ensure that we are providing valuable and meaningful services to our members. This is done through the measurement of effectiveness of program services and activities to meet benchmark goals developed around specific areas of focus and targeted populations. The annual PHM Impact Analysis analyzes the impact of achieving quality outcomes for members through care management services and outlines new strategies to implement when opportunities for improvement are identified. This is performed through interpretation and quantitative comparison of results with established benchmarks set for relevant clinical, cost/utilization, and member experience measures:

- Clinical measures evaluate the comparison of incidence or prevalence rates for desirable or undesirable health outcomes or the clinical performance based on practice guidelines and clinical specifications for 4 focus areas designated by the PHM Strategy.
- Cost/utilization measures evaluate cost, resource use by occurrence or outcomes that demonstrate a desirable increase or decrease in utilization.
- Experience measures member feedback sourced from member satisfaction surveys and member complaints flagged by Grievance and Appeals specific to Complex Case Management (CCM).

This annual PHM Impact Analysis is reviewed at the Quality Improvement Committee (QIC) meeting, chaired by the Chief Medical Officer (CMO) and drives the PHM Strategy for the following year. The PHM Impact Analysis includes a quantitative and qualitative analysis of Case Management programs performed by the Population Health Management (PHM) Workgroup which includes the Manager and Director of Case Management, Director of Quality & Process

Improvement, Director of Long Term Services and Supports, Manager of Behavioral Health and NCQA Project Manager.

## PHM Focus Areas & Target Populations

The focus areas and target populations of the PHM program focuses on a whole-person approach to identify members at risk and to provide strategies, programs, and services to mitigate or reduce that risk. We also aim to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. SCFHP promotes a program that is both sustainable, person and family-centered, and enables CMC members to attain their personal health goals. We do so by providing timely access to appropriate, coordinated health care services and community resources, including home and community-based services and behavioral health services. SCFHP's plan of action for each of the Focus Areas include measurable goals for specific targeted member populations.

### Focus Areas:

- 1) Keeping Members Healthy
- 2) Managing Members with Emerging Risk
- 3) Managing Multiple Chronic Illnesses
- 4) Patient Safety or Outcomes Across Settings
- 5) Member Experience with PHM Programs

## Focus Area 1: Keeping Members Healthy

**Focus Area Goal:** Increase the number of newly enrolled CMC members with no claims or utilization data to have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results.

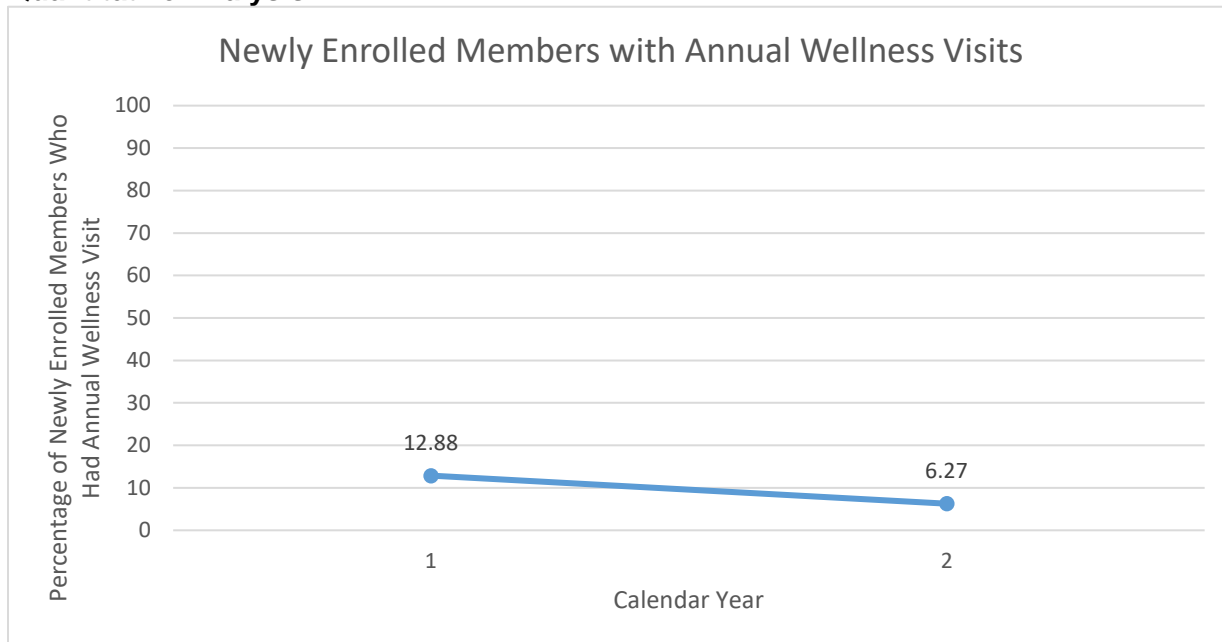
**Goal Relevance Statement:** Based on analysis of Information Technology (IT) Risk Stratification data, utilization information on many of our newly enrolled CMC members was minimal. Annual Wellness Visits (AWV) are critical to maintaining the health of all CMC members.

**Population Targeted:** All CMC members not residing in a skilled nursing facility (SNF).

**Programs & Services:** Basic Case Management, Transitions of Care (TOC), Provider Engagement.

**Utilization Measure Methodology:** This study compares the rate of in office Annual Wellness Visits of the 2,282 newly enrolled Cal MediConnect members in CY 2020 to the rates of in office Annual Wellness Visits for the 3,890 newly enrolled members in CY 2019. The analysis is based on the paid claims for office-based primary care visits billed services codes G0438 & G0439 of all CMC members from January 2020 – December 2020.

## Quantitative Analysis:



The Annual Wellness Visit (AWV) Graph shows in 2019, 501 out of 3,890 of the newly enrolled members had one or more in-office Annual Visit encounters for a total of 12.88% of the newly enrolled population. In 2020, 143 of the 2,282 newly enrolled members who had one or more Annual Wellness Visit encounters for a total of 6.27%. A 10.43% negative percent change was noted in the current measurement year.

For members who are managed by specialists, an in-home Initial Health Assessment (IHA) is completed by an external vendor. In 2019, 41.49%, or 1,1614 of the 3,890, newly enrolled members received an IHA compared to 29.62%, or 676 of the 2,282, newly enrolled members in 2020.

This Focus Area goal was not met as we identified a significant decrease in members who received an Annual Wellness Visit. This may largely be due to many providers had office closures during CY 2020 due to restrictions related to the novel coronavirus, COVID-19. Even after provider offices and clinics reopened, many members may have avoided leaving their homes for fear of contracting the virus. In addition, many members may not have known that telephonic or video visits were available and/or they may not have the appropriate equipment to accomplish this. In-home IHA also had a decrease as many members may not have wanted individuals to enter their home outside of their immediate circle with whom they live for fear of introducing the virus into their home.

Care Coordination staff will continue to educate the members on the importance of seeing their PCP for an Annual Wellness Visit. In order to increase engagement and collaboration with the members, the PHM Workgroup will develop and implement new ways to ensure regular follow up with the member occurs throughout the year by the Care Coordination staff. We will continue to send IHAs to PCPs in our ongoing collaboration with PCPs.

## PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Inability to do in-person visits with limited Primary Care Provider (PCP) availability due to office closures	Increase member education and engagement and provide assistance to members who need assistance to access their PCP	Continue to remind members the importance of seeing PCP for AWV during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development  Develop and implement follow up outreach throughout the year for members who did not complete AWV and offer assistance	Ongoing  Complete by Q3 2021
2	Members may not be aware that telehealth visits are available or be able to access telehealth visits	Educate members on the availability of telehealth visits and how it works	Case Coordination staff will make members aware of the availability of telehealth visits through during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development  Assist members to make telehealth visits with PCP if needed	Ongoing  Ongoing
3	Members with Chronic Conditions managed by Specialist rarely adequately engage with PCP for annual visits.	Provide in-home Initial Health Assessment information to PCPs Through the ICP/ICT process	Care Coordination staff will continue to review Initial Health Assessments (IHA) and notify PCP.	Ongoing

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to increase the AWV percentage for the next measurement year.

## Focus Area 2: Managing Members with Emerging Risk

**Focus Area Goal:** Increase glycated hemoglobin (HbA1c) control rate by 2 percentage points compared to baseline

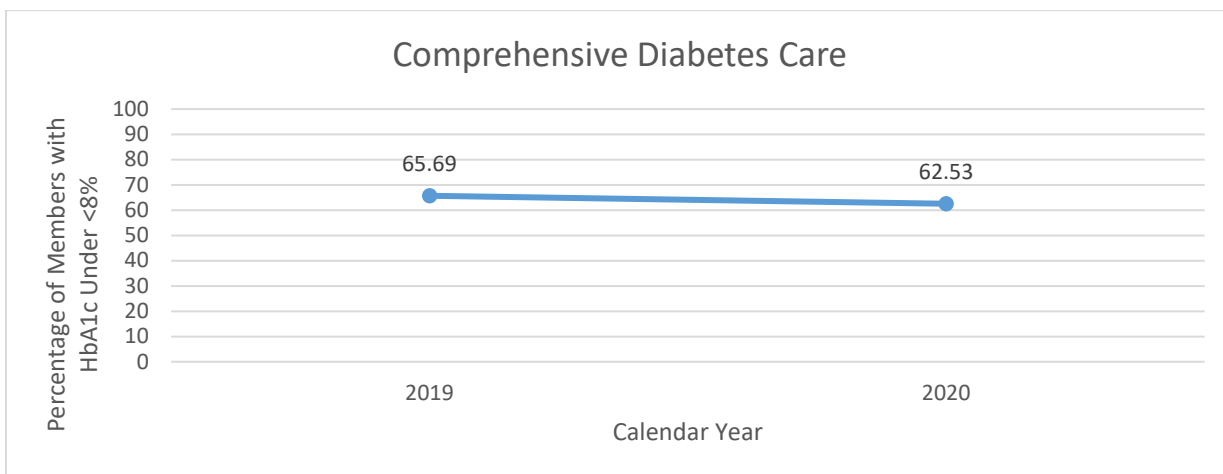
**Goal Relevance Statement:** Within SCFHP CMC line of business, there are 1,450 or 18% of members that meet the HEDIS definition of diabetes. The plan also has a larger population of Hispanic and Asian members who are at higher risk for diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.

**Population Targeted:** All members with a controlled chronic condition of diabetes with an HbA1c over 8%

**Programs & Services:** Basic Case Management, Complex Case Management, Health Education, Provider Engagement, Behavioral Health (SMI), Gaps in Care

**Control Rate – Methodology:** Data is gathered through claim/encounter data and pharmacy data. SCFHP uses both methods to identify the eligible population. Claims data includes members who are identified through either method are included in the sample. Members who have at least one acute inpatient encounter or at least 2 outpatient on different dates of services due to diabetes diagnosis. Pharmacy data includes members who were dispensed insulin or hypoglycemic / antihyperglycemics on an ambulatory basis during the measurement year. CPT codes are isolated to identify members most recent HbA1c level is <8.0% out of those that are not <8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Medical records are reviewed, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result.

### Quantitative Analysis:





The Comprehensive Diabetes Care graph illustrates the percentage of members whose HbA1c was less than 8%. In 2019, the Comprehensive Diabetes Care Control Rate was 65.59%, or 270 of the 411 diabetic members whose HbA1c was lower than 8%. In 2020, this percentage decreased to 62.53%, or 411 of the 257 members. This outcome does not meet the goal of a 2 percentage point increase.

Due to restrictions and fears related to COVID-19, the negative percentage change may be due to members not wanting to leave their home for otherwise regularly scheduled follow up appointments and/or HgA1c testing. A change in diet may also have contributed as members and members' family may not have had access to fresh produce and resorted to an increase in processed foods due to the longer shelf life to reduce the need of going to the grocery store.

### PHM Work Group Qualitative Analysis & Opportunities for Improvement:

Priority	Barrier	Opportunity	Action	Status
1	Members have difficulty maintaining blood glucose levels	Develop and implement Diabetes program to provide education and assist with coordinating care	Identify target population  Identify necessary actions to effectively manage diabetes  Implement targeted outreach to members to assist with obtaining necessary equipment and services	Complete by Q3 2021  Complete by Q3 2021  Complete by Q3 2021

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to increase the CDC percentage for the next measurement year.

## Focus Area 3: Managing Multiple Chronic Illnesses

**Focus Area Goal:** Reduce the number of members with multiple unmanaged chronic conditions who also have had 3 or more avoidable Emergency Department (ED) visits in the past year, by 10 percentage points.

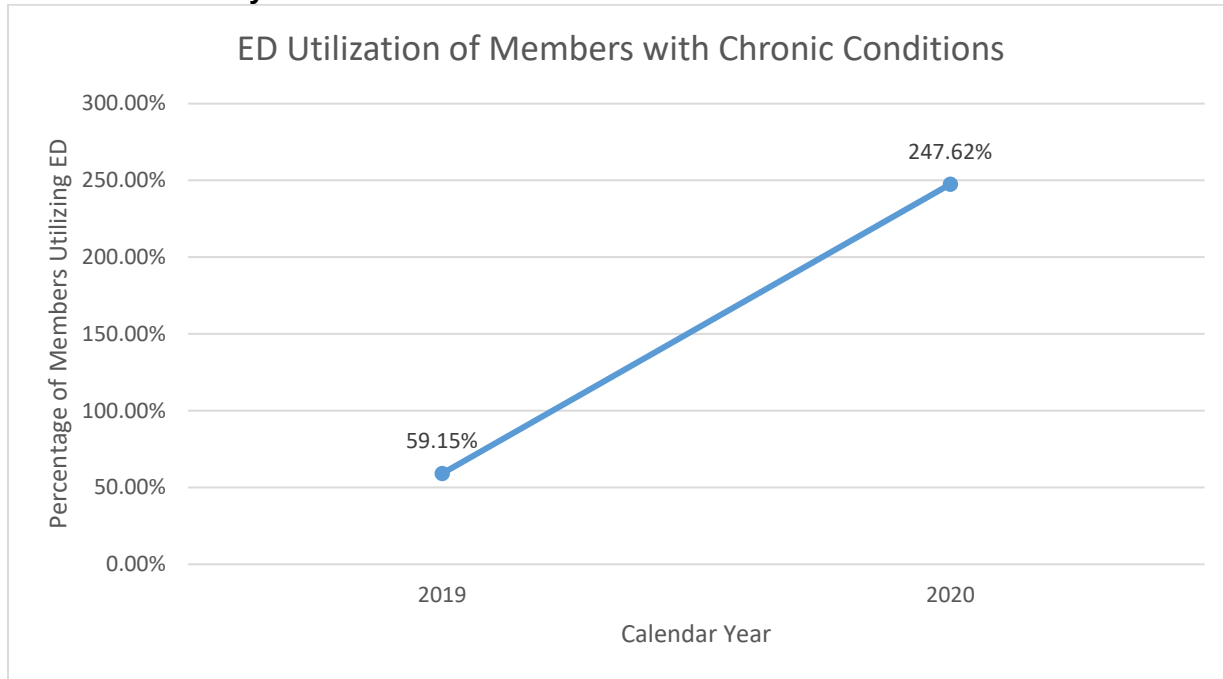
**Goal Relevance Statement:** Unmanaged multiple chronic conditions often results in avoidable ER utilization.

**Population Targeted:** Members who had one or more unmanaged chronic condition(s) that resulted in 3 or more ED visits in 2020 at a safety net hospital within Santa Clara County.

**Programs and Services:** Complex Case Management, Medication Therapy Management, 24 Hour Nurse Advice Line

**Utilization Measure – Methodology:** This study compares the amount of ED utilization in 12 months compared to the same targeted population in the measurement year.

**Quantitative Analysis:**



This graph illustrates a large increase in ED utilization by members with chronic conditions. In 2019, 71 of the members who had chronic conditions had 42 ED utilization. This drastically increased in 2020 where 42 members had 104 ED utilization.

The increase in ED utilization may be the result of decreased specialist availability, decreased willingness to attend follow up appointments, and decrease in medication adherence due to restrictions and closures related to COVID-19.

There is opportunity for increased follow up post ED utilization for further assessment of the member's needs. With targeted outreach, Care Coordination staff will be able to assist with obtaining necessary equipment and services to better manage the member's chronic condition that contributes to ED utilization.

**PHM Work Group Qualitative Analysis & Opportunities for Improvement:**

Priority	Barrier	Opportunity	Action	Status
1	Lack of ED follow up	Utilize available ED census data from safety net hospitals to target outreach and follow up	Develop and implement workflow for Care Coordination staff follow up post ED utilization  Provide education on available non-emergent services like the 24 Nurse Advise Line and	Complete by Q3 2021  Ongoing

Priority	Barrier	Opportunity	Action	Status
			contracted urgent care clinics	

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to decrease ED utilization for the next measurement year.

## Focus Area 4: Patient Safety or Outcomes across Settings

**Goal:** Decrease 30 Day Readmission rate for CMC members by 1 percentage point.

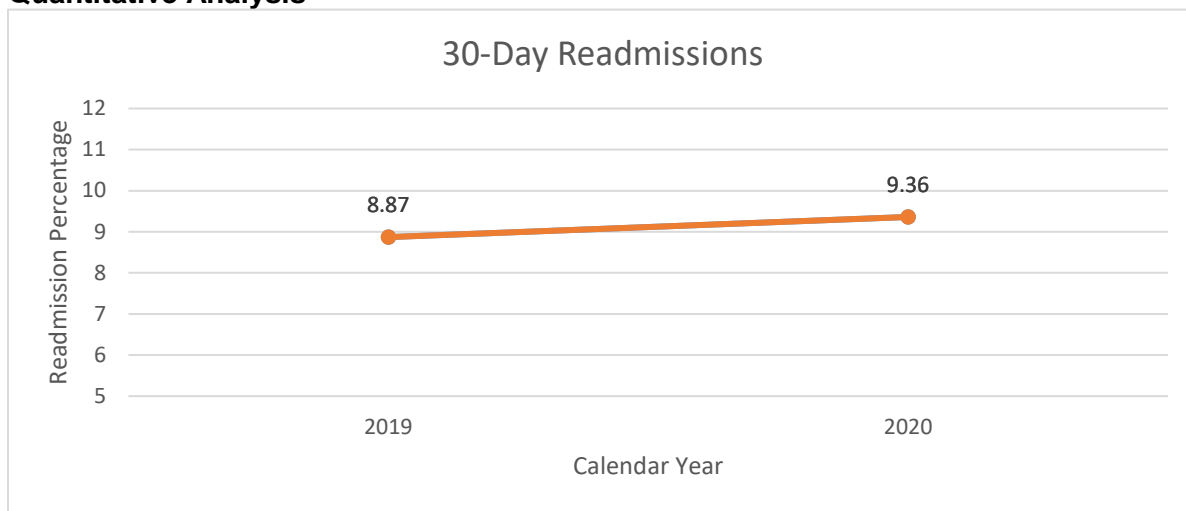
**Goal Relevance Statement:** Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members. Through targeted outreach as the member moves across the care continuum between different settings of acute care, long term care, behavioral health and home and community based settings, potential gaps will be identified and assistance will be provided to improve continuity of care.

**Population Targeted:** Members readmitted within 30 days of discharge

**Programs & Services:** Transitions of Care (TOC), Complex Case Management

**Utilization Measure – Methodology:** This study evaluates the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

### Quantitative Analysis



The 30-Day Readmission Graph illustrates in 2019 Plan All-Cause Readmissions (PCR) Observed Readmission Rate was 8.87% compared to 2020 which was 9.36% resulting in an increase of PCR. In 2019, there were 87 readmissions of the 981 hospitalizations compared to the 84 readmissions out of 897 in 2020.

The increase in readmissions may be due to decrease PCP and specialist availability for follow up in combination with unsafe discharges due to the overcrowding in hospitals related to COVID-19. The updated Transitions of Care program will be monitored closely for effectiveness. Priority will be put on Targeted Case Management programs along with automation opportunities and platform updates.

### PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Transitions of Care program was fragmented between business units	Reduce gaps as members move across the care continuum	Monitor newly implemented Transition of Care program for effectiveness	Ongoing
2	Increase collaboration with PCP	Collaborate with PCP and appropriate specialist for disease management	Notify PCPs of discharges  Assist members to make follow up appointments with PCPs and specialists	Started In June 2021  Started in June 2021

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to decrease ED utilization for the next measurement year.

## Focus Area 5: Member Experience with CCM

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with Complex Case Management (CCM) Program with the goal of reaching a 90% or better satisfaction rating. The purpose of measuring member satisfaction for CM specific programs is to ensure adequate satisfaction with the program and that the program objectives are achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and complaints related to CMC Complex case management services. This analysis allows the organization to identify opportunities for improving the CM and CCM program services through action plans in order to provide the highest quality of case management services. Annual survey results contribute to the overall Population Health Management (PHM) program effectiveness evaluation.

### Process

Santa Clara Family Health Plan measures CCM program effectiveness and overall member satisfaction with the Complex Case Management services through quarterly reporting and annual monitoring of complaints from members related to Complex Case Management services by performing regular CCM member satisfaction surveys. All members that were enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Members that meet inclusionary criteria are outreached by phone at least twice and are

offered assistance to complete the survey in their preferred language. Surveys are completed in the CM platform Essette. All survey responses are captured and reported by IT. Additionally the Grievance and Appeals department flags member complaints and reports them to CM leadership. Case Management leadership receives a report of survey outcomes and grievances and completes an annual analysis of all member experience data.

### **Satisfaction measures:**

1. Information about the overall program.
2. The program staff.
3. Usefulness of the information disseminated.
4. Members' ability to adhere to recommendations.
5. Percentage of members indicating that the program helped them achieve health goals.

### **CCM Member Satisfaction Survey Inclusion Criteria:**

All members who participated in CCM for 60 days or more who have transitioned to a lower level of case management. Members have the right to refuse to participate in all or parts of the survey.

Members who were able to be reached by phone and who were willing to complete the 16 question survey were pulled into the survey population. Results were generated from the survey population that met the inclusion criteria who participated in answering all 16 survey questions.

### **Methodology**

Essette case management was configured to house the survey assessment. Case Management staff conduct 2 telephonic outreach calls and document the outcomes with in the survey assessment. Then number of members who are reached to complete the survey is a subset of the number of members that the health plan attempted to reach. Survey responses are data entered the survey assessment in real time by Personal Care Coordinators (PCCs). Survey responses can be provided by member or formal/informal caregiver on record. Survey responses are scored based on the members answer to the questions. Answers are scored as follows Strongly Agree/Very Satisfied, Agree/Satisfied, Disagree/Somewhat Satisfied, and Strongly Disagree/Not at all Satisfied. Percentage for each response will be rounded up to report in whole numbers. Overall goal is to have members respond "agree or "strongly agree" for questions 1-15 and "satisfied" or "very satisfied" for question 16 for an overall satisfaction percentage rate of 95% or better. Members are also encouraged to leave feedback which is documented in the comments section. Survey responses are collected annually throughout the look back year starting January 1, 2020 through December 31, 2020. Survey responses were pulled into the CCM survey response report and analyzed.

### **Member Complaints**

The process for measuring member CCM complaints is through the Grievance and Appeals department. Member filed grievances for CCM are flagged and reported directly to Case Management Leadership. CCM Leadership works directly with G &A to resolve the grievance. CCM grievances are measured and reported annually. To date there have been (0) grievances for CCM services.

## CCM Satisfaction Survey Results

2020 CCM Satisfaction Survey	Strongly Disagree		Disagree		Agree		Strongly Agree		Goal Met
	#	%	#	%	#	%	#	%	Y/N
<b>Total Survey Sample: 21 Members enrolled in CCM in CY 2020</b>									
The Program Staff		0		0					
My case manager treated me with respect	0	0	0	0	9	42.9	11	52.4	Y
My case manager listened to what I had to say.	0	0	0	0	15	71.4	6	28.6	Y
My case manager returned my phone calls in a timely manner.	0	0	0	0	18	85.7	3	14.3	Y
Usefulness of Information									
My case manager helped me find services that I needed.	0	0	0	0	20	95.2	1	4.8	Y
My case manager involved me in discussing and planning my care.	0	0	0	0	19	90.5	2	9.5	Y
I better understand my disease or condition after being in the case management program.	0	0	0	0	21	100.0	0	0.0	Y
My case manager helped me better communicate with my providers.	0	0	0	0	21	100.0	0	0.0	Y
Ability to Adhere to Recommendations									
I am able to better manage my health and health care after being in the case management program.	0	0	0	0	21	100.0	0	0.0	Y
I know what to do if I need help.	0	0	0	0	21	100.0	0	0.0	Y
I know what to avoid when it comes to my health conditions.	0	0	0	0	18	85.7	3	14.3	Y
Members Indicating that the Program Helped Them Reach Their Health Goals									
I feel like I have achieved my CCM goals.	0	0	0	0	20	95.2	1	4.8	Y
My situation is better because of my case manager's help.	0	0	0	0	19	90.5	3	14.3	Y

I feel ready to transition to a lower level of case management.	0	0	0	0	21	100.0	0	0.0	Y
Overall Program									
My Care Plan was clear and easy to understand.	0	0	0	0	20	95.2	1	4.8	Y
My input was considered when developing my plan of care.	0	0	0	0	21	100.0	0	0.0	Y
Overall, how satisfied are you with the Case Management Services you received?	<b>Very Unsatisfied</b>		<b>Dissatisfied</b>		<b>Satisfied</b>		<b>Very Satisfied</b>		<b>Goal Met</b>
Total	0	0	0	0.00%	16	76.2	5	23.8	Y

## PHM Work Group Qualitative Analysis & Opportunities for Improvement

SCFHP met the 90% performance goal in focus areas

1. Information about the overall program (100%)
2. The Program staff (100%)
3. Usefulness of the information disseminated (100%)
4. Members ability to adhere to recommendations (100%)
5. Percentage of members indicating that the program helped them reach their health goals (100%)
6. Member Complaints (0)

The CCM program was effective in managing members with multiple unmanaged chronic conditions and impacting better health outcomes among those enrolled in the program for greater than 60 days. Enrollees and their caregivers have benefited from intensive care coordination support to address complex medical, psychosocial, and social determinants of health needs. Through the CCM program, the risk of adverse health outcomes for members decreased by linking members with doctors, pharmacy, specialty and DME providers in collaboration with the Interdisciplinary Care Team.

The Member Satisfaction surveys showed that 100% of members who engaged in the CCM program had better health outcomes due to actions directly related to linkage to covered benefits and community based services. Members agreed that overall the information provided by their CMs was useful, easy to understand and helped them reach their health goals.

### Opportunities for improvement:

Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement with Care Coordination staff.

## Moderate CM Satisfaction Survey Results

NCQA 2020 Behavioral Health Member Survey		I Don't Know		No		Yes		Totals		Average Score	Performance Percentage	Goal Met
NCQA Area	Questions	#	%	#	%	#	%	#	%			Y/N
Overall Program Information	Overall, how satisfied are you with the Case Management Services you received?	-								8.1	81%	N
Program Staff	My case manager treated me with respect.	-								9.6	96%	Y
	My case manager listened to what I had to say.	-								9.3	93%	Y
	My case manager returned my phone calls in a timely manner.	-								8.3	83%	N
Usefulness of Information disseminated	Did you customize a care plan with behavioral health at SCFHP?	0	0%	1	4.3%	22	95.7%	23	100%	-	95.7%	Y
	My case manager involved me in discussing and planning my care.	-								9.0	90%	Y
	My case manager helped me find the benefits and community resources that I needed.	-								8.1	81%	N
	My case manager helped me better communicate with my providers.	-								8.2	82%	N
	I found the information my CM provided to be useful.	-								8.6	86%	N
Member's ability to adhere to recommendation	Did participating in BH help you to follow your treatment recommendations?	5	22.7%	2	9.1%	15	68.2%	22	100%	-	68.2%	N
	I know what to avoid when it comes to my health conditions.	-								8.7	87%	N
	I know what to do if I need help.	-								8.2	82%	N
Achieving member health goals	My situation is better because of my case manager's help.	2	9.1%	3	13.6%	17	77.3%	22	100%	-	77.3%	N
	I feel like I have achieved my health goals.	3	13.6%	6	27.3%	13	59.1%	22	100%	-	59.1%	N

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

## NCQA 2020 BH Member Experience Survey Results Analysis

The Santa Clara Family Health Plan (SCFHP) – Behavioral Health Program set a goal to achieve 90% member satisfaction in four of five NCQA areas. A member experience survey was administered to SCFHP members who were both enrolled in the Cal Medicconnect (CMC) line of business and participated in behavioral health program case management services. One hundred CMC members were identified for contacting. A total of 23 responded to the survey. The five NCQA



areas include, information about the overall program, the program staff, usefulness of the information disseminated, member’s ability to adhere to recommendations, and percentage of members indicating the program helped them reach their health goals. Respectively, the areas scored 81%, 90.7%, 86.9%, 79.1% and 68.2%. The overall satisfaction with behavioral health case management services received was 81%.

A focus group was conducted with SCFHP behavioral health (BH) case management staff to present the findings and identify barriers and areas of opportunity to improve member satisfaction in areas that scored below 80%. The following survey questions/statements scored below 80% and were the primary focus of the discussion;

- Did participating in BH help you to follow your treatment recommendations? (68.2%)
- My situation is better because of my case manager’s help. (77.3%)
- I feel like I have achieved my health goals. (59.1%)

The group identified a variety of barriers to achieving member health goals and treatment adherence including member cognitive limitations, language barriers, health literacy, care giver support, coordination of transportation services, substance use, case management intensity, treatment confidentiality, and member’s lived experience with other case management programs. Limited communication/collaboration with community partners and member engagement were identified as the primary barriers to achieving member health goals. BH case management staff suggested that implementing strategies to address these barriers should be the focus for the program moving forward. The group highlighted that members may be participating in multiple case management programs that they may be unaware of. Lack of communication and coordination between SCFHP and these alternate programs may create confusion and a misalignment of health goals if members have active care plans with multiple organizations. Participants also stated concerns with unengaged members and advised that a follow up process should be implemented to outreach to these members.

The group identified that these barriers present an opportunity to strengthen professional relationships and community partnership. The Behavioral Health Program seeks to accomplish increased collaboration with external behavioral health program partners by more clearly defining the population it serves, exploring opportunities to improve communication between Santa Clara County and SCFHP behavioral health case managers, and providing program education to community clinics. To improve member engagement and follow up, the behavioral health program seeks to implement a procedure to track unengaged members and conduct progressive outreach accordingly.

NCQA Area	Performance Percentage	Goal Met ≥ 90% performance
Information about the overall program	81%	No
The program staff	90.7%	Yes
Usefulness of the information disseminated	86.9%	No
Members ability to adhere to recommendations	79.1%	No
Percentage of members indicating that the program helped them reach their health goals	68.2%	No

**Opportunities for improvement:**

Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement with Care Coordination staff.

**Recommendation:** We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

**Conclusion**

Members and their caregivers have benefited from intensive support from Care Coordination, however, there is still need for improvement of expanding the criteria to enroll more members into Targeted Case Management programs.

The PHM Workgroup will continue establish action plans and evaluate the accuracy of actual CM impacts on this target group with in the greater HEDIS CDC metrics and consider different reporting strategies. Additionally staff will be provided additional training on case management best practices and in-services on the latest technologies in specialty diabetic supplies and resources to support new approaches to diabetic management.

CM programs continue to strive to keep members healthy through comprehensive annual wellness assessment and preventative screenings. Members who complete an Annual Wellness Visit (AWV) are more likely to receive important preventive care services like vaccines and cancer screenings than those who do not. In office AWVs focus on members self-identified health status, psychosocial, socio-economical, past medical history, level of independence and other potential risk factors. Due in part to the large CMC population and the number of members who rely on Specialty Care above Primary Care SCFHP contracted with Signify Health to complete in-home Initial Wellness Assessments (IHA). Initial Health Assessments are performed by nurse practitioners in the member's home and are comparable to in office AWVs. CM success in meeting this measure is largely due to evaluation and transmission of valuable assessment information to providers as well as member education on the importance of preventative screenings.

Targeted Case Management Programs identify members at risk and aim to promote safety across with additional evaluation and follow up. The value of connecting members with their PCP for discharge follow up has been shown to decrease the likelihood for readmissions. CM support post discharge promotes greater linkage to follow up services and ongoing management support through regular outreach and follow up to assist the member meets their health care goals.

**Upcoming Improvements**

In addition to increased collaboration within business units, many automation opportunities have also been identified to explore with IT. This, coupled with an anticipated platform version upgrade and updated and new procedures and workflows, will simplify the work for Care Coordination staff so the focus will be on best assisting the member with care coordination needs.

PHM 2C Activities and Resources based on the 2021 Population Health Assessment

**Bold indicates new activity or resource**

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>Financial insecurity</b> Interventions aimed at finding options for members to access food, subsidize rent or utilities, and ensure members are aware of pharmacy benefits will be beneficial to all members.</p>	<ul style="list-style-type: none"> <li>• <b>Explore opportunities to improve social determinants of health (SDOH) and social needs for members by developing an SDOH strategy</b></li> </ul>	<ul style="list-style-type: none"> <li>• Care coordination staff are trained annually in the Aunt Bertha platform that includes all community resources for this county. They are trained in how to use the system, make referrals and participate in a closed loop system so that referrals can be tracked to help them learn if the member actually received services referred.</li> <li>• Designated staff is assigned as a liaison to the Aunt Bertha staff to work on expanding agencies participating in the platform and to ensure that resources on Aunt Bertha are up to date.</li> <li>• <b>Community Resource Center (CRC) will allow for member access to SCFHP staff in Customer Service and Case Management and will facilitate member access to the Aunt Bertha platform on site.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Members who identify as needing help with financial security can be referred to resources on the Aunt Bertha platform that support the member’s needs. Depending on the impact of the financial insecurity (e.g. housing stability, food insecurity), the resources needed may vary. Case Managers can also assist the member with accessing additional benefits such as CalFresh or Supplemental Security Income (SSI).</li> </ul>

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>Language:</b> Interventions should focus on ensuring members are aware of interpreter services, including language lines, know how access these services and are able to access them when needed.</p>	<ul style="list-style-type: none"> <li>• Annual refresher training and onboarding - for Providers to educate them on translation and interpreter services offered at no-cost 24/7 to SCFHP members</li> <li>• C&amp;L Toolkit – created to educate Providers about LEP (limited English proficiency) speakers and services/tips available, quick reference guide with Language Line access numbers for Providers.</li> <li>• <b>SCFHP Member ID card – Medi-Cal cards have the member’s preferred spoken language listed to help Providers identify members that need interpreter services. (April 2021)</b></li> <li>• Quarterly Newsletters – all MC and CMC member newsletters have information on accessing language services free of charge.</li> <li>• Member letters – all member letters include tagline on language assistance services offered to them, and how to access the services free of charge.</li> </ul>	<ul style="list-style-type: none"> <li>• Annual internal refresher training C&amp;L Training for Customer Service, Case Management, Behavioral Health, LTSS teams on interpreter/ translation services for LEP members.</li> <li>• SCFHP wide annual training through Litmos, (SCFHP’s training portal) on Cultural Competency to describe the role of communication and language in providing culturally competent care.</li> <li>• <b>Hiring of 4 Outreach Coordinator full-time staff for Outreach Programs – staff proficient in Vietnamese, Cantonese, Tagalog, &amp; Spanish. Outreach to members will be prioritized to the Coordinator who speaks that language. (May 2021)</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Planned expansion of Health Education programs for both Medi-Cal and Cal Medi-Connect lines of business.</b> <ul style="list-style-type: none"> <li>- <b>Contracting with organizations to offer health education opportunities such as classes, workshops, webinars, etc. in additional threshold languages, including Vietnamese and Chinese both virtually and in-person at Community Resource Center.</b></li> </ul> </li> <li>• Supporting local community – SCFHP endorses and promotes health prevention and wellness by supporting call-to-action letters from supporting organizations on topics such as reducing tobacco use, asthma and allergy awareness.</li> </ul>

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>Transportation:</b> Interventions should aim to educate members about transportation benefits for medical appointments and connect members to community resources to aid their transportation needs.</p>	<ul style="list-style-type: none"> <li>• <b>Review Aunt Bertha data and determine if there are opportunities for improving education to staff and members on transportation benefits</b></li> </ul>	<ul style="list-style-type: none"> <li>• Care coordination staff are trained annually in the Aunt Bertha platform that includes all community resources including those that address transportation needs. Additional trainings for staff are provided by providers including those providing paratransit.</li> </ul>	<ul style="list-style-type: none"> <li>• Care coordination staff and members have access to the Aunt Bertha platform that connects members to the appropriate contacts for transportation.</li> </ul>

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>Admission for Sepsis:</b> There is a need for further exploration to assess the behavior of SMI sub-population and those in LTSS, particularly enrollees in SNFs that may lead to infectious disease and eventually to sepsis so case managers can provide education to members on preventative strategies.</p>	<ul style="list-style-type: none"> <li>• <b>CDC handouts to members who are at risk of contracting sepsis or for members who have recovered from sepsis</b></li> <li>• Educational materials and tools related to sepsis are provided on the SCFHP website targeted for providers.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>In-service to CM staff on sepsis prevention and how to identify members at risk</b></li> </ul>	<ul style="list-style-type: none"> <li>• Continue to share best practices, resources and trainings to BH and LTSS partners on sepsis</li> </ul>

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>Behavioral Health Emergency Department (ED) admission:</b> Interventions should focus on understanding this population and helping to address their needs to prevent ED visits.</p>	<ul style="list-style-type: none"> <li>• Identification of CMC and Medi-Cal members that have multiple ED visits for untreated or unstable symptomology by creating a report to review on a regular basis</li> <li>• Agreement of number of ED visits to qualify for outreach</li> <li>• Outreach to member/caregiver to assess current needs</li> <li>• <b>Education about how to access behavioral health treatment services on SCFHP website, Community Resource Center, and with contracted providers</b></li> <li>• <b>SCFHP BH team plans on establishing and strengthening relationships with community based organizations who provide BH case management to members</b></li> </ul>	<ul style="list-style-type: none"> <li>• Coordination with IT for creation of access to ED utilization</li> <li>• Hiring of one BH Supervisor to review utilization and assign to BH Case Manager</li> <li>• SCFHP Behavioral Health Social Work Case Managers to initiate outreach and complete assessment of need, connect to services</li> <li>• Ongoing education on motivational interviewing and stages of change model</li> </ul>	<ul style="list-style-type: none"> <li>• Connection to county behavioral health services: <ul style="list-style-type: none"> <li>- For members who are not connected to county services: complete an assessment of need and current barriers to treatment by utilizing motivational interviewing techniques. Assist with calling BH Call Center to complete screening and placement of appropriate clinic.</li> <li>- For members who are currently connected to county services: Connect to member, caregivers, and BH provider/case manager to address barriers to treatment, supportive services to establish/maintain symptom management</li> </ul> </li> <li>• Referrals to: <ul style="list-style-type: none"> <li>- Peer Support Programs</li> <li>- Community Support groups</li> <li>- New Directions Care Coordination</li> </ul> </li> </ul>

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
<p><b>COVID-19:</b> Educate members on how to protect themselves and their families, identify signs and symptoms of potentially contracting COVID-19 and how to access vaccines as they become available.</p>	<ul style="list-style-type: none"> <li>• COVID flyer - Mailed flyer to refer members to our website for COVID information and resources, reiterate CDC COVID guidelines, call the nurse advice line for health questions, and call Customer Service for all other help</li> <li>• COVID Robocall - Robocalls to high risk members telling them they may be more vulnerable to COVID-19, reiterate CDC's guidelines to stay safe, call doctor for health questions or call nurse advice line, visit our website for more information on resources, and call Customer Service for questions.</li> <li>• COVID outbound calls – identified vulnerable populations &amp; called these members to share resources and support</li> <li>• Case Management informed newly enrolled members of COVID resources</li> <li>• Inbound calls - All member facing teams (HHP, CM, Customer Service) had COVID talking points when speaking with members to share resources and support, if requested from member</li> <li>• Pharmacy - Formulary expanded to include disinfectant and gloves amidst pandemic; Refills available via mail-order for 90 day fills; pharmacy overrides to allow early refills</li> <li>• Transportation - Amended agreements with two vendors to make special accommodations and cleaning relating to transporting suspected or confirmed COVID members</li> </ul>	<ul style="list-style-type: none"> <li>• Shared COVID educational materials with all member facing staff</li> <li>• COVID workgroup – assembled COVID workgroup from different business units to meet on weekly basis</li> <li>• Email communication – COVID email communication to all-staff from CMO re: tips to stay safe, COVID info, etc.</li> <li>• Transitioned 97% of staff to work from home</li> <li>• <b>On-boarded temp staff for COVID vaccine outreach; some were bilingual to meet members' cultural &amp; linguistic needs (March 2021)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Community Resource Sheet – used to share &amp; promote local programs and organizations for different issues (e.g. food, housing, jobs)</li> <li>• <b>COVID vaccine community clinic – partnered with County Emergency Operations Center (EOC) to host vaccine clinic at SCFHP's Community Resource Center, available to all (April 2021, with more clinics planned in the future)</b></li> <li>• <b>County partnership - Participated in County's COVID-19 Vaccine Community Stakeholders Working Group and subgroups to support the development and implementation of strategies to reach priority vulnerable groups, advise on communication strategies related to vaccine planning, and serve as a champion in support of vaccination and risk reduction. (ongoing)</b></li> </ul>



Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
	<ul style="list-style-type: none"> <li>• Telehealth - Added capability for Nurse Advice Line to offer members telephonic physician consultation</li> <li>• Website – created COVID webpage to share latest COVID news and information from the State and County</li> <li>• Members newsletter – shared educational COVID articles in newsletter</li> <li>• Social media – shared latest COVID news and information from the State and County</li> <li>• <b>Flyer – sent flyer to unvaccinated Medi-Cal members age 65+ to share information on how to schedule COVID vaccine appointment via phone or website (April 2021)</b></li> <li>• <b>Live calls outreach – identified vulnerable populations &amp; called these members to help schedule COVID vaccine appointment (March – May 2021)</b></li> <li>• <b>Robocall – sent robocalls to unvaccinated members to share information on how to schedule COVID vaccine appointment via phone or website (Mary 2021)</b></li> <li>• <b>Letter – send letter to unvaccinated members to share information on how to schedule COVID vaccine appointment via phone or website (pending – ETA early June)</b></li> <li>• <b>Ad campaign - Launched COVID vaccine digital and radio ad campaign to promote COVID vaccination (April 2021)</b></li> </ul>		



# Santa Clara Family Health Plan™

Population Health Management Strategy 2021

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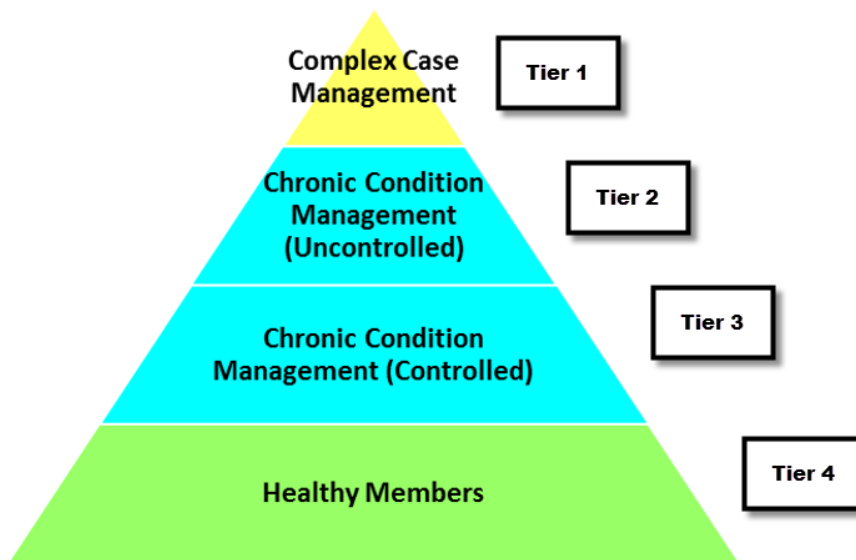
# I. Comprehensive Population Health Management Strategy

In accordance with the NCQA 2021 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, and in compliance with regulatory requirements set forth by the Center for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).

At a minimum, annual evaluations of the various elements of this Population Health Management (PHM) strategy will assess the Plan’s performance against the Institute for Healthcare Improvement (IHI) Triple Aim dimensions to improve patient experience of care, improve the health of populations, and reduce the per capita cost of healthcare.

The member population is segmented into subset targeted populations based off assessment of population needs and there are specific programs and services to address the four focus areas. To accomplish this, SCFHP has developed a tier of programs and qualifying populations that would be eligible for each program. This tier stratification is applicable to both the Cal MediConnect (CMC) and Medi-Cal (MC) lines of business.

## Populations Targeted for PHM:



### A. Tier 1: Complex Case Management (CCM) Eligibility Criteria

Members who have 3 or more hospitalizations in the past year and one other Tier 1 criteria or members who meet three or more Tier 1 criteria:

- Age 75+ with 3 ADLs (as identified through the Health Risk Assessment)
- >3 Emergency Department (ED) visits in the past year
- Hospitalized in the past 180 days
- Member has a diagnosis of Dementia (as identified through claims data)
- 3 or more chronic conditions and at least one uncontrolled\*
  - \*Uncontrolled is defined as 1 ED Visit or Inpatient stay within the past year, with a primary diagnosis of the member's chronic condition*

#### B. Tier 2: Chronic Condition Management Uncontrolled Eligibility Criteria

Newly enrolled members with no claims or utilization history or members that have at least one of the below criteria AND have at least one chronic condition that is uncontrolled:

- 75+ with 3 ADLs (as identified through the Health Risk Assessment)
- >3 ED Visits in the past year
- Hospitalized in the past 180 Days
- 3 or more hospitalizations in the past year
- 1 or more Social Determinant of Health (as identified through Health Risk Assessment)

OR

- Member is enrolled in the Multipurpose Senior Services Program (MSSP) or Community Based Adult Centers (CBAS) or In Home Supportive Services (IHSS)
- Member has uncontrolled symptoms of severe mental illness (SMI) (as identified through psychiatric admissions data)
- Member has been identified as homeless (through demographic data such as address or diagnosis code)

#### C. Tier 3: Chronic Condition Controlled Member Eligibility Criteria

Members that do not meet criteria for Tier 1 or 2 and have more than one controlled chronic conditions, and have greater than \$3,000 claims costs per year after facility and pharmacy costs are removed, or

- Member is in Long Term Care (LTC) in a skilled nursing facility (SNF) with no discharge plan
- Member has been admitted to Hospice within the last 12 months
- Members with chronic conditions and SMI who are able to access primary and specialty services

#### D. Tier 4 Healthy Members Eligibility Criteria

All other members that do not meet criteria for Tiers 1-3 are eligible for Tier 4.

## II. Population Health Program Focus Areas

SCFHP aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. The following four areas of this strategy focus on a whole-person approach to identify members at risk and to provide strategies, programs and services to mitigate or reduce that risk:

- 1) Keeping members healthy
- 2) Managing members with emerging risk
- 3) Promoting member safety and positive outcomes across settings
- 4) Managing multiple chronic illnesses

## III. Population Health Management Programs and Services by Focus Area

SCFHP promotes a program that is both sustainable and member-centered, and enables beneficiaries to attain or maintain personal health goals. This is done by providing timely access to appropriate, coordinated health care services, community resources, including home and community-based services, and behavioral health services.

**Table 1: Programs and Services by Focus Area**

Programs & Services	LOB		NCQA Focus Area				Tier
	CMC	MC	Keeping Members Healthy	Managing Members with Emerging Risk	Patient Safety or Outcomes Across Settings	Managing Multiple Chronic Illnesses	
Complex Case Management	X	X		X	X	X	1
Moderate Case Management	X	X	X	X	X	X	2
Basic Case Management	X	X	X	X	X		3, 4
Long Term Care Transitions	X	X	X	X	X	X	3
Transitions of Care	X	X	X	X	X	X	1 to 4
Behavioral Health Severe Mental Illness	X		X	X	X	X	2 to 4
Provider Engagement	X	X	X	X	X	X	1 to 4
Nurse Advice Line	X	X	X	X	X	X	1 to 4
Utilization Management & Concurrent Review	X	X	X	X	X	X	1 to 4
Health Education	X	X	X	X			1 to 4
Health Homes Program		X		X	X	X	2 to 4

Community Resources Integration	X		X	X	X	X	1 to 4
Medication Therapy Management (MTM)	X					X	1 to 4
Gaps in Care	X	X	X	X	X	X	1 to 4

## IV. Population Health Management Goals

SCFHP’s plan of action for each of the focus areas include measurable goals for specific targeted populations as follows:

### Keeping members healthy

**Goal:** Increase the number of newly enrolled CMC members with no claims or utilization data have an Annual Wellness Visit within 365 days of their enrollment by 5 percentage points compared to the prior year results

**Goal Justification:** Annual Wellness Visits are critical to maintaining the health of all CMC members. Based on analysis of IT risk stratification data, SCFHP frequently does not have utilization information on many of our newly enrolled CMC members.

**Population Targeted:** All CMC members who are not receiving LTC in a SNF

### Managing members with emerging risk

**Goal:** Increase diabetic control rate by 2 percentage points compared to prior year results

**Goal Justification Statement:** The plan also has a larger population of Hispanic and Asian members who are at higher risk for diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.

**Population Targeted:** All members with a controlled chronic condition of diabetes with an HbA1c over %

### Promoting member safety or positive outcomes across settings

**Goal:** Decrease 30 Day Readmission rate for CMC members by 1 percentage point compared to prior year results

**Goal Justification Statement:** Members discharged from an acute or skilled nursing facility setting are at high risk for readmission if members do not understand their discharge instructions and next steps to managing their condition. By improving continuity of care across acute care, long term care, behavioral health and home and community-based settings, we can decrease the risk of readmission to the hospital. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.

**Population Targeted:** Members who were recently hospitalized

## Managing multiple chronic illnesses

**Goal:** Reduce the number of members with multiple chronic conditions with 3 or more ED visits at safety net hospitals in Santa Clara County (SCC) in the past year by 10 percentage points.

**Goal Justification Statement:** The number of CMC members visiting a safety net hospital in the last year more than doubled. Unmanaged multiple chronic conditions often results in avoidable ED utilization.

**Populations Targeted:** All CMC members with 3 or more ED visits in the last year at a SCC safety net hospitals

## V. Population Health Management Goal Outcomes by Focus Area & Target Population

<b>Segmentation by Focus Area: Keeping Members Healthy</b>						
<b>Goal</b>	<b>Programs &amp; Services</b>	<b>Targeted CMC Population</b>	<b>Opt-in / Out</b>	<b>Member Communication</b>	<b># of Eligible CMC Members</b>	<b>% of Membership</b>
<b>Newly enrolled CMC members with no claims or utilization data have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results</b>	1. Basic Case Management	All Tiers	Opt-out	Interactive	9908	100%
	2. Nurse Advice Line	All Tiers	Opt-Out	Interactive	9908	100%
	3. Health Education	All Tiers	Opt-In	Interactive & Passive	9908	100%
	4. Wellness & Prevention	Per benefit	Opt-Out	Interactive & Passive	9908	100%
	5. Community Resource Integration	All Tiers	Opt-Out	Interactive	9908	100%
	6. Provider Engagement	All Tiers	Opt-Out	Physician Passive & Interactive	9908	100%
	7. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9908	100%



*Segmentation by Focus Area: Managing Members with Emerging Risk*

Goal	Programs & Services	Targeted CMC Population	Opt-in / Out	Member Communication	# of Eligible CMC Members	% of Membership
<b>Increase diabetic control rate by 2 percentage points compared to prior year results</b>	1. Basic Case Management	All Tiers	Opt-Out	Interactive	9908	100%
	2. Health Education	All Tiers	Opt-In	Interactive	9908	100%
	3. Provider Engagement	All Tiers	Non-Member directed	Physician	9908	100%
	4. Behavioral Health, Severe Mental Illness (SMI)	Tier 2	Opt-Out	Interactive	256	3%
	5. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9908	100%

**Segmentation by Focus Area: Patient Safety across settings**

Goal	Programs & Services	Targeted CMC Population	Opt-in / Out	Member Communication	# of Eligible CMC Members	% of Membership
<b>Decrease 30 day Readmission rate by 1 percentage point</b>	1. Basic Case Management	All Tier	Opt-Out	Interactive	9908	100%
	2. Transition Of Care (TOC)	All Tiers	Opt-Out	Interactive	9908	100%
	3. Long Term Care Transitions	Tier 2	Opt-Out	Interactive & Passive	256	3%
	4. Provider Engagement	All Tiers	Opt-Out	Interactive & Passive	9908	100%

## Segmentation by Focus Area: Managing Multiple Chronic Illness

Goal	Programs & Services	Targeted CMC Population	Opt-in / Out	Member Communication	# of Eligible CMC Members	% of Membership
Decrease the number of members with 3+ ED Visits by 10 percentage points	1. Complex Case Management	Tier 1	Opt-In	Interactive	194	2%
	2. Moderate Case Management	Tier 2	Opt-Out	Interactive	256	3%
	3. Medication Therapy Management	All Tier	Opt-In	Interactive	9908	100%
	4. Nurse Advice Line	All Tiers	Per benefit	Interactive	9908	100%
	5. Behavior Health Case Management	Tiers 2-4	Opt-Out	Interactive	9714	98%

### IV. Description of Case Management Program and Service Activities

Members are identified for case management through multiple sources, including but not limited to, eligibility files, medical and pharmacy claims data, Health Risk Assessment data and utilization management data. Members may also self-refer, or be referred by providers, discharge planners, caregivers, delegates, vendors and community partners.

Members are assigned to CM programs based on risk stratification, member's responses to the health risk assessment, additional assessments, clinical evaluation and consultation with members to determine their willingness to participate. Members can move between programs as appropriate to provide the most appropriate level of support at the time.

## A. Case Management Activities:

### Health Information Form/ Member Evaluation Tool (HIF/MET)

SCFHP uses the HIF/MET data to help identify newly enrolled Medi-Cal members who may need expedited services. It is included in the new member packet mailed to all newly enrolled Medi-Cal beneficiaries including a postage paid business reply envelope for response.

Within the 90 days of a new member's effective date of enrollment, SCFHP Production Services and the Customer Service Department oversee the receipt and processing of completed HIF/MET forms returned via USPS mail and all HIF/MET data is entered into Case Management platform, Essette. Members that need Case Management (CM) intervention are identified and escalated to CM immediately through Essette. Referrals from HIF/METs include an outbound call to the member to discuss the results and follow up on care coordination as needed. If the member falls within the Seniors and Persons with Disabilities (SPD) population, the HIF/MET is used to initiate the completion of a Health Risk Assessment (HRA) and any subsequent care coordination as appropriate.

In addition, SCFHP Customer Service (CS) conducts at least two outreach calls to members if a completed HIF/MET is not returned within 30 days of the member's enrollment date.

### Long Term Services and Supports (LTSS) Assessment

Care Coordination for members enrolled in Long Term Services and Supports (LTSS) benefit programs who are dually eligible for Medicare and Medi-Cal and not enrolled in the Cal MediConnect line of business is provided in collaboration with LTSS providers. SCFHP retains and compiles a copy of assessments and care plans for members enrolled in Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Long Term Care (LTC) in a skilled nursing facility. This information is documented in Essette and a designated LTSS Care Coordinator or Case Manager conducts a review to determine if further care coordination is needed.

### Health Risk Assessment (HRA)

CMC and Medi-Cal SPD members are assessed upon enrollment and, at a minimum, on an annual basis using the Health Risk Assessment (HRA). This tool consists of questions related to health, psychosocial needs, and Social Determinants of Health (SDOH) to assess the members' understanding of their health status and to identify wellness goals and appropriate assignment for Case Management programs and services. All assessments completed are analyzed to adjust clinical risk level of members.

### Individual Care Plan (ICP)

Upon completion of an HRA or through any demonstrated need, an Individual Care Plan (ICP) will be developed with the members' participation. The ICP is to include the member's goals and preferences, measureable objectives, and community resources as appropriate, to meet member-prioritized health care goals. The ICP will be shared with the member and their Primary Care Provider (PCP) and members are encouraged to share the ICP with anyone that provides care coordination to them. ICP's are updated based on the member's condition and preferences and, at a minimum, on an annual basis. Members who cannot be reached or who refuse to engage in the

ICP process will receive a preventative ICP with their assigned care coordinators contact information.

#### Interdisciplinary Care Team (ICT)

SCFHP will assist members to identify their Interdisciplinary Care Team (ICT) when a need is demonstrated or as requested by the member or the member's authorized representative. ICTs are comprised of professionals appropriate for the needs, preferences, and abilities of the member and will integrate the member's medical care, LTSS needs, and behavioral health services as appropriate. The members' ICT will be led by professionally knowledgeable and credentialed personnel that will include, at a minimum, the member, individuals approved by the member, County In-Home Support and Services (IHSS) social worker, the member's Primary Care Provider, and SCFHP Care Coordination staff. Additional providers, such as social workers, specialists, LTSS providers, community-based case managers, and caregivers are included at the request of the member. The ICT collaborates with the member to stabilize medical conditions, increase compliance with the ICP, and meet ICP goals for optimal health and functional status. Meetings with a member's ICT will be offered and conducted periodically as needed for the member's care or if requested by the member. Members have the right to opt-out of participation on the ICT without disrupting their access to care coordination. Members who opt out will receive a preventative ICP with their assigned care coordinators contact information.

#### Use of SCFHP Software Systems to Coordinate Member and Provider Programs

The Case Management platform, Essette, includes data from all areas of the plan for care coordination communication. Data includes pharmacy claims, medical claims (including ED visits and hospitalizations), UM authorizations, and lab data. Member demographic data is pulled from the claims processing and Utilization Management platform, QNXT. SCFHP Care Coordination staff documents outreach to members in Essette for cross-departmental transparency and collaboration. Referrals to Case Management are also documented within Essette for appropriate follow up. Other pertinent information including, but not limited to, external assessments and Medication Therapy Management (MTM), are also pushed into the system and incorporated into the member's overall condition.

## B. Case Management Programs

- 1. Complex Case Management** is provided to all eligible members in Tier 1 and is described in detail in the corresponding procedure. These members are offered intensive support and are established based on member's preference and needs. Members are engaged in a thorough initial assessment.
- 2. Moderate Case Management** is provided to members in Tier 2 and includes those members with multiple chronic conditions with at least one uncontrolled and complex social determinants of health. It includes members receiving MSSP services and care coordination around severe mental illness (SMI).

3. **Basic Case Management** is provided to members in Tiers 3 and 4 and includes, at a minimum, the completion of an HRA and further assessment as needed for benefit coordination in collaboration with the PCP.
4. **Transitions of Care (TOC)** is provided across all CM Tiers for members to support discharge planning from acute hospital or long term care facility. Outreach is made to members who recently discharged from the acute hospital, inpatient psychiatric hospital, or skilled nursing facility to ensure a safe transition to the appropriate level of care and minimize risk of readmission. This service is also provided to support continuity of care for members transitioning between providers. Members will be reassessed for the appropriate tier of CM after their transition period. Case management services include integration of the discharge plan into the current ICP including facilitating follow up visits to the member's providers, post-discharge medication reconciliation, and confirmation that the discharge plan has been implemented. If a member is not connected to a Behavioral Health (BH) care team in the community following discharge from an inpatient psychiatric hospital, both the discharging hospital and the BH CM will ensure coordination of a timely visit.
5. **Long Term Care (LTC) Transition** case management is provided to the subgroup of nursing facility members who are authorized for long term care but have been identified as able to discharge back to the community. Case management includes working with the member and their family or caregivers and the nursing facility team to assess readiness for discharge and coordination of a discharge plan. The LTC RN CM visits the member to conduct a face-to-face assessment, provides information about long term services and supports (LTSS) benefits and other community-based resources, and facilitates arrangement of and authorization for services and supports needed post-discharge. This includes addressing social determinants that may be a barrier to discharge including income benefits, lack of housing and family support and coordination with community resources. The CM coordinates closely, as appropriate with other community-based services targeted to nursing home residents including the Community Care Transitions (CCT) program and county initiatives such as the Whole Person Care program. The Case Manager conducts a TOC call following discharge notification and follows all TOC and case management processes as outlined below for TOC. After 30 days following transition, the member is referred to the appropriate CM team.
6. **Behavioral Health (BH) Case Management** is provided to members who are diagnosed with Severe Mental Illness (SMI) any tier, based on their level of stability. The BH CM team will participate with the other CM teams to coordinate the medical and LTSS case management services as needed. Behavioral Health Services as provided by the SCFHP BH CM team, include comprehensive services across all settings. Specific focus areas of BH Services include:
  - Reduction of ED visits for those who have any BH diagnosis;
  - Concurrent review and follow up for all members who are hospitalized in a psychiatric hospital;
  - Follow up after psychiatric hospitalization to ensure safety for members and that all members have a follow up visit with a BH provider at 7 and 30 days;
  - Care coordination with community BH providers for the SMI population who are served in Specialty Mental Health clinics.
7. **Health Homes Program (HHP)** is a benefit for Medi-Cal members enrolled in Managed Care Plans (MCPs). This program services members with multiple chronic conditions and social

determinants on July 1, 2019, and began serving members with Serious Mental Illness on January 1, 2020. The HHP serves eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries. SCFHP contracts with local clinics and agencies in the community to provide these services to our members on behalf of the plan. SCFHP also directly provides HHP services to a portion of eligible members that cannot be assigned to a local clinic and/or agency due to capacity or other reasons. This program will be transitioning to Enhanced Care Management in 2022.

## C. Case Management Supportive Services

### 24/7 Nurse Advice Line:

The Nurse Advice Line is a nurse-driven telephonic support program that empowers members to better manage their health. Highly trained registered nurses help participants navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors. Nurse Advice Line data is provided to SCFHP Care Coordination staff for review and follow-up as needed. All Nurse Advice Line calls resulting in a 911 disposition will be immediately referred to SCFHP Care Coordination staff for appropriate follow-up.

### Whole Person Care Nursing Home Diversion Program

SCFHP has partnered with the Santa Clara County Health and Hospital System in the operation of their Whole Person Care (WPC) Pilot through the year 2021. One component of the WPC program is the Nursing Home Transition & Diversion Program that combines intensive case management, housing services and additional services to enable successful transitions for long term care members in a nursing facility. This program is administered by a provider contracted with the County – Institute on Aging (IOA) in partnership with community housing resources, safety net hospital, Behavioral Health Department and other community-based providers. SCFHP members may be identified for the program by the nursing facility staff, Institute on Aging or SCFHP UM or case management staff. The targeted population is members whose primary barrier to transition is the lack of housing and the need for ongoing intensive case management pre and post-discharge from Long Term Care. WPC case management is provided in collaboration with the SCFHP assigned case manager.

### Provider Engagement

SCFHP engages providers in the member's care in various ways. Member PCPs are provided their specific CMC enrollment data monthly so that they can identify new members requiring an Initial Health Assessment (IHA). They also receive a copy of the member's ICP. Through IHA and the ICP, the provider can engage the member in discussions about preventative services, regular screenings, maintenance therapies, and health education programs, such as nutrition and physical activity education. PCPs are also members of the members' Interdisciplinary Care Team (ICT) and are invited to attend any scheduled ICT meetings. To further engage the provider network, educational materials are made available on the external SCFHP website. The Provider Network Operations (PNO) team also schedules visits and distributes a quarterly provider newsletter.

## Utilization Management and Concurrent Review

The Utilization Management (UM) team includes clinical and non-clinical staff who determine medical necessity of inpatient and outpatient services. Concurrent review of hospitalization stays are completed by California-licensed RNs who collaborate with the facility and other providers to coordinate member's discharge needs and related follow up care. Care coordination related to discharge planning may include referrals to any available CM programs and coordinating benefits across health care settings, such as Durable Medical Equipment (DME), home health, Long Term Services and Supports (LTSS), behavioral health and outpatient services.

Within 72 business hours of a member's discharge to a residential home or his or her community setting such as an assisted living facility, the UM team notify the Case Management team of a member's discharge for Transition of Care (TOC) outreach and assessment. The TOC assessment within Essette evaluates for any member or caregiver support and/or resources which are needed to minimize gaps in care which may otherwise result in readmissions or preventable emergency room visits.

## Health Education

The Health Education program has a variety of classes and workshops available for members to help maintain and improve their health and manage their illnesses. SCFHP works with a number of agencies within the community to provide programs covering topics from chronic disease, counseling services, weight management, smoking cessation, safety programs, and more. A complete list of these programs are available on the SCFHP website ([www.scfhp.com](http://www.scfhp.com)). Members may self-refer to all programs, except for the Diabetes Prevention Program. Self-referral is completed through the mySCFHP Member Portal or by contacting Customer Service. Referrals are also received from PCPs and all SCFHP departments.

## Community Resources Integration

Cal MediConnect and Medi-Cal SCFHP members face many barriers in the form of Social Determinants of Health (SDOH). From the population assessment, many members stated they ran out of money to pay for food, bills, rent, or medications. In order to help remove these barriers, SCFHP contracts and partners with Aunt Bertha (AB), a [social care network](#) that offers an online database of community resources specific to Santa Clara County. The LTSS team serves as the liaison with AB to coordinate updates and training for all case managers. This, combined with any additional community resources we are made aware of, assist the CMs with addressing social determinants of health experienced by Cal MediConnect and Medi-Cal SCFHP members. Designated SCFHP LTSS staff also manage local relationships with key community providers and attend relevant community meetings to stay abreast of available resources and changes in eligibility.

All CM staff receive initial and annual training on AB and community-based programs and services with detailed information on program scope, eligibility, referral processes and key contacts. This information is updated at least annually. Case managers and supporting staff also have access to trainings with providers, face-to-face visits and presentations by providers with new resources shared on an ongoing basis.



Community resources that address the most common social determinants of health needs identified by our members are food, housing, transportation, socialization, caregiver support and respite, legal services, public benefits and services such as protective services, and specialized case management (e.g. HIV). CM referrals are made as part of the individual care plan development and goal setting to facilitate coordination of benefits and community resources. Through AB Single Sign-on platform, SCFHP staff can directly send referrals to community based providers and AB will continue to update that referral status to make sure members have been connected to programs successfully. Cal MediConnect and Medi-Cal members may also access AB on their own through the SCFHP website and reports can be run to determine the highest needs identified by programs and resources searched by Cal MediConnect and Medi-Cal SCFHP members.

### Medication Management Therapy (MTM)

The goal of MTM is to optimize drug therapy and improve therapeutic outcomes for members. Members that take medications for multiple different medical conditions may be eligible to receive MTM services at no cost. Members that qualify are automatically enrolled in to the program and mailed a welcome letter explaining the program and instructions for opting out. Specific eligibility criteria is posted both on [www.scfhp.com](http://www.scfhp.com) and within the member handbook. MTM is only performed for the CMC line of business. MTM services may include:

- Calls from a pharmacist or other health professional to review all of the members' medications and discuss medication benefits, concerns, and questions
- Written, mailed summary of the medical review as well as a medication action plan and personal medication list
- Follow up from the pharmacist or other health professional every 3 months to ensure records are up to date as well as the safety and cost effectiveness of medications

### Gaps in Care

When a member's profile is searched in QNXT, automated notifications pop up that alert the reader when a member has not received a specific wellness screening. Customer Service Representatives can provide members with this information when they call in to ask a question. Members who have questions or who need assistance to schedule appointments to their PCP or require transportation assistance can be helped immediately. Gaps in Care pop-ups also serve to alert the care coordination team to include annual wellness and prevention screening elements as a member's goal of care.

## V. Informing Members

Cal MediConnect and Medi-Cal members are informed about all available PHM programs and services at any level of contact including the Plan's website, direct mail, e-mail, text or other mobile applications, telephone or in-person. Many programs offered are communicated to Cal MediConnect and Medi-Cal members within their Evidence of Coverage/Member Handbook document, which is mailed to members annually and upon enrollment, as well as through [www.scfhp.com](http://www.scfhp.com). Additionally, a catalog of all PHM programs was created and made available on the health plan website so that members may be informed of all programs that they may be eligible. The catalog will be updated annually and can be mailed to members upon their request. Members will receive a mailing on how to access this information on line or how to request it from customer services annually.

Cal MediConnect and Medi-Cal members deemed eligible for inclusion in any PHM program involving interactive contact may opt-out of participation at any time. Cal MediConnect and Medi-Cal members or their Authorized Representatives may request to opt-out by calling SCFHP’s Customer Service department at 408-376-2000, sending a secure email to the SCFHP’s case management department at [www.CaseManagementhelpdesk@scfhp.com](mailto:www.CaseManagementhelpdesk@scfhp.com), or via USPS mail delivery.

## VI. Population Health Delivery System Support

SCFHP provides support to practitioners and providers providing population health management to our members and to support the achievement of program goals. Below are a list of activities conducted by the Plan that support PHM programs or services not directed at individual members.

Table 2: Indirect Member Interventions for Cal MediConnect and Medi-Cal Lines of Business

Indirect Interventions	Focus Area(s)
SCFHP shares member data with providers to assist them in delivering services, programs and care to our members. We mail, fax, and/or verbally inform providers of their members individualized care plans and goals at least annually and after any updates. We also inform providers via fax when we have been unable to reach a member to complete a comprehensive Health Risk Assessment (HRA) and request their assistance. Additionally, we electronically send our providers member eligibility reports, language, and demographic data, and gaps in care reminders via the online provider portal.	1-4
SCFHP’s Provider Network Operations (PNO) team completes provider education and required trainings, including the provision of continuing education units (CEUs/CMEs). These trainings include: cultural competency, Screening, Brief Intervention and Referral to Treatment (SBIRT), communicating across language barriers, Long Term Services and Supports (LTSS), and the Staying Healthy Assessment.	1-4
Quarterly provider newsletters, distributed by fax and e-mail and posted on the website	1-4
SCFHP presents quarterly to a Provider Advisory Council (PAC) on topics such as behavioral health treatment advances, opioid addiction, and other topics relevant to the characteristics of our SCFHP member population.	2, 3

Indirect Interventions	Focus Area(s)
<p>SCFHP participates in monthly community Safety Net Network meetings. Discussions within these meetings with our community partners include topics such as food resources, housing, and resources that address social determinants impacting the member population.</p>	1, 3
<p>Coordination with Housing Services Information System: SCFHP participates in the County’s Homeless Management Information System (HMIS) - an online database that enables organizations to collect data on the services they provide to people experiencing homelessness and people who are at risk for homelessness. Members who are in the HMIS database may have priority access to housing assistance.</p>	2-4
<p>Nursing Home Support and Training The LTSS team has designated clinical and provider network staff to manage relationships with all contracted nursing facilities serving a large member population. This includes conducting regular visits, to support utilization and case management for long term care members including collaboration for care transitions. A provider liaison monitors quality measures, troubleshoots issues related to authorizations claims, or contracting and conducts periodic trainings for SNF staff.</p>	2-4
<p>Behavioral Health Services coordinates and partners with the County Behavioral Health Services Department (CBHSD), community-based organizations, and providers to facilitate patient outcomes across all settings. This could include collaboration with acute and outpatient staff disposition, follow up and ongoing BH treatment for best outcome results. The coordination includes continuous education to Specialty Mental Health Clinics about the CMC population, consultation to providers and regular monthly CMC care coordination meetings.</p>	1-4
<p>Behavioral Health Services provides training materials to provider offices regarding SBIRT assessment and counseling.</p>	1-4
<p>Quality department provides intermittent training for contracted providers on appropriate wellness and preventative services (e.g. USPSTF, clinical practice guidelines) as appropriate. Clinical practice guidelines are also available to providers on the website.</p>	1, 3
<p>Pharmacy department performs quarterly drug use evaluations (DUEs) on various clinical areas (e.g. polypharmacy, asthma controller medication review) to look for gaps in care and contacts providers as appropriate for intervention.</p>	1-4

Indirect Interventions	Focus Area(s)
<p>SCFHP notifies the community and providers about Aunt Bertha and how to access it through <a href="http://scfhp.auntbertha.com">scfhp.auntbertha.com</a> in an e-newsletter. Providers can also access Aunt Bertha through the resource page found on the plan’s website (<a href="http://scfhp.com">scfhp.com</a>).</p>	1-4
<p>SCFHP shares evidence-based guidelines with our provider network on the health plan website, <a href="http://scfhp.com">scfhp.com</a>. The information is located within the Provider Resources section on the website and includes guidelines for:</p> <ul style="list-style-type: none"> <li>i. Cervical Cancer Screening</li> <li>ii. Clinical and Preventive</li> <li>iii. BMI calculations</li> <li>iv. Recommended immunization schedules</li> </ul>	1-4

## VII. Coordination of Cal MediConnect and Medi-Cal Member Programs

Internal and external population health programs and services are coordinated across settings, providers and levels of care to minimize confusion to Cal MediConnect and Medi-Cal members from being contacted from multiple sources.

To provide care in a coordinated manner, SCFHP has several programs offered to Cal MediConnect and Medi-Cal members as specified in Section IV, depending on their clinical conditions and psychosocial needs. The health plan strives to provide the right care at the right time in the right place to members in order to improve patient experience of care, the health of populations and reduce the per capita cost of healthcare.

To better understand where the member is in the continuum of care, SCFHP Care Coordination staff collaborates with all internal departments, vendors, and community partners to identify potential member coordination opportunities, access and education needs. The CM team coordinates with community based service partners to align members with non-benefit resources to support their ICP through the ICT process.

Interdepartmental coordination is key to effective service coordination. SCFHP’s case management software platform, Essette, acts as the central point of documentation for all care management programs and services related to the member. All members are assigned to an SCFHP Care Coordination staff member who acts as the primary point of contact for population health management support. In addition to the ICT discussed above, internal case conferencing across specialties is facilitated for coordination of care plan development and implementation across member needs including medical, LTSS and BH.

For care coordination across organizations, including delegates and community level case management programs, SCFHP Case Management programs coordinate with external partners as needed.

Members identified with Serious Mental Illness are assigned to the Behavioral Health Case Management program and are referred to community programs as appropriate; this referral process is coordinated through the appropriate Behavioral Health (BH) Care Coordination staff to ensure services are not duplicated by external programs, and that the needs (i.e. medical needs, social determinants of health) of

the member are met. In addition, BH collaborates with the county through county reporting of new assessments from their call center.

### VIII. Impact Analysis of Population Health Management Strategy

At least annually, SCFHP conducts a comprehensive analysis of the impact of its PHM strategy that includes quantitative results for relevant clinical/cost and utilization and experience measures. Quantitative and qualitative analysis is conducted based on these results. Comparison of results with established benchmarks are evaluated for evidence of program effectiveness and room for improvement. This analysis will be conducted by the Health Services department in conjunction with IT, Member Services, Provider Services, and Grievance & Appeals to support the members and promote an effective Population Health Management Strategy.

<b>Last Update:</b>	<b>Author(s):</b>	<b>Approval Date:</b>
June 2021	Dr. Laurie Nakahira, Chief Medical Officer, Health Services Angela Chen, Interim Director, Case Management Shawna Cagle, Manager, Case Management Natalie McKelvey, Manager, Behavioral Health Lori Andersen, Director, Long Term Services and Supports (LTSS) Johanna Liu, Quality & Process Improvement Lucille Baxter, Quality & Health Education	

## **Review of Quality Improvement Policies**

**QI.17** Behavioral Health Care Coordination

**QI.18** Sensitive Services, Confidentiality, Rights of Adults and Minors

**QI.20** Information Sharing with San Andreas Regional Center (SARC)

**QI.21** Information Exchange Between SCFHP & Health Services Dept.

**QI.22** Early Start Program (Early Intervention Services)

**QI.23** Alcohol Misuse: Screening and Behavioral Counseling Interventions  
in Primary Care

**QI.24** Outpatient Mental Health Services: Mental Health Parity

**QI.25** Intensive Outpatient Palliative Care

**QI.27** Informing Members of Behavioral Health Services

## POLICY

<b>Policy Title:</b>	<b>Behavioral Health Care Coordination</b>	<b>Policy No.:</b>	QI.17
<b>Replaces Policy Title (if applicable):</b>	<b>Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure</b>	<b>Replaces Policy No. (if applicable):</b>	<b>CM106_1</b>
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

Santa Clara Family Health Plan (SCFHP) 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, SCFHP 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. SCFHP 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. SCFHP 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 with or without an Autism diagnosis and other evidence based behavioral intervention services that develop or restore functioning. SCFHP provides BHT for members who are under 21, have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary and that the member is medically stable without the need for 24 hour medical nursing monitoring. SCFHP requires Primary Care Physicians (PCP) to administer the Department of Health Services approved assessment tool as detailed in the procedure.
- D. To define how SCFHP 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.

# POLICY

### 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)

DHCS All Plan Letter 18-006, Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

### V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature		Signature		
Jeff Robertson, MD		Laurie Nakahira, MD		
Name		Name		
Medical Director		Chief Medical Officer		
Title		Title		
6/10/2020		6/10/2020		
Date		Date		
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## POLICY

<b>Policy Title:</b>	<b>Sensitive Services, Confidentiality, Rights of Adults and Minors</b>	<b>Policy No.:</b>	QI.18
<b>Replaces Policy Title (if applicable):</b>	Sensitive Services, Confidentiality, Rights of Adults and Minors	<b>Replaces Policy No. (if applicable):</b>	CM036_04
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> 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.
  - 1. The following services are considered confidential and sensitive services for adult and minor children aged 12 and older without parental consent:
    - a. Sexually transmitted diseases
    - b. Family planning
    - c. Sexual assault
    - d. Pregnancy testing
    - e. HIV testing and counseling
    - f. Abortion
    - g. Drug and alcohol abuse
    - h. 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


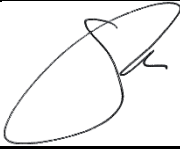
- A. Health Services works with IT, Provider and Customer Services, providers and community services to provide sensitive and confidential services to members without requiring prior authorization.

### 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**

# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director of Quality and Process Improvement		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
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 08/05/2016	Quality Improvement Committee	Approve 08/05/2016	
V1	Reviewed; 08/09/2017	Quality Improvement Committee	Approve 08/09/2017	
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V1	Reviewed; 06/10/2020	Quality Improvement Committee	Approve 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

## POLICY

<b>Policy Title:</b>	<b>Information Sharing with San Andreas Regional Center (SARC): MOU</b>	<b>Policy No.:</b>	QI.20
<b>Replaces Policy Title (if applicable):</b>	None	<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> 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) without regard to diagnosis. 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 provided by SCFHP including primary care, and carve out services such as California Children's Services, Specialty Mental Health Services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for comprehensive diagnostic evaluations (CDE's) for members/clients who are suspected of needing BHT services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for BHT services for members who meet criteria as outlined in APL 18-006 or any revised version of these APL's.
- SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.
- SCFHP and/or its subcontracted providers and vendors shall be available to assist, the SARC in the development of the Individual Program Plan (IPP) or Individualized Family Services Plan (IFSP) as necessary.

#### **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 without regard to diagnosis for evaluation for medically necessary BHT services upon client/member request for BHT services.

- SARC shall provide case management & care coordination services related to SARC's Early Start Program clients to SCFHP for medically necessary BHT services.
- 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.
- SARC will share information on community resources to SCFHP and/or its sub-contracted providers and vendors.
- SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families to assure timely access to health, developmental, social, educational, and vocational services.

TCM includes, but is not limited to:

- a. Coordination of health related services with SCFHP to avoid duplication of services; and
  - b. Provision of referrals to specialty centers and follow-up with schools, social workers and others involved in the IPP and IFSP
- SARC agrees to provide periodic training to SCFHP's staff as requested by the SCFHP concerning SARC services and requirements
  - SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.



### **III. Responsibilities**

See Memorandum of Understanding between SARC and SCFHP. Policies and Procedures to be attached. 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  
DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Regional Centers, 03/02/2018  
DHCS All Plan Letter 18-006 Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

### **Approval/Revision History**

First Level Approval		Second Level Approval		
				
Signature Jeff Robertson, MD		Signature Laurie Nakahira, MD		
Name Medical Director		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
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V1	Reviewed; 08/09/2018	Quality Improvement Committee	Approved 08/09/2018	
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V1	Reviewed; 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

## POLICY

<b>Policy Title:</b>	<b>Information Exchange Between Santa Clara Family Health Plan &amp; County of Santa Clara Behavioral Health Services Department</b>	<b>Policy No.:</b>	QI.21
<b>Replaces Policy Title (if applicable):</b>	Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara County	<b>Replaces Policy No. (if applicable):</b>	HS 409
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

This policy is to provide detailed instructions for how Santa Clara County Behavioral Health Services Department and Santa Clara Family Health Plan (SCFHP) will perform activities to support the provision of Medi-Cal Specialty Mental Health and/or drug Medi-Cal services as a managed care benefit under the Medi-Connect program. SCFHP and the County of Santa Clara Behavioral Health Services Department (formerly known as Santa Clara County Mental Health Department and Santa Clara County Department of Alcohol and Drugs) entered into a MOU effective January 1, 2014 to specify how roles and responsibilities between the two entities were to be performed.

### II. Policy

It is the policy of the SCFHP to provide coordination of care for the purpose of providing services to CMC members which are coordinated with Santa Clara County BHSD, their mental health clinics and contractors. The SCFHP and the CBHSD will follow the medical necessity criteria for Medi-Cal specialty mental health 1915 (b) waiver services described in Title 9, California Code of Regulations. DHCS has developed a matrix of Roles and Responsibilities "Behavioral Health Benefits in the Duals Demonstration" which is attached to the MOU. Medical necessity for Drug Medi-Cal Substance Abuse Services will be as found in Title 22, California Code of Regulations (CCR).

### III. Responsibilities

#### 1. Assessment Process

The SCFHP and CBHSD shall develop and agree to written policies and procedures regarding screening and assessment processes that comply with all federal and state requirements. SCFHP completes a Health Risk Assessment (HRA) pursuant to the CMC three way contract guidelines. SCFHP Behavioral Health Department reviews and/or completes the HRA with special attention to the depression Indicators as well as Severe Mental Illness indicators. The HRA, in conjunction with claims and pharmacy Information, is utilized to create a preliminary interdisciplinary care plan (ICP). The ICP is reviewed with the member and sent to the member's primary care physician and the member's Specialty Mental Health provider for their review and changes.

# POLICY

## 2. Referrals

The SCFHP and the CBHSD shall develop and agree to written policies and procedures regarding referral processes including:

- a. CBHSD will accept referrals from SCFHP staff, providers, and members' self-referral for determination of medical necessity
- b. SCFHP will accept referrals from CBHSD for services needed are provided by the SCFHP and not the CBHSD and the member does not meet the Medi-Cal Specialty mental health and/or Drug Medi-Cal medical necessity criteria. This will include mild to moderate levels of care needs which are the responsibility of SCFHP.

## 3. Information Exchange

- a. CBHSD will develop and agree to information sharing policies and procedures. CBHSD Director has provided a memo to County Clinics and Sub-contractors stating that basic information may be shared in order to determine if a member is being seen and who is the provider in the agency.
- b. SCFHP will create a list of members who are receiving Medi-Cal specialty mental health services, and/or Drug Medi-Cal services.
- c. A signed mental health release of information is obtained from the member in order to 1. Share information with behavioral health services agencies; 2. Provide care coordination and 3. Complete and updated ICP and an interdisciplinary care team (ICT) meeting as needed.
- d. The information sharing policies and procedures developed by the CBHSD and SCFHP will include milestones agreed upon for shared roles and responsibilities for sharing personal health information. Meetings with County BHSD providers and their contractors will be held to provide training to discuss the policies and procedures which have been agreed upon for sharing of personal health information.

## 4. Care Coordination

- a. The SCFHP and CBHSD will develop and agree to policies and procedures for coordinating Medical and behavioral health care for members enrolled in SCFHP and receiving Medi-Cal specialty mental health or Drug Medi-Cal services.
- b. The policies and procedures will include:
  - An identified point of contact from both CBHD and SCFHP who will initiate and maintain ongoing care coordination
  - CBHSD and their contractors will participate in ICT's for members receiving County services and identified as needing an ICT.
  - At the County's request, the SCFHP will assist the CBHSD in developing behavioral health care plans
  - SCFHP will have a process for reviewing and updating the care plans as clinically indicated and following a hospitalization or significant change such as level of care.
  - SCFHP will have regular quarterly meetings to review the care coordination process
  - SCFHP will coordinate with the County to perform an annual review, analysis & evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.



## IV. References

California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000  
Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health  
DHCS Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Enrollees, D. Mental Health Services  
MMCD Policy Letter 00-01

# POLICY

Title 9, CCR, Chapter 11, Division 1, Section (s) 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205 (b) (1); 1830.210; 1850.210 (I); 1850.505  
 Title 22, CCR, Chapter 3, Article 4, Section (s) 51305; 51311; 51313; 51183  
 Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (1) and the State of California Alcohol and/or Other Drug Program Certification Standards Welfare and Institutions Code Section 5600.3; and 14016.5

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Jeff Robertson, MD		Signature Laurie Nakahira, MD		
Name Medical Director		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
Date		Date		
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V1	Review; 06/09/2021	Quality Improvement Committee		



## POLICY

<b>Policy Title:</b>	<b>Early Start Program (Early Intervention Services)</b>	<b>Policy No.:</b>	QI.22
<b>Replaces Policy Title (if applicable):</b>	Early Start Program (Early Intervention Services): Developmental Delay Identification, Referral and Care Coordination	<b>Replaces Policy No. (if applicable):</b>	CM.005_03
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

**I. Purpose**

Santa Clara Family Health Plan (SCFHP) ensures that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

**II. Policy**

Santa Clara Family Health Plan (SCFHP) identifies members (aged 0 to 2.9 years) who have, or are at risk of acquiring developmental delays or disabilities and need early intervention services. SCFHP will coordinate the referral of members to the Early Start Program, which is a collaborative effort between the San Andreas Regional center (SARC) and the Santa Clara County Office of Education.

**III. Responsibilities**



The Health Services Department of the SCFHP is responsible for referring members to Early Start as they are identified by the primary care physicians, case managers and others. The Department is also responsible to notify SCFHOP delegates of their responsibilities to refer to Early Start.

**IV. References**

DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Health Care Plans and Regional Centers, 03/02/2018

# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Jeff Robertson, MD		Signature Laurie Nakahira, MD		
Name Medical Director		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
Date		Date		
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V3	Revised 06/02/2019	Quality Improvement Committee	Approved 06/02/2019	
V4	Revised 06/10/20	Quality Improvement Committee	Approved 06/10/2020	
V4	Review 06/09/2021	Quality Improvement Committee		

## POLICY

<b>Policy Title:</b>	<b>Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care</b>	<b>Policy No.:</b>	QI.23
<b>Replaces Policy Title (if applicable):</b>	Screening, Brief Intervention and Referral for Treatment for Misuse of Alcohol	<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

- A. SCFHP’s policy is to support the contracted network in providing an expanded alcohol screening for members 18 years of age and older who answer “yes” to the alcohol question in the Individual Health Education Behavioral Assessment (IHEBA).
- B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) expanded contractual requirements for identification of potential alcohol misuse problems.
- C. Providers in SCFHP primary care settings must offer and document AMSC services are offered.
- D. The SCFHP will not limit behavioral counseling interventions. Beneficiaries who meet criteria for an alcohol use disorder or whose diagnosis is uncertain, are to be referred for further evaluation to the County Gateway program at 1-800-488-9419.



### III. Responsibilities

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

### IV. References

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

V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Jeff Robertson, MD		Signature Laurie Nakahira, MD		
Name Medical Director		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
Date		Date		
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V1	Reviewed 06/10/2020	Quality Improvement Committee	Approve 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		

## POLICY

<b>Policy Title:</b>	<b>Outpatient Mental Health Services: Mental Health Parity</b>	<b>Policy No.:</b>	QI.24
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

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

### III. Responsibilities

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

SCFHP will be responsible for outpatient mental health services as follows:


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

# POLICY

## IV. References

DHCS All Plan Letter 17-018 Medi-Cal Managed Care Health Plan Responsibilities For Outpatient Mental Health Services, 10/27/2017  
 Mental Health Parity Final Rule (CMS-2333-F)  
 Title42, CFR 438.915 (a) (b)  
 CA Health and Safety Code 1367.01

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature		Signature		
Jeff Robertson, MD		Laurie Nakahira, MD		
Name		Name		
Medical Director		Chief Medical Officer		
Title		Title		
06/10/2020		06/10/2020		
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 02/21/2018	Quality Improvement Committee	Approved 02/21/2018	
V1	Reviewed 06/03/2019	Quality Improvement Committee	Approved 06/03/2019	
V1	Reviewed 06/10/20	Quality Improvement Committee	Approved 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		

## POLICY

<b>Policy Title:</b>	<b>Intensive Outpatient Palliative Care</b>	<b>Policy No.:</b>	QI.25
<b>Replaces Policy Title (if applicable):</b>	None	<b>Replaces Policy No. (if applicable):</b>	None
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> CMC

### I. Purpose

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

### II. Policy

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

### III. Responsibilities


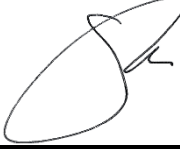
- A. Health Services collaborates with other SCFHP departments (IT, Claims, Benefits, Provider Services, and Member Services) as well as contracted IOPC providers and member providers and delegates to identify, coordinate services, coordinate benefits, and provide eligible members with IOPC palliative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

### IV. References

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

# POLICY

## V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Laurie Nakahira, D.O.		
Name Director, Quality and Process Improvement		Name Chief Medical Officer		
Title 06/10/2020		Title 06/10/2020		
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 06/12/2019	Quality Improvement Committee	Approved 06/12/2019	
V1	Reviewed 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		



## POLICY

<b>Policy Title:</b>	<b>Informing Members of Behavioral Health Services</b>	<b>Policy No.:</b>	QI.27
<b>Replaces Policy Title (if applicable):</b>		<b>Replaces Policy No. (if applicable):</b>	
<b>Issuing Department:</b>	Health Services	<b>Policy Review Frequency:</b>	Annually
<b>Lines of Business (check all that apply):</b>	<input checked="" type="checkbox"/> Medi-Cal		<input checked="" type="checkbox"/> CMC

### I. Purpose

The purpose of this policy is to address how members are informed of their eligibility for services through the Santa Clara Family Health Plan (SCFHP), the Santa Clara County Behavioral Health Services Department and under the Behavioral Health (BH) Department. The information to the members includes:

- A. Member eligibility to participate in the BH programs
- B. How to use BH program services
- C. How to opt in or out of BH program services

### II. Policy

It is the policy of the SCFHP, specifically, the BH Department to offer services to those Cal Medi Connect (CMC) members who are diagnosed with a Severe Mental Illness (SMI) and/or Substance Use Disorder (SUD). Services include care coordination to ensure that the members receive the specialty mental health, substance use treatment, physical health and other psycho-social services they need to be able to live in the least restrictive environment possible and to be as healthy as possible. In addition, the BH Department will provide consultation and support to the other departments and the community to assist all those members with a behavioral health diagnosis and/ or substance use disorder to access needed services.

- A. Eligible members will be identified through claims, referrals from community providers, and referrals from other departments, from the Health Risk Assessment (HRA) or through self-referral. In addition, through data-sharing agreements and MOUs, the County Behavioral Health Services Department will provide information to the SCFHP BH Department to identify the members who are eligible for Specialty Mental Health Services.
  1. Behavioral Health program services will be initiated through outreach to the member, completion of the HRA and care plan and care coordination to assist the member to meet their own goals.
  2. The BH Social Worker or Personal Care Coordinator (PCC) will explain to the member that the County Behavioral Health Services Department will provide a screening through their Call Center to determine if the member is qualified for Specialty Mental Health.
  3. The member receives information from the BH Social Worker or PCC that if the member is not eligible for Specialty Mental Health services, then the SCFHP will assist with providing services such as counseling and care coordination.
  4. The information regarding BH services is also provided on the SCFHP website [www.SCFHP.com](http://www.SCFHP.com)

## POLICY

5. Information on how to reach the County Call Center is provided on the member identification card.
6. Members may participate in the BH program as they would any of the SCFHP programs. The member may opt out of any part of the case management program including the HRA and care plan or ICP.


### III. Responsibilities

Behavioral Health Services Department has the primary responsibility for carrying out the policy requirements. Case management and the Customer Services Department may be responsible for referring members into BH services.

### IV. References

DPL # 14-003 CROSSOVER CLAIMING RESPONSIBILITY FOR MENTAL HEALTH SERVICES PROVIDED TO CAL MEDICCONNECT BENEFICIARIES

### V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature		Signature		
Jeff Robertson, MD		Laurie Nakahira, MD		
Name		Name		
Medical Director		Chief Medical Officer		
Title		Title		
06/10/2020		06/10/2020		
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 11/08/2018	Quality Improvement Committee	Approved 11/08/2018	
v1	Reviewed 06/03/2019	Quality Improvement Committee	Approved 06/03/2019	
v1	Reviewed 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
v1	Review 06/09/2021	Quality Improvement Committee		



**Santa Clara Family  
Health Plan™**

## Quality Improvement Committee

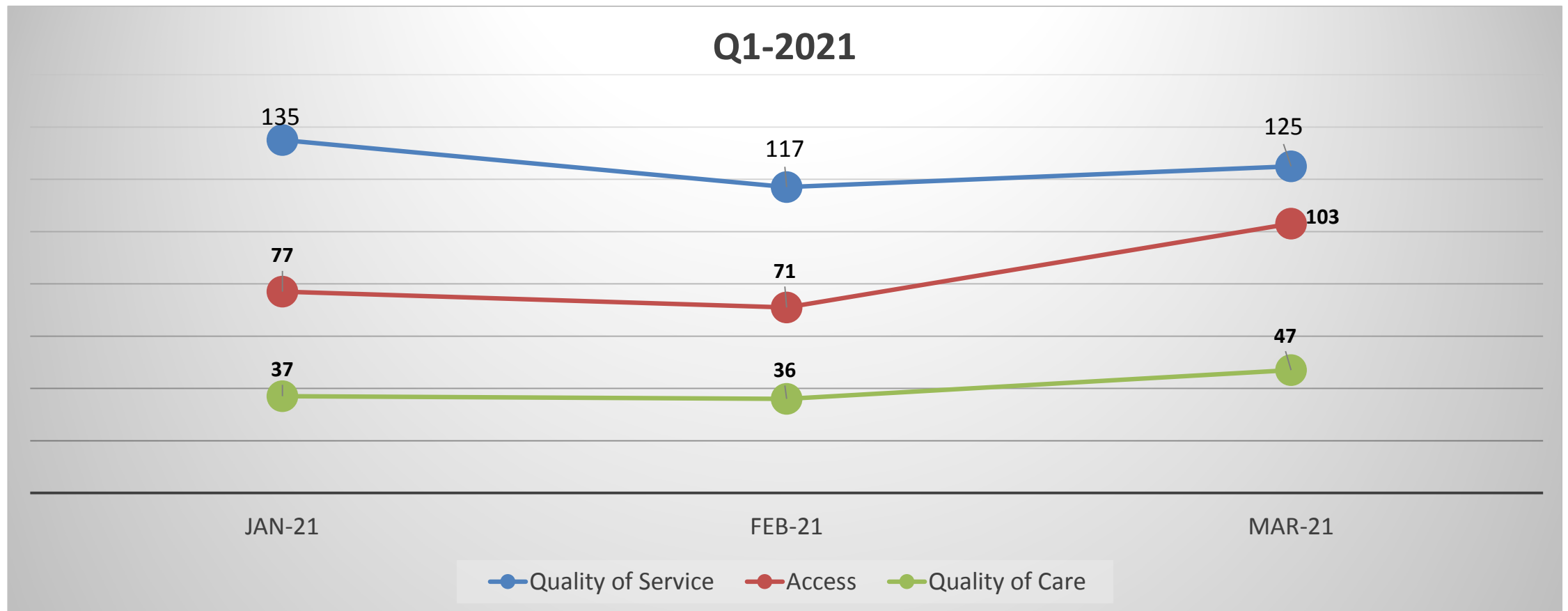
Q1 2021 Grievance & Appeals Data

# Total Grievances & Appeals

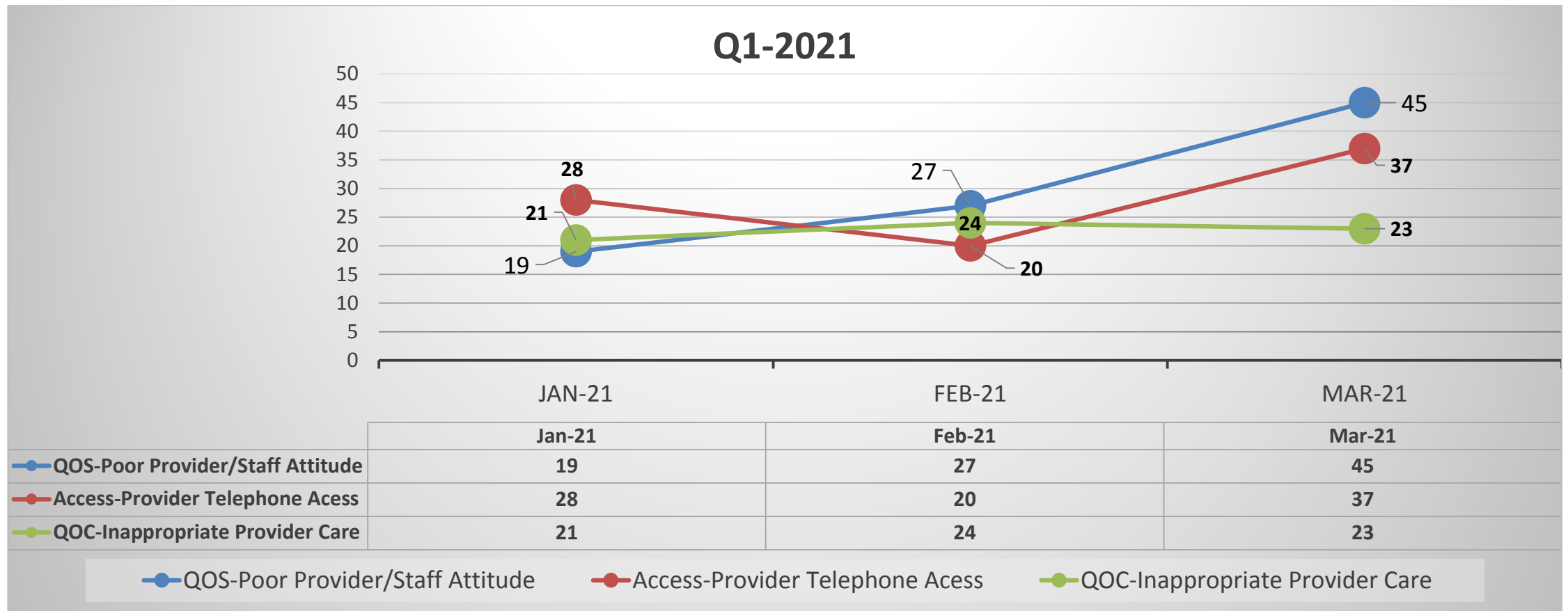
*(Rate per 1000 Members)*

	Jan-20	Feb-20	Mar-20	Jan-21	Feb-21	Mar-21
<b>Total Appeals</b>	<b>70</b>	<b>88</b>	<b>77</b>	<b>96</b>	<b>89</b>	<b>99</b>
<b>CMC Total Membership</b>	<b>8,401</b>	<b>8,486</b>	<b>8,601</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>
<b>Rate per 1,000</b>	8.33234	10.37	8.95245	9.78893	8.99626	10.0202
<b>Total Grievances</b>	<b>150</b>	<b>152</b>	<b>147</b>	<b>115</b>	<b>139</b>	<b>165</b>
<b>CMC Total Membership</b>	<b>8,401</b>	<b>8,486</b>	<b>8,601</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>
<b>Rate per 1,000</b>	17.855	17.9119	17.091	11.7263	14.0503	16.7004
	Jan-20	Feb-20	Mar-20	Jan-21	Feb-21	Mar-21
<b>Total Appeals</b>	<b>121</b>	<b>97</b>	<b>94</b>	<b>92</b>	<b>102</b>	<b>127</b>
<b>MC Total Membership</b>	<b>231,435</b>	<b>231,548</b>	<b>233,229</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>
<b>Rate per 1,000</b>	0.52282	0.41892	0.40304	0.34969	0.38477	0.47572
<b>Total Grievances</b>	<b>234</b>	<b>263</b>	<b>244</b>	<b>276</b>	<b>253</b>	<b>299</b>
<b>MC Total Membership</b>	<b>231,435</b>	<b>231,548</b>	<b>233,229</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>
<b>Rate per 1,000</b>	1.01108	1.13583	1.04618	1.04906	0.95437	1.12001

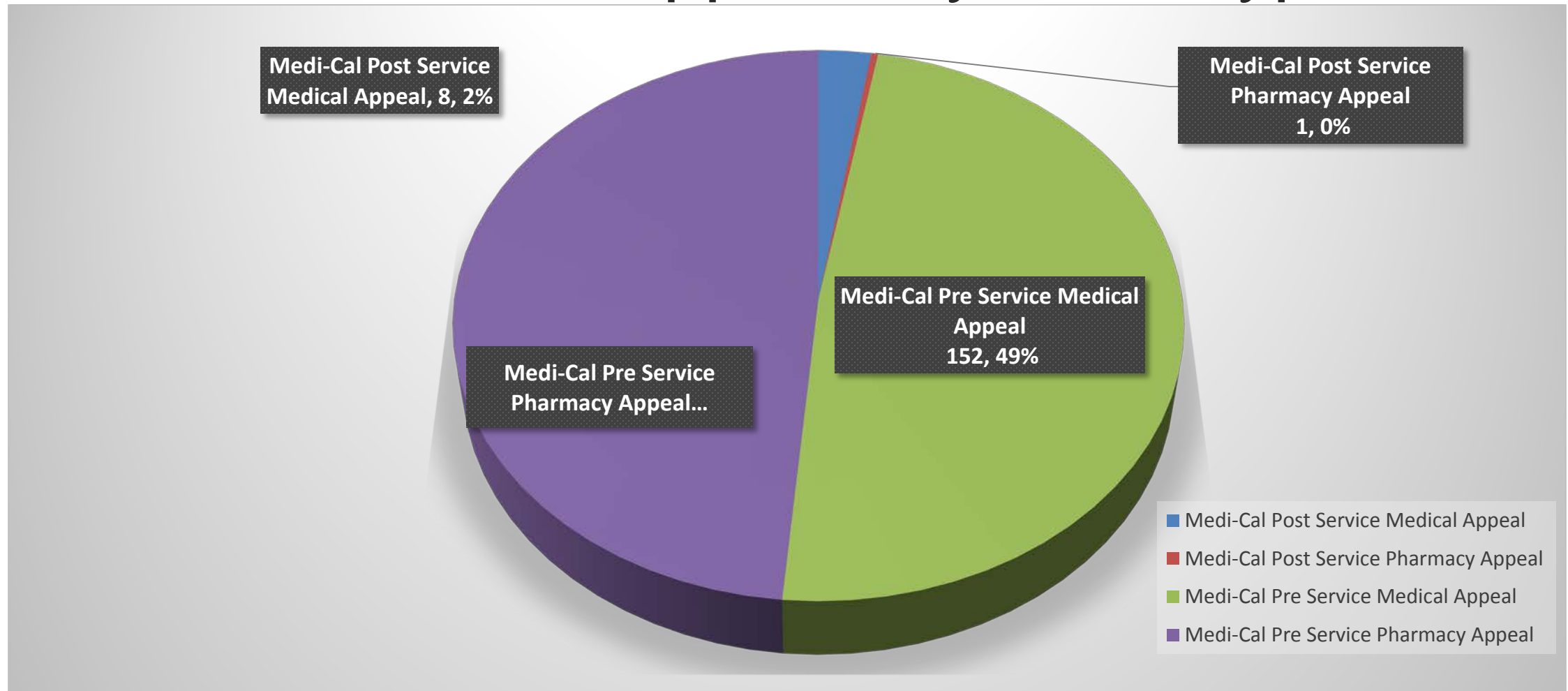
# Q1 2021: Top 3 Medi-Cal Grievance Categories



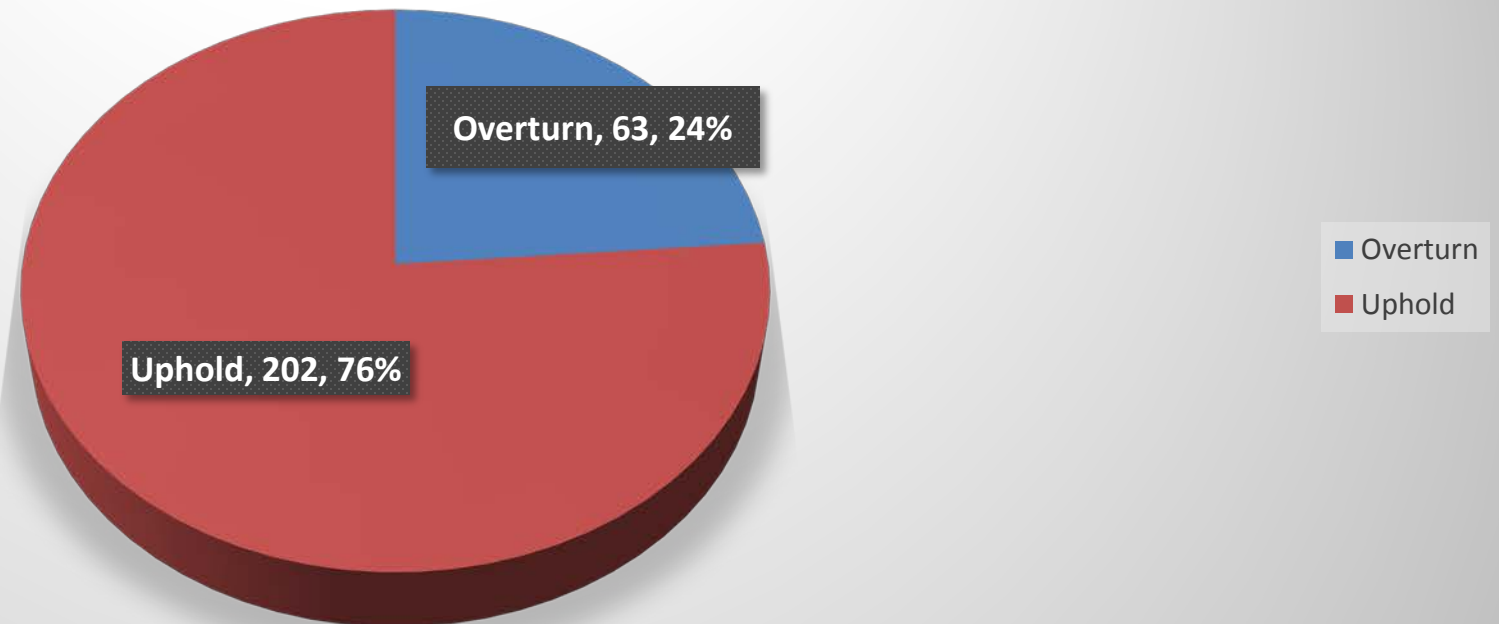
# Q1 2021: Top 3 Medi-Cal Grievance Subcategories



# Q1 2021 Medi-Cal Appeals by Case Type

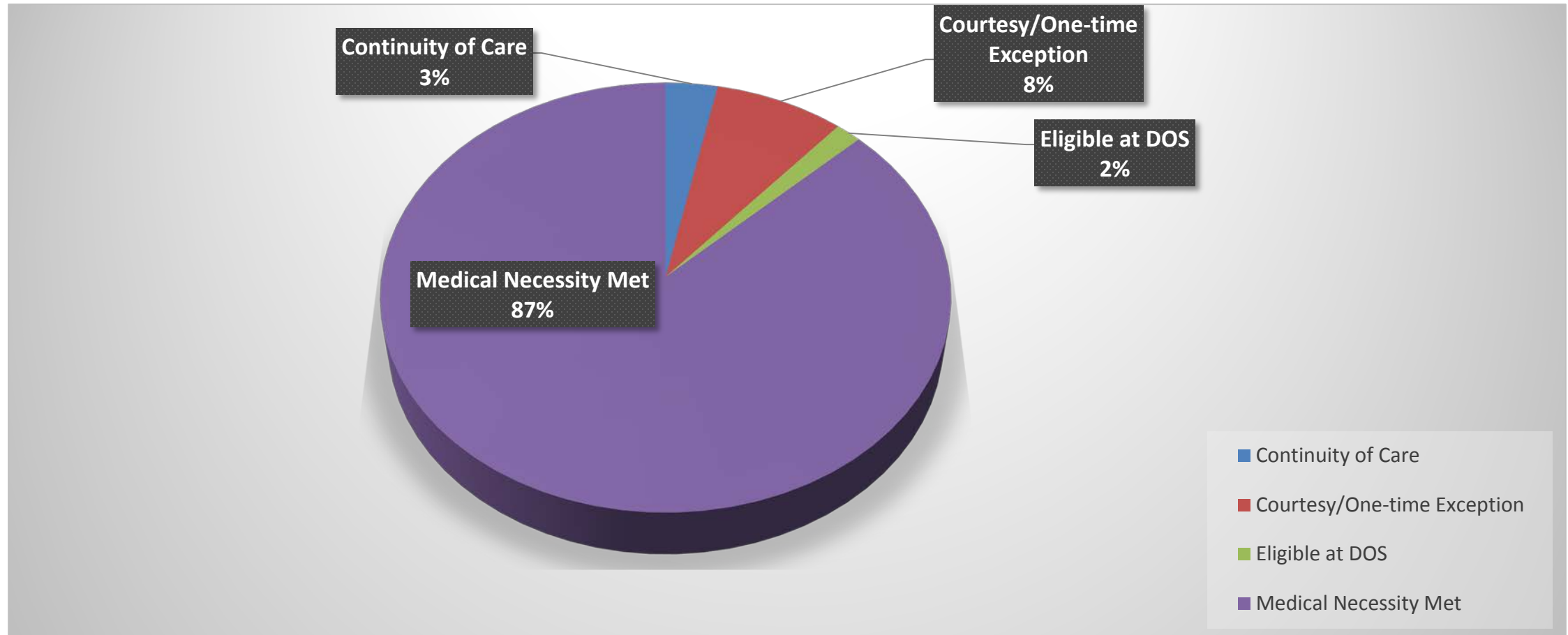


# Q1 2021 MC Appeals by Disposition

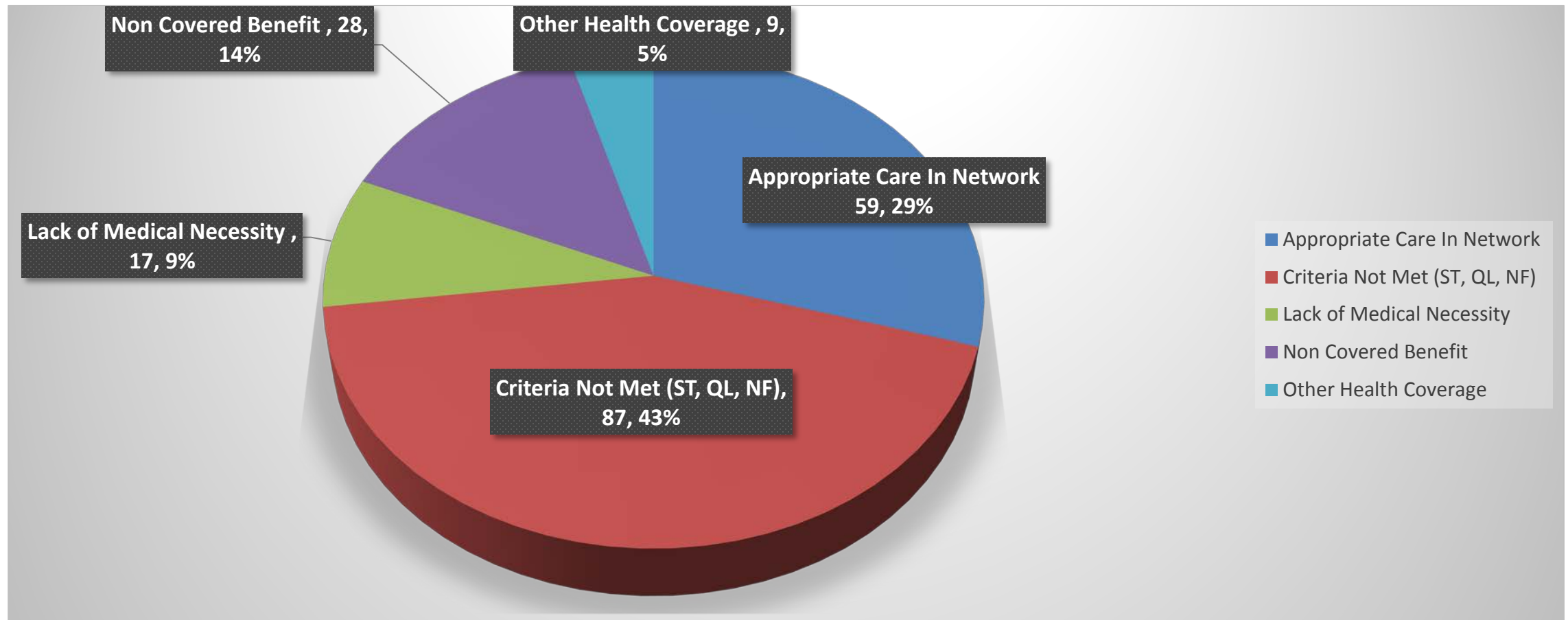




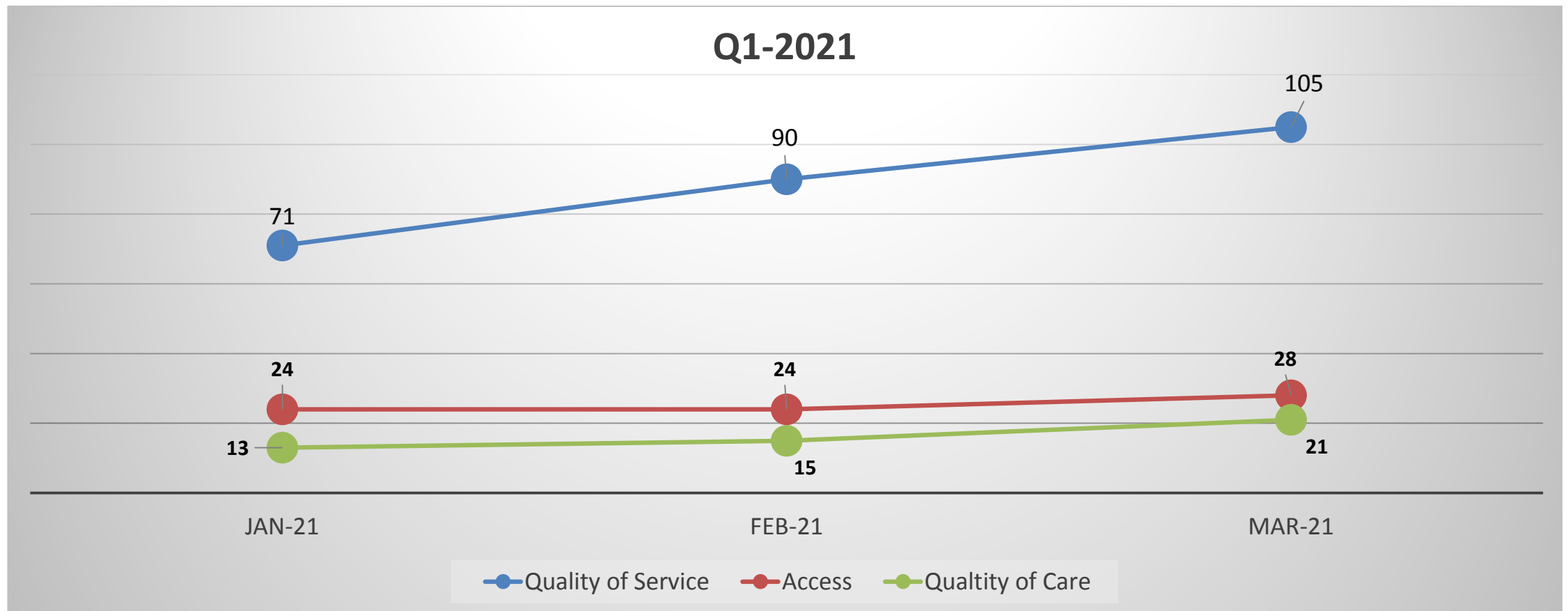
# Q1 2021 MC Appeals: Overturn Rationale



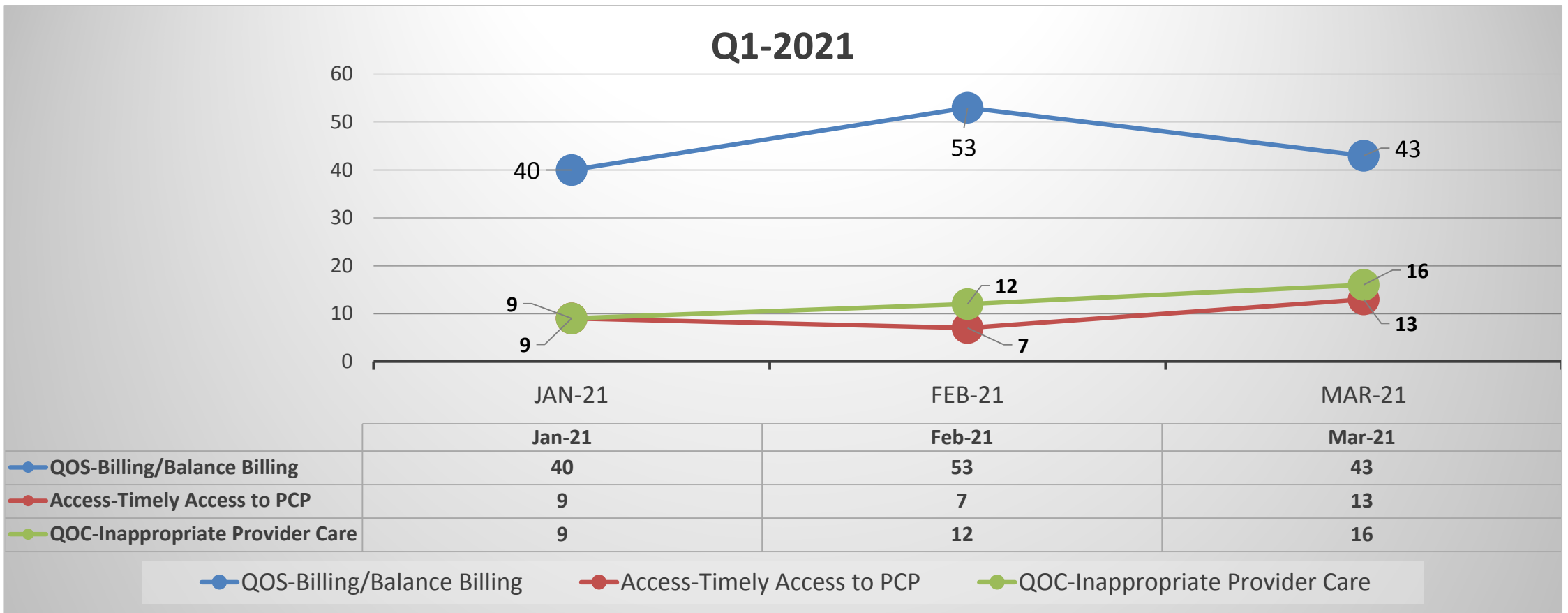
# Q1 2021 MC Appeals: Uphold Rationale



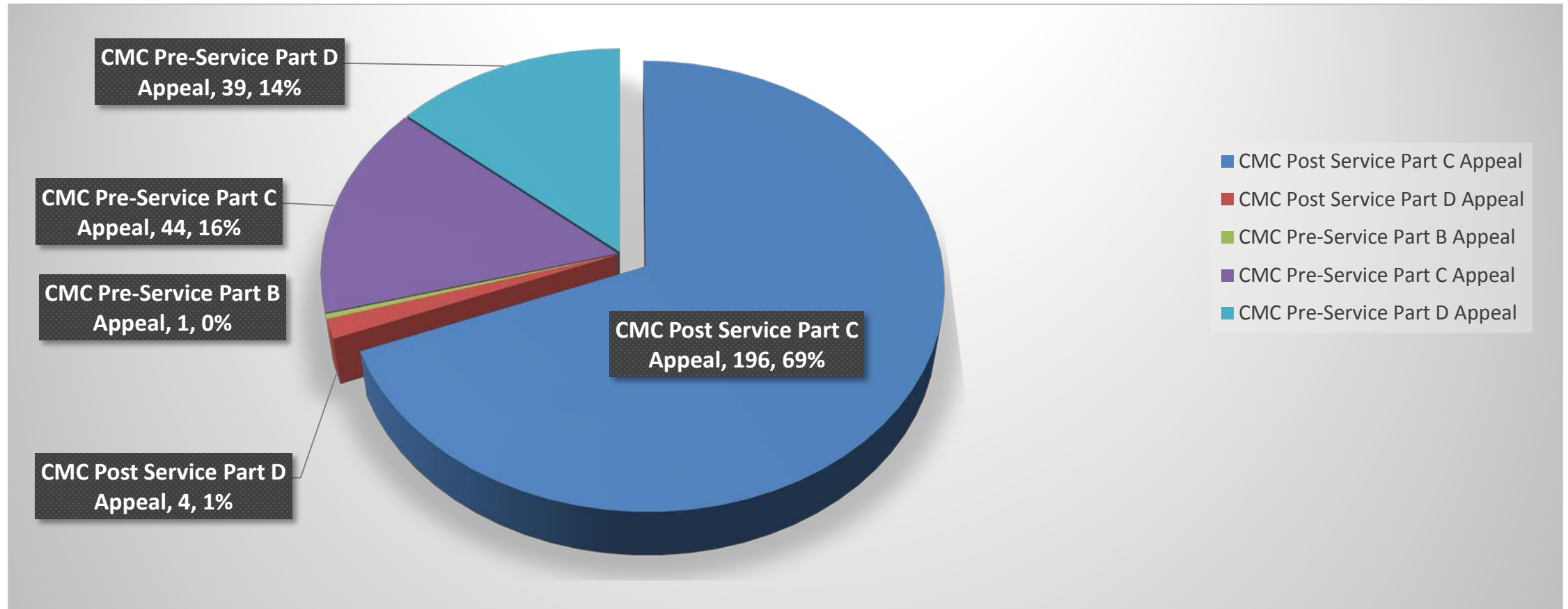
# Q1 2021: Top 3 Cal MediConnect Grievance Categories



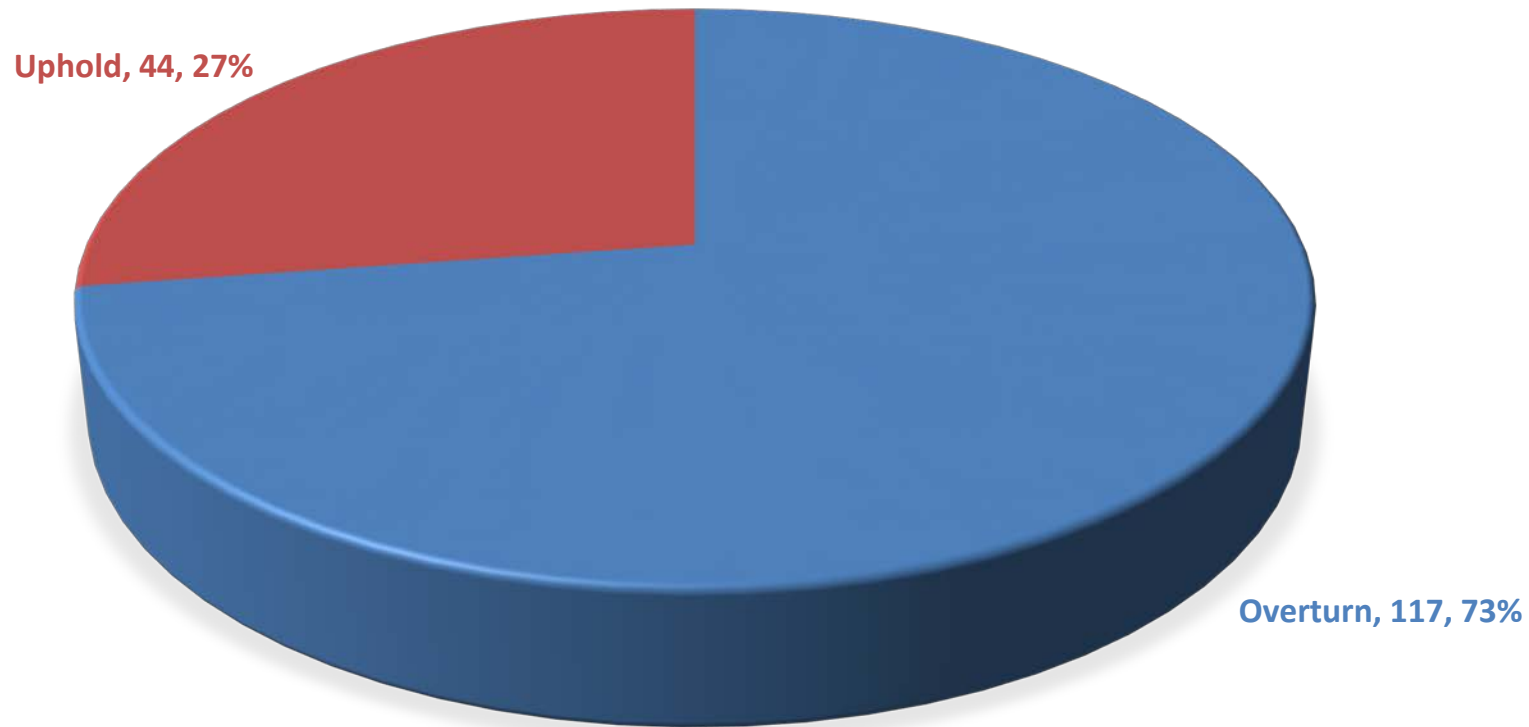
# Q1 2021: Top 3 Cal MediConnect Grievance Subcategories



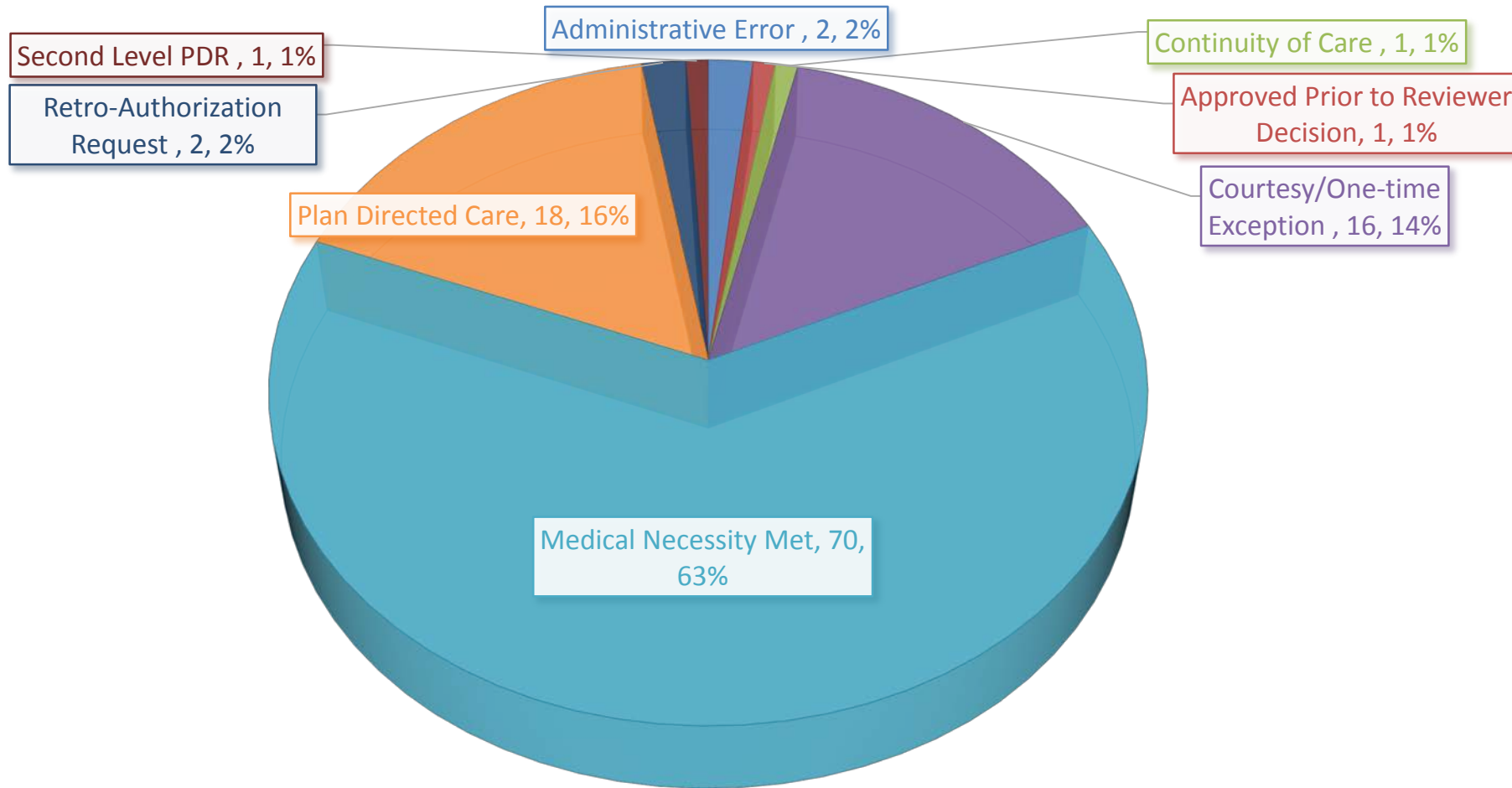
# Q1 2021 CMC Appeals by Case Type



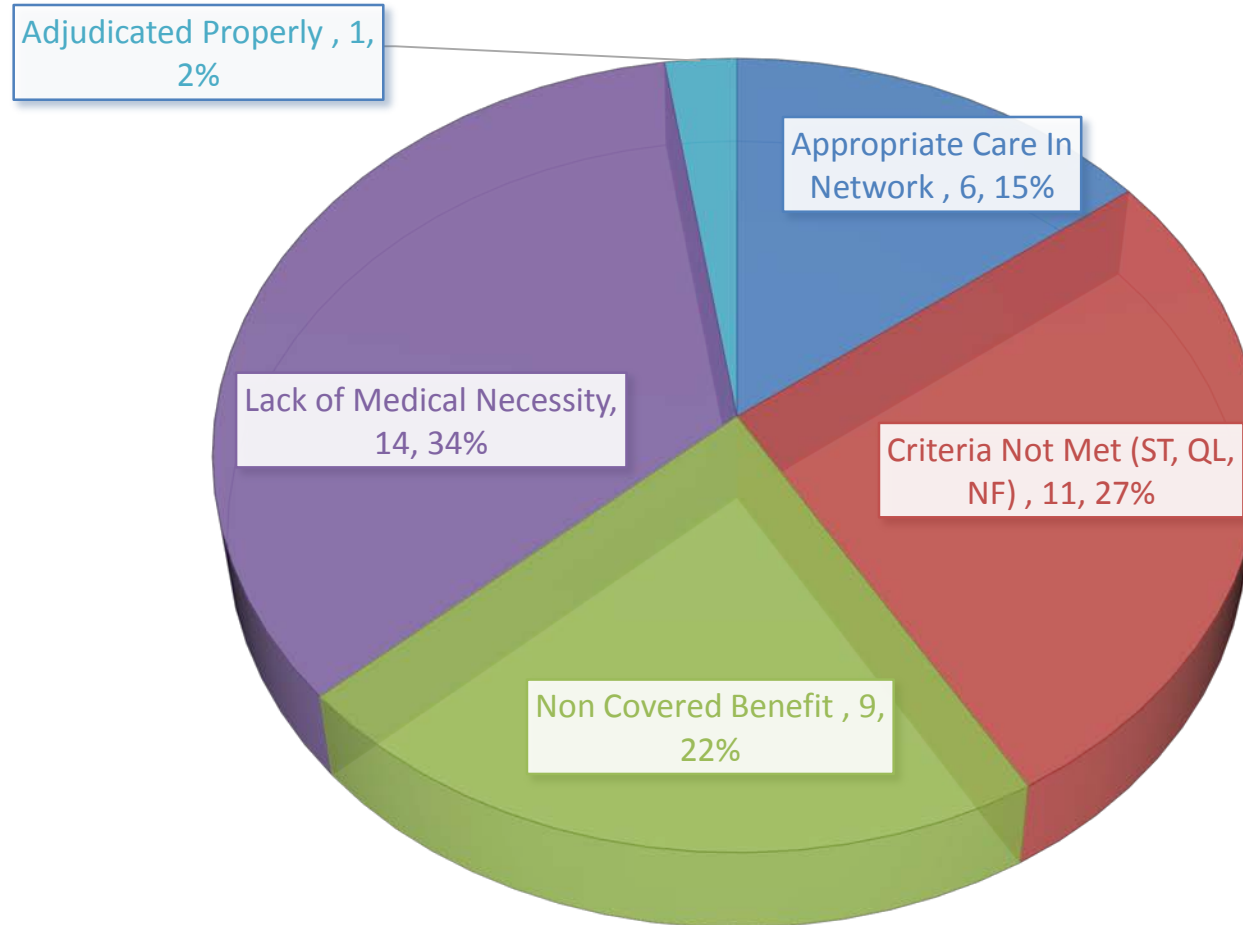
# Q1\_2021 CMC Appeals by Disposition



# Q1\_2021 CMC Appeals: Overturn Rationale



# Q1\_2021 CMC Appeals: Uphold Rationale





Regular Meeting of the  
**Santa Clara County Health Authority**  
**Utilization Management Committee**

Wednesday, April 21, 2021 6:00 – 7:30 PM  
Santa Clara Family Health Plan  
6201 San Ignacio Ave, San Jose, CA 95119

## Minutes - DRAFT

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### Members Present

Jimmy Lin, M.D., Internal Medicine, Chair  
Ali Alkoraishi, M.D., Psychiatry  
Ngon Hoang Dinh, OB/GYN  
Laurie Nakahira, D.O., Chief Medical Officer  
Habib Tobbagi, PCP, Nephrology

### Members Absent

Dung Van Cai, D.O., Head & Neck  
Indira Vemuri, Pediatric Specialist

### Staff Present

Christine Tomcala, Chief Executive Officer  
Dang Huynh, PharmD, Director, Utilization  
Management & Pharmacy  
Lily Boris, M.D., Medical Director  
Natalie McKelvey, Manager, Behavioral  
Health  
Luis Perez, Supervisor, Utilization  
Management  
Hoang Mai Vu, Utilization Management &  
Discharge Planning Nurse  
Amy O'Brien, Administrative Assistant

### 1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:05 p.m. Roll call was taken and a quorum was established. Dr. Huynh introduced the new SCFHP Utilization Management and Discharge Planning Nurse, Hoang Mai Vu.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

The minutes of the January 20, 2021 Utilization Management Committee (UMC) meeting were reviewed.

**It was moved, seconded, and the minutes of the January 20, 2021 UMC meeting were unanimously approved.**

**Motion:** Dr. Nakahira

**Seconded:** Dr. Tobbagi

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi

**Absent:** Dr. Cai, Dr. Dinh, Dr. Vemuri

### 4. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, highlighted the Plan's collaboration with the County Emergency Operations center to hold pop-up vaccination clinics at the Community Resource Center (CRC). At least 300 vaccines were administered during each clinic. The most recent clinic was held on January 19, and SCFHP

was given 470 vaccines. Of those 470 vaccines, there were some left over, which may be attributable to the vaccine hesitancy issue. Ms. Tomcala confirmed SCFHP will connect with Dr. Lin on the best way to inform his patients of upcoming clinics.

Dr. Tobbagi expressed concern with vaccine waste. Ms. Tomcala advised that, up until yesterday's clinic, vaccine waste was not an issue. SCFHP provides the location; the Public Health department coordinates all the staffing and clinical details. The Public Health department is concerned about vaccine waste and this issue is being addressed. Dr. Lin asked for the date of the next clinic. Ms. Tomcala replied that Public Health does not give the Plan advance notice. SCFHP has requested that Public Health devise a more routine schedule which would encourage more public participation and less vaccine waste. Dr. Nakahira directed Dr. Lin to our website which has a link to the Public Health Department. Vaccine availability has increased and Levi Stadium is under consideration as a potential pop-up vaccination site. Ms. Tomcala welcomes the committee's ideas and recommendations to overcome vaccine hesitancy amongst our members.

## **5. Chief Medical Officer Update**

### **a. General Update**

Dr. Laurie Nakahira, Chief Medical Officer, began with a reminder to committee members to sign the annual SCFHP confidentiality agreement. Dr. Nakahira provided the Committee with a COVID-19 update. The Plan provides assistance to members who are 65 years of age and older to help them make vaccine appointments online in conjunction with the Public Health department. Public Health has agreed to reserve a certain number of vaccine appointments for our high-risk members. The Plan continues to call our members to confirm if they have been vaccinated, provide assistance on how to make appointments to be vaccinated, and, if applicable, the reasons why vaccination is declined. The most common reason given is concern over long-term side effects.

Dr. Nakahira continued with the Plan's successful completion of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) audits in March 2021. A final audit report is pending. The Plan is focusing on Enhanced Case Management (ECM) and In-Lieu-of-Services (ILS). The Plan is preparing for the sun-setting of the County's Whole Person Care and Home Health programs.

### **b. Annual Confidentiality Agreements**

This item was addressed in the CMO update.

## **6. Old Business/Follow-Up Items**

### **a. Plan-All-Cause Readmission (PCR) Rates**

Dr. Dang Huynh, PharmD, Director Utilization Management and Pharmacy, presented an overview of PCR Rates, and ways to reduce the number of readmissions. PCRs are readmissions that occur in acute settings within 30 days. The Plan's Fiscal Year goal is to reduce Medi-Cal PCRs to 7.48%. Dr. Huynh described the strategies the UM department will implement in order to achieve this goal. The UM department is expanding their TLC in the Case Management department, so calls, follow-up reviews, and HRA's are all in alignment. UM is identifying individuals who are candidates for further outreach, and working with the Plan's provider groups for more oversight on their concurrent review and discharge planning processes, which reduces their PCR, as well as the Plan's PCR. The UM department has built strong relationships with the Plan's contracted hospitals to strategize a more proactive approach to prior authorizations and timely discharge planning procedures. Finally, the UM department will improve their analytics on ADT data to support provider groups. Dr. Lin stated that Medicare readmissions rates are significantly higher than the Plan's 9.58%, and he approves of the Plan's emphasis on communication with contracted hospitals and providers.

## 7. UM Program Evaluation - 2020

Dr. Lily Boris, Medical Director, presented the Committee with the annual review of the UM Program Evaluation for 2020. The UM Program Evaluation is a requirement of the state, as well as the NCQA. It is divided into Quality of Clinical Care and Quality of Service. The UM department successfully completed quality of clinical care and corresponding HEDIS metrics such as: current reporting; quality of inpatient care; readmissions; the UM Program Description; medical necessity criteria policy; and prior authorizations on outpatient and inpatient stays. The only 2 items that were not completed were Item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, and Item #16 Conduct Member and Provider Satisfaction Surveys. Item #9 was not measured, as the Plan did not have access to the data set. A new parameter has been built so the Plan can provide this information next year. Item #16 was not completed as Medi-Cal and Medicare satisfaction surveys are conducted outside of the Plan's purview. Otherwise, all quality of clinical care and HEDIS items were reviewed and completed in a timely fashion.

**It was moved, seconded and** the UM Program Evaluation - 2020 was **unanimously approved**.

**Motion:** Dr. Tobbagi

**Second:** Dr. Lin

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi

**Absent:** Dr. Cai, Dr. Dinh, Dr. Vemuri

## 8. UM Work Plan – 2021

Dr. Boris next presented the UM Work Plan for 2021 to the Committee. The UM Work Plan reflects the goals for 2021. The requirements are divided by quarter. Dr. Boris highlighted item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, as the strongest focus area of the 2021 Work Plan. Dr. Boris also directed the committee's attention to item #15 Annual Inter-Rater Reliability which should be conducted on an annual basis, not a bi-annual basis as listed in the Work Plan, with achievement of an 80% pass rate for all UM staff.

**It was moved, seconded and** the UM Work Plan – 2021 was **unanimously approved**.

**Motion:** Dr. Tobbagi

**Second:** Dr. Lin

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi

**Absent:** Dr. Cai, Dr. Dinh, Dr. Vemuri

## 9. Care Coordinator Guidelines

Mr. Luis Perez, Supervisor, UM, provided an overview of the UM Care Coordinator Guidelines to the Committee. Dr. Lin remarked that it appears there is improvement on SNF transitions to long-term care, and Mr. Perez agreed. Dr. Lin asked if patients in hospice care remain under SCFHP, or do they qualify for carve out? Mr. Perez clarified hospice care patients remain under the jurisdiction of SCFHP.

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of the Behavioral Health Care Coordinator Guidelines to the Committee. Ms. McKelvey explained that the most important factor for Care Coordinator Guidelines is to follow APL 19-014. The Care Coordinator can approve anything less than 25 hours per week in direct services. Anything above 25 hours per week requires a Manager or a doctor's review and approval.

**It was moved, seconded and** the Care Coordinator Guidelines were **unanimously approved**.

**Motion:** Dr. Tobbagi

**Second:** Dr. Lin

**Ayes:** Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi

**Absent:** Dr. Cai, Dr. Dinh, Dr. Vemuri

## 10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA – 2020

Dr. Boris gave an overview of the 2020 UM 1B Annual Assessment of Senior Level Practitioners, as required by NCQA. The purpose is to determine how a senior level practitioner participates in the Plan's UM Committee. Dr. Boris co-chairs this committee with Dr. Lin. Dr. Alkoraishi also participates in this committee to address the Behavioral Health perspective. Dr. Boris explained how the answers to 6 targeted questions demonstrate the fact that senior level practitioners meet the necessary NCQA standards and elements.

## 11. Home Health Services Authorization Procedure

Dr. Huynh presented the Committee with an overview of the purpose of procedure HS.01.23 Home Health Services Authorization. Dr. Huynh explained that the UM department uses MTV as the criteria in order to evaluate the number of approved visits. The MTV recommendation for the 50<sup>th</sup> percentile is limited to commercial and Medi-Cal lines of business. As the Plan has Medi-Cal beneficiaries, a procedure was developed which clearly outlines how the UM team will approve the numbers of visits for Medicare and Cal MediConnect beneficiaries. The UM reviewer will be able to approve up to 200% of the Medicare 50<sup>th</sup> percentile recommended visits. Any additional visits will require appropriate notes that establish medical necessity.

Dr. Boris directed the Committee's attention to the MCG criteria. Dr. Boris explained that the Plan relies on MCG criteria in situations where neither Medicare nor Medi-Cal have clear criteria for what constitutes an approval or denial. It was necessary for the UM team to show specific reasons for denials of service, as the Plan's auditors require a concrete procedure. Dr. Lin expressed his concern with the establishment of the 200% of the 50<sup>th</sup> percentile guideline. Ms. Tomcala responded that our members deserve the right care at the right time. Dr. Boris reminded Dr. Lin that the Plan's Medi-Cal and MediCare patients have a higher acuity, and the typical Medicare patient does not have the co-morbidity rate or social issues of the typical Medi-Cal patient. Dr. Boris emphasized that all patients must still meet the criteria of medical necessity.

Dr. Huynh explained that this procedure will help to establish the maximum number of home health visits that will be approved per patient on a case by case basis. During audits, the Plan can explain their rationale for approvals or denials through use of this procedure. Dr. Boris stated that the UM department will do an evaluation of this procedure after 6 months and discuss the results at the October 2021 meeting.

*Dr. Dinh joined the meeting at 6:42 p.m.*

## 12. Reports

### a. Membership

Dr. Boris gave a brief summary of the Membership Report from April 2020 through April 2021. Cal MediConnect membership has increased to 9,924 members, and Medi-Cal membership has increased to 269,043 members. The Plan's total population has increased from 243,774 members to 278,967 members, largely attributable to the pause on Medi-Cal redeterminations due to COVID. The majority of our members remain delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Kaiser Permanente, and Premier Care.

### b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the calendar year 2020, with a comparison to the results from 2019. Dr. Boris also summarized the results for the Cal MediConnect line of business, with a comparison to the data from 2019. Dr. Boris next summarized the number of admissions and re-admissions for both the Medi-Cal and Cal MediConnect lines of business. Ms. Tomcala asked if admissions and readmissions were affected by COVID and the fact that many elective procedures were put on hold. Dr. Boris replied that the UM department will analyze COVID admissions and readmissions for 2020 and bring these

results to the July 2021 meeting. Dr. Huynh advised that some of the data may have been affected by the HEDIS change.

Dr. Boris concluded with a summary of the Cal MediConnect readmission rates, which have increased since 2019. The UM team will perform analysis to determine how COVID may have affected this increase in PCR rates.

**c. Dashboard Metrics**

- Turn-Around Time – Q1 2021

Mr. Perez summarized the Cal MediConnect Turn-Around Time metrics for Q1 2021. The turn-around times in all categories are compliant at 99% or better, with the exceptions of expedited pre-service prior authorization requests with a 95.9% rate, expedited Part C initial determinations at 96.9%, standard prior authorization requests for Part B drugs at 94.6%, and expedited prior authorization requests for Part B drugs at 97.4%.

Mr. Perez next summarized the Turn-Around times for Medi-Cal authorizations for Q1 2021. The turn-around times for all Medi-Cal authorizations combined is compliant at 98% or better.

Dr. Huynh explained that some of the turn-around times were impacted by issues with the mail room and the fax line. The UM Department is focusing on better reporting, streamlining processes, and additional training, with a commitment to 100% compliance with contractual and regulatory requirements. Dr. Huynh explained to Dr. Lin that even 1 non-compliant case found by the CMS auditors triggers an impact analysis to determine if there are additional cases of non-compliance.

**d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2021**

Dr. Huynh summarized the data from the Q1 2021 Cal MediConnect and Medi-Cal Quarterly Referral Tracking reports for the Committee. Dr. Huynh explained that the UM team tracks the cycle of prior authorizations from the time the prior authorization is issued through to claims payment. The average claims cycle is 90 days. This report is affected by a claims data lag. Dr. Huynh explained that the annual review, which incorporates this data lag, presents a more accurate picture of timeframes within the claims cycle. Dr. Lin asked how the 2020 results compare with 2019. Dr. Huynh replied that he will review these numbers and present the results at the July 2021 meeting. Dr. Huynh agrees that COVID has affected the number of outpatient services and prior authorization requests.

**e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2021**

Dr. Boris summarized the results of the Q1 2021 Quality Monitoring of Plan Authorizations and Denial Letters for the Committee. Dr. Boris reported that the UM department received a 100% score in virtually all categories, with the exception of a small handful of written notifications that either contained unexplained medical terminology, grammatical and punctuation errors, or omitted the rationale for the denial. Dr. Huynh will ensure these errors will be reviewed with all UM staff members. UM leadership will continue to take an active role in QA oversight.

**f. Behavioral Health UM**

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of utilization of the Behavioral Health Treatment program. Ms. McKelvey highlighted the number of developmental screenings, and Dr. Lin remarked on the high number of Q1 screenings for VHP and PMG. Ms. McKelvey believes this could be due to a claims lag, or the fact that the providers do not promptly bill for services. Ms. McKelvey will provide an update at the July 2021 meeting. Ms. McKelvey discussed how important it is for BH providers to complete ACES Aware training and conduct trauma screenings. Ms. McKelvey discussed the fact that the Plan provides assistance to providers in how to conduct trauma screenings which includes peer-to-peer training via Zoom.

Dr. Tobbagi asked for an explanation of payment structure, and Ms. McKelvey advised the County is responsible for providing specialty mental health, and health plans are responsible for serving the mild to

moderate symptoms population. The payment structure is complicated, as it is based primarily on the patient's function level. A discussion ensued amongst Ms. McKelvey, Dr. Tobbagi, and Dr. Lin as to the Plan's top 10 billing providers, and the cost of BH services. Ms. McKelvey advised BH is not a capitated service with respect to autism. The Plan follows the APL and EPSDT requirements for treatment for kids. Treatment plans are approved every 6 months to confirm medical necessity. Dr. Tobbagi asked about the amount of compensation for initial BH consultations for adults. Ms. McKelvey replied she does not have the specific numbers, but the Plan pays over the Medicare and Medi-Cal rates.

Dr. Boris pointed out that, with respect to the bar graph which shows the top 10 billing providers, the graph includes all BH treatment provided from 2018-2020 and includes children who receive a combination of ABA therapy in the home. Ms. McKelvey clarified the bar graph does not include speech or occupational therapies. The BH team regularly meets with ABA providers to ensure the standard of medical necessity is met, and discussions continue to understand what the community standard is for BH treatment.

Dr. Tobbagi asked why so many patients are having trouble getting referrals to Stanford when they change their primary care physician. Dr. Nakahira and Dr. Boris agreed this may be an issue with Stanford's process. They will research this issue to confirm there is not a problem with the Plan's referral process.

### 13. Adjournment

The meeting adjourned at 7:26 p.m. The next meeting of the Utilization Management Commitment is on July 21, 2021 at 6:00 p.m.

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Jimmy Lin, M.D, Chair  
Utilization Management Committee

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Date

QUALITY IMPROVEMENT  
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity:

Monitoring or Meeting Period:

Credentialing Committee

04/07/2021

**Areas of Review or Committee Activity**

Credentialing of new applicants and recredentialing of existing network practitioners

**Findings and Analysis**

<b>Initial Credentialing (excludes delegated practitioners)</b>		
Number initial practitioners credentialed	34	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
<b>Recredentialing</b>		
Number practitioners due to be recredentialled	6	
Number practitioners recredentialled within 36-month timeline	6	
% recredentialled 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%
<b>Terminated/Rejected/Suspended/Denied</b>		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 03/31/2021	291	

(For Quality of Care ONLY)	Stanford	LPCH	VHP	PAMF	PMG	PCNC
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1384	1220	777	828	420	135

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.



**Regular Meeting of the  
Santa Clara County Health Authority  
Provider Advisory Council (PAC)**

Wednesday, May 12, 2021, 12:15 – 1:45 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave, San Jose, CA 95119

## MINUTES - Draft

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### Committee Members Present

Thad Padua, MD, Chair  
Clara Adams, LCSW  
David Mineta  
Dolly Goel, MD  
Michael Griffis, MD  
Bridget Harrison, MD  
Jimmy Lin, MD  
Peter L. Nguyen, DO  
Sherri Sager  
Meg Tabaka, MD

### Committee Members Absent

Pedro Alvarez, MD

### Staff Present

Christine Tomcala, Chief Executive Officer  
Laurie Nakahira, DO, Chief Medical Officer  
Dang Huynh, PharmD, Director, Pharmacy &  
Utilization Management  
Janet Gambatese, Director, Provider Network  
Operations  
Brandon Engelbert, Manager, Provider Network  
Operations  
Rita Zambrano, Executive Assistant  
Robyn Esparza, Administrative Assistant

### Additional Staff

Tyler Haskell, Director, Government Relations  
Tami Otomo, Clinical Pharmacist, Pharmacy  
Karen Fadley, Analyst, Provider Network Operations  
Natalie McKelvey, Manager, Behavioral Health  
Lucille Baxter, Manager, Quality & Health Education  
Claudia Graciano, Provider Network Associate, Lead,  
Provider Network Operations

### 1. Roll Call/Establish Quorum

Thad Padua, MD, Chair, called the meeting to order at 12:20 pm. Roll call was taken and a quorum was established.

### 2. Meeting Minutes

The minutes of the February 10, 2021 Provider Advisory Council (PAC) meeting were reviewed.

**It was moved, seconded, and the February 10, 2021 Provider Advisory Council (PAC) were unanimously approved.**

Motion: Dr. Padua

Second: Dr. Michael Griffis

Ayes: Dr. Lin, Ms. Adams, LCSW, Dr. Goel, Dr. Harrison, Dr. Nguyen, Dr. Tabaka, Ms. Sherri Sager,  
Mr. Mineta; Dr. Padua



### 3. Public Comment

There was no public comment.

### 4. Chief Executive Officer Update

#### Enrollment Summary:

Ms. Christine Tomcala, CEO, presented the May 2021 Enrollment Summary, noting total enrollment of 281,235, with 9,989 members in Cal MediConnect and 271,246 members in Medi-Cal.

#### Pharmacy Carve-out Update:

Ms. Tomcala advised the council that Mr. Haskell described at the last PAC meeting there was late breaking news on February 10, 2021 regarding the planned Pharmacy Cave-out that was to take effect April 1, 2021. She noted it may or may not take place. If it does happen, it will not be until January 2022.

#### COVID Update:

Ms. Tomcala updated the council on COVID vaccination efforts. She was happy the Plan was able to extend the use of our new Blanca Alvarado Community Center as a community vaccination site. She further noted that everyone is seeing a drop off in vaccination due to hesitancy issue.

#### Health Plan's Vision

Ms. Tomcala advised the council that the Plan has been going through the process for many months of refreshing our mission values and the Plan's vision for the organization, as well as our strategic plan, which were happily approved by the Board in March. She shared the new mission of SCFHP. She noted it's always been our mission to improve the wellbeing of our members by addressing their health and social needs in a culturally competent manner, and partnering with providers and organizations in our shared commitment to the health of our community. While the mission is all about the work we do today, the vision is more of an aspirational statement and a place where we would like to be in maybe twenty years, and is something we can't necessarily accomplish on our own. So SCFHP's new vision is 'health for all, a fair and just community, where everyone has access to opportunities to be healthy'. SCFHP also created a new list of values. Finally, SCFHP updated our strategic plan over the next three years, and focuses on three primary goal categories: community health leadership, quality access and equity, and organizational excellence.

Mr. Mineta asked at what point it was approved by the Board. Ms. Tomcala noted the development process started last fall. Ms. Sherri Sager, Stanford Children's Health, shared it was a really interesting process because the Executive Committee thought that they had worked all the details out, however every time it was presented to the Board, it was pushed back as they wanted to have input on it. So, there was so much discussion, we ended up having to have special meetings, to get it accomplished. It was very thorough and all perspectives were brought into account to make sure that we came up with something that reflected the diverse inclusive communities and that have equity provisions throughout. The wording was careful and deliberative.

Dr. Padua inquired as to which stakeholders other than the Board and other groups assisted with the development. Ms. Tomcala noted our staff was surveyed so that they could have input. Then, we did focus groups with the community clinics, which many of them participated. We also included various stakeholders, elected officials, provider groups, and IPAs. We included information that we had recently gathered via another process through our Marketing Department that included a survey of people in the community, such as The Second Harvest Food baskets. The information gathered was referenced as we developed the strategic plan.

Ms. Tomcala noted there was a good discussion when refreshing the Plan's vision. Focus groups with community groups, elected officials, IPA(s) were conducted. In addition, Marketing also surveyed members in the community to solicit information as well. Ms. Tomcala noted the information on the vision statement is a just preview and that a final statement will be posted in the near future and Plan will be more than delighted to share copies with the council.

## 5. Quality

### How to Improve Quality Measures Rates by Documentation:

Ms. Lucille Baxter, Manager, Quality and Health Education, gave an extensive presentation on ‘How to Improve Quality Measures Rate by Documentation’. She provided examples of fall outs during chart review, for example, weight assessment (height, weight, BMI percentile), blood lead screening, immunization, controlling blood pressure, comprehensive diabetes care, cervical cancer and colorectal cancer screening, advanced directives, medical list and review, pain screening (except chest pain), discharge summary, medication reconciliation, and documentation. Dr. Padua inquired if a pattern or trend was identified and whether some clinics do better than others on Well Child Visit Weight Assessment. Ms. Baxter confirmed this, noting that some clinics do BMI, rather than BMI percentile. Dr. Peter Nguyen noted that it would be beneficial for providers to be made aware of the fall outs. Ms. Baxter encourage members of the council to take back and share with their providers. She also noted that Ms. Gambatese and Mr. Engelbert of PNO will be communicating the information as well.

Dr. Laurie Nakahira, CMO, noted the Plan is trying to work with providers. There is an issue with providers using paper charts vs. EMRs (electronic medical records). When using EMR, the templates must be turned on to alert them to missing documentation. So we have been working on the education part of it. She noted that, as Ms. Baxter indicated, we are trying to target some of our providers on documentation. We actually just did a survey of all of our providers to see who are doing paper charts versus EMRs. We'll take a review of that and then start breaking it down and working with our practice transformation group. We've hired two vendors, who will be assessing the EMR to see if they are getting a lot of the documentation if they just have to change our template, turning on the percentiles versus just putting the BMI which automatically calculates it correctly, so this is part of our process that we're reviewing.

Dr. Griffis commented that as a delegate of SCFHP, we meet with Lucille and the Quality Team on a very regular basis It has been very helpful in terms of helping us to teach the providers around documentation. It has been really instrumental in how we've been able to do it even better. He noted he really wanted to comment on this presentation, which he thought was a lot of complex information and put forth in a very straightforward fashion and much appreciated.

## 6. Pharmacy

### Standing Reports:

Dr. Dang Huynh, Director, Pharmacy and Utilization Management, presented the “2021 Q1 Top 10 Drugs by Total Cost” and the “Top 10 Drug Classes by Prior Authorization Volume” for reporting period of January 1, 2021– March 31, 2021. For the Medi-Cal line of business, it was noted that prior authorizations for both Humira and Golytely have had significant increases over the last quarter. With regard to the CMC line of business, it is similar to that of the last quarter. There was an increase in total utilization cost for Jardiance and Trulicity.

### Pharmacy Updates:

Dr. Huynh advised the council we are working on increasing utilization of our 30 day supply to a 90 day supply. Dr. Harrison inquired if this is a new process, as she believed it to be only 30 day supply for Medi-cal. Dr. Huynh noted opioid maybe limited, but maintenance drugs are billable for 90-day supply. With regard to birth control, it is a year supply. Dr. Laurie Nakahira noted fee-for-service (FFS) also allows for a one-year supply.

He noted updates from the last March P&T Committee meeting including adding additional Vitamin D3 over the counter products, diclofenac 1% gel, and Movantik for opioid-induced constipation.

Dr. Huynh highlighted some medications in the pipe line that are coming on to market. Generic glucagon was approved in December. Generic Lyrica has been out on the market quite some time with the controlled-release recently approved in April. We're waiting to see if that actually gets circulated onto the market. The plan is excited for Bystolic's generic pipeline approval in September of this year.

## 7. Utilization Management:

Dr. Dang Huynh, Director, Pharmacy and Utilization Management, provided the council with operational related to Utilization Management. He noted the following updates:

The Plan's I.T. Department developed an internal prior authorization platform. It's currently being tested with some selected providers. The online submission portal will save time, confusion, and a lot of fax papers. Dr. Huynh noted he will bring an update and statistics when available.

Dr. Huynh advised that the UM Department is doing a lot more delegation oversight of our delegates. We are taking a deep dive into UM program descriptions identifying best practices. SCFHP has partnered up with the Care Management Team at Connor, Regional, St. Louise, Good Samaritan, El Camino, Valley Medical Center and Stanford. We're meeting with them on a consistent basis to discuss complex cases, helping to provide proactive authorizations to get patients discharged timely and appropriately to improve our quality metrics as a managed care plan.

## 8. Provider Network Operation (PNO) Updates

### Provider Network Access:

Ms. Karen Fadley, Provider Data Analyst, PNO, provided a presentation on a FY20/21 Plan Objective She reviewed the following topics:

- We are expanding our Provider Network in Accordance with DHCS Standards which is at the overall network level. Next year it will be at the delegate/individual network level..
- DHCS Standards are run against SCFHP membership and anticipated membership using a Census File.
- We have a new analytics tool for this work called the QES Tool through Quest Analytics. She reviewed a dashboard, which broke out Independent Physicians, Physicians Medical Group of San Jose, Premier Care, and Valley Health Plan, noting the percentage of members within access stands time or distance.
- Our action plan for gaps: we are working with delegates to identify gaps and contracting accordingly.
- Annual Network Certification was completed and submitted to DHCS at the beginning of May. She noted improvements of HIV/AIDS/Infectious Disease gaps before and after the contracting efforts. The gap ultimately filled the Plan is now working on contracting with Endocrinology, Physical Therapy and Rehab providers.

Dr. Peter Nguyen inquired about referrals too behavioral health, noting it can take a month. Ms. Natalie McKelvey noted this is currently be addressed. Rather than routing call directly to Call Center, working on getting calls routed directly to contracted provider. She noted, she is excited about the Array Empathy being contracted, who have Psychiatrists, MFTs. Ms. Clara Adams also noted that there is always Michelle Webber, LCSW, who is actually physically located next to SCFHP. Ms. Adams noted that council should feel free to contact her and she will do her best to reach out to Ms. Webber.

### Provider Training:

Mr. Brandon Engelbert, Manager, Manager, Provider Network Operations, encouraged the council to let him know of any initiatives or education needs they are interested in learning about, either by way of presentations or personal training. Mr. Engelbert informed the council not to hesitate to reach out to him to alert him to their wants / needs for educational training(s).

## 9. Old Business

### CME Update:

Dr. Laurie Nakahira, Chief Medical Officer, advised the council on the previously discussed Continuing Medical Education (CME) planning. She briefly noted the two previous providers who planned to provide CME are unable to because they are inundated with patients. She noted the plan is to continue to provide a CME within the fiscal year.

## 10. New Business

### Chief Medical Office Update:

- **Appropriate ED Utilization**

Dr. Laurie Nakahira, CMO, provided presentation on Low Acuity and Non-Emergent (LANE) Clinical Efficiency to the council. Dr. Nakahira informed the council instances of LANE, which include low acuity of non-emergency services; potentially preventable ER visits for conditions that can be addressed in an ambulatory or primary care setting, and quantifies potential cost savings if the services were delivered in a more appropriate level of care. The presentation identified which ED visits are considered LANE, SCFHP Top 15 Grouped LANE Diagnosis Codes, California LANE visits by dates of the week, and Strategies to reduce LANE visits, which include working on script for WEB, newsletter and education, identifying qualification for urgent vs PCP visits, and strategies to reduce LANE visits.

- **Trauma Screening / Family Therapy Benefit**

Ms. Natalie McKelvey, Manager, Behavioral Health, provided a presentation on Trauma Screening / Family Therapy Benefit, noting she is working on a new initiative related to trauma screening. She noted ongoing trauma effecting health and the need to understanding trauma screening. She reminded council that Medi-Cal providers can complete the 2-hour training via ACEs Aware and that they need to attest to completing the training on the DHCS website at [www.medi-cal.ca.gov/TSTA/TSTAattest.aspx](http://www.medi-cal.ca.gov/TSTA/TSTAattest.aspx). Providers receive \$100 incentive from SCFHP if training and attestation is completed by June 30, 2021.

Ms. McKelvey voiced her interest in hearing from the council members of their trauma screening barriers. She wanted providers to know what they can do. That they can learn how to be trauma informed and that there is a resource available for them on the SCFHP provider portal. She noted that with regard to Family Therapy, the extension on outpatient treatment still does not include treatment for couples and that a DSM diagnosis is needed. With regard to Family Therapy risk factors, she noted if a score of 4+ or any risk factor to go ahead and refer. She noted COVID is not on the list, as well as gender identity. Additional information related to trauma screening details, screening tools, barriers known to completing screening, possible interventions, family therapy eligibility, family therapy risk factors, ongoing needs and concerns, as well as her contact information can be found in detail in the presentation.

- **Governmental Affairs  
CalAIM**

Mr. Tyler Haskell, Director, Government Relations, briefed the council on CalAIM, a set of changes to Medi-Cal that includes the following: a new Enhanced Care Management and In Lieu of Services programs, a carve-in of major organ transplants, new mandatory managed care populations, a requirement to implement a population health management program, the transition from Cal MediConnect to a D-SNP, regional capitation rates, and a new NCQA accreditation requirement.

## 11. Discussion / Recommendations

There were no further discussions and/or recommendations.

## 12. Adjournment

The meeting adjourned at 2:05 p.m. The next meeting is scheduled for Tuesday, August 10, 2021.

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Dr. Thad Padua, Chair

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Date

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

Tuesday, June 8, 2021, 6:00 PM – 7:00 PM  
Santa Clara Family Health Plan - Teleconference  
6201 San Ignacio Ave., San Jose, CA 95119

## MINUTES - Draft

### Members Present

Debra Porchia-Usher, Chair  
Rebecca Everett  
Blanca Ezquerro  
Rachel Hart  
Vishnu Karnataki  
Maria Cristela Trejo Ramirez  
Ishendra Sinha  
Tran Vu

### Members Absent

Barifara (Bebe) Barife

### Guest

Khoa-Nathan Ngo

### Staff Present

Christine Tomcala, Chief Executive Officer  
Chris Turner, Chief Operating Officer  
Laura Watkins, Vice President, Marketing and Enrollment  
Chelsea Byom, Director, Marketing, Communications and Outreach  
Lucille Baxter, Manager, Quality and Health Education  
Mike Gonzalez, Manager, Community Resource Center  
Natalie McKelvey, Manager, Behavioral Health  
Theresa Zhang, Manager, Communications  
Cristina Hernandez, Manager, Marketing & PR  
Amy O'Brien, Administrative Assistant

### 1. Roll Call

Debra Porchia-Usher, Chair, called the meeting to order at 6:02 pm. Roll call was taken and a quorum was established.

### 2. Public Comment

There were no public comments.

### 3. Meeting Minutes

The minutes of the March 9, 2021 Consumer Advisory Committee meeting were reviewed.

**It was moved, seconded, and the minutes of the March 9, 2021 Consumer Advisory Committee meeting were unanimously approved.**

**Motion:** Mr. Vu

**Seconded:** Mr. Sinha

**Ayes:** Ms. Everett, Ms. Ezquerro, Mr. Karnataki, Ms. Porchia-Usher, Ms. Ramirez, Mr. Sinha, Mr. Vu

**Absent:** Ms. Barife, Ms. Hart



#### 4. Health Plan Update

Christine Tomcala, Chief Executive Officer, presented the enrollment update. The Plan's enrollment continues to grow. As of June 1, 2021, total enrollment is 282,670 members, an 11.3% increase since June 2020, with 272,590 Medi-Cal members and 10,080 Cal MediConnect members.

Ms. Tomcala noted that the public health emergency is beginning to draw to a close. The Department of Health Care Services (DHCS) is planning to resume Medi-Cal eligibility redeterminations, with a target date of January 1, 2021 to restart the redetermination process. The Governor issued his revised May budget, which includes \$1 billion for the CalAIM program. The areas of particular focus for SCFHP are ECM (Enhanced Care Management), for our more complex Medi-Cal members, and ILOS (In-Lieu-of-Services), which provides non-standard services for our Medi-Cal members. Further details will be provided at our September 14, 2021 meeting.

SCFHP celebrates an enrollment milestone of 10,080 Cal MediConnect members. In addition, as the pandemic winds down, SCFHP has begun to finalize plans to reopen the main office, as well as the Blanca Alvarado Community Resource Center (CRC). Currently, the CRC is used for vaccination clinics, and will begin to provide enrollment assistance by July. Ms. Tomcala mentioned that the main office will likely reopen after Labor Day 2021. She concurred that future meetings of the CAC may take place at the CRC.

#### 5. Mission, Vision, Values, and Strategic Plan

Laura Watkins, Vice-President, Marketing and Enrollment, presented SCFHP's Mission, Vision, Values, and Strategic Plan. Health equities and health disparities were the driving force behind the Plan's mission, vision, and values. Ms. Watkins outlined the key strategies in place to ensure achievement of the goals of the Strategic Plan. The Strategic Plan is found on the SCFHP website, and Ms. Watkins encouraged all committee members to read the plan and bring their questions to the September 2021 meeting. Ms. Porchia-Usher asked for details about community engagement. Ms. Watkins agreed this is a good topic for our September agenda, as the Plan has implemented work groups with various CBOs (community-based organizations) and member and non-member community members. Ms. Watkins discussed the ways in which the CRC will nurture and encourage connections between our members and the community.

Mr. Sinha expressed his concerns with finding doctors who will accept Medicare. Mr. Sinha is concerned that there appear to be very few doctors accepting Medicare patients in his area, and San Jose is too far away to travel for urgent care. He has spoken to our Customer Service department many times with these concerns. Ms. Turner suggested our Customer Service Director reach out to Mr. Sinha to resolve this issue. Mr. Sinha also expressed his concerns with the transportation service. Ms. Turner advised she will work with our Customer Service Director and the Provider Network team to assist.

Ms. Watkins added that committee members will soon receive an email from Christine with a diversity survey. Members are encouraged to complete the anonymous survey and provide their feedback so SCFHP can better understand how the diversity of our committees represent the communities we serve. Results will be shared during the September 2021 meeting. Ms. Porchia-Usher remarked that it would be interesting to see the diversity of both the members and the committees. Ms. Tomcala agreed that the results of the survey will be an opportunity to identify and resolve any unintentional gaps in diversity. Ms. Watkins thanked all the committee members for their thoughtful feedback.

#### 6. Community Resource Center

Mike Gonzalez, Manager, CRC, presented the Committee with an update on the activities occurring in preparation for the full opening of the CRC. Mr. Gonzalez gave an overview of the ideas for virtual and in-person programming at the CRC. The CRC will host its 5<sup>th</sup> vaccination clinic next week. Over 1,000 vaccines have been administered over the last 2 months. The CRC is located in the zip code that was the hardest hit by COVID. The next vaccination clinics will accommodate evening hours until 7:00 p.m. Gift cards to local merchants are also offered as incentives.

Mr. Gonzalez discussed the CRC's application assistance program. The Health Trust program will sunset and transfer to SCFHP, with SCFHP getting certified by Covered California as a certified enrollment entity. Mr. Gonzalez is in the process of hiring community health workers for the CRC.

Mr. Gonzalez discussed the elements of the community-led CRC Planning Process. He also explained the goals of the CRC System Partner Advisory Group and Resident Advisors group. Community stakeholder sessions are scheduled for July and August. Mr. Gonzalez solicited ideas from committee members as to the best ways to involve them in this process.

Mr. Sinha was pleased to know the Plan is working on bringing communities together. Ms. Ezquerro suggested that CBOs should also be part of this process and Mr. Gonzalez noted that they will be included. Ms. Ramirez asked about volunteer opportunities. Mr. Gonzalez suggested she consider joining the Resident Advisors group. Mr. Sinha asked if the Resident Advisors Group is open only to East San Jose residents. Mr. Gonzalez responded that the group is open to everyone, but it is a priority to have representation from residents of East San Jose. Ms. Tomcala added that the Plan is looking for opportunities to better connect with residents in South County and on the Peninsula, as well as other areas that are less densely populated with Medi-Cal members.

## **7. Behavioral Health – Taking Care of Health and Wellbeing during Times of Uncertainty**

Natalie McKelvey, Manager, Behavioral Health, gave a presentation on how stress during a pandemic affects overall mental health, and the importance of self-care during difficult times. Ms. McKelvey began with describing some of the more positive aspects of the pandemic, such as the fact that more and more people are finally talking about behavioral health, and people are more prone to expressing themselves and supporting each other. These positives are in alignment with the mission of SCFHP.

Ms. McKelvey shared some tips on how to cope as we continue to redefine what is normal. Ms. McKelvey discussed suggestions on how to keep up your mental outlook and your physical health. Self-care has become such an important topic that The National Association of Social Workers now includes employee self-care in their code of ethics. Ms. McKelvey encouraged members who are struggling to seek talk therapy, among other effective therapy methods. There is a significant increase in Emergency Room visits for children with mental health conditions, and the need for behavioral health therapy has risen. Ms. McKelvey discussed the Behavioral Health resources available for members of SCFHP, as well as the phone numbers for the Santa Clara County Behavioral Health Call Center and the Santa Clara County Gateway program.

Mr. Sinha added that people are now living in a state of fear. Mr. Sinha suggested SCFHP establish more of a media presence, such as on television or via podcasts. He encouraged members not to live in the past, nor worry about the future. Ms. McKelvey agreed there are numerous issues going on that have impacted the mental health of our communities. The Governor has substantially increased behavioral health care funding, which enables the Behavioral Health team to look at creative ways of providing mental health care. Ms. McKelvey is happy to help members connect with talk therapy services.

## **8. SCFHP Member Communications**

Theresa Zhang, Manager, Communications, gave an overview of the member communications completed since the March 2021 CAC meeting. Mailings included the spring newsletter, which contained an article that reminded members that their primary care physician cares for all of you, so you are encouraged to ask your doctor both physical and mental health questions, as it is their goal to treat you as a whole person. The 24/7 nurse advice line is available for members who are unsure if they are having a medical emergency. The nurse advice line is free for members. Additional articles include '7 Common Questions about the COVID Vaccine', a reminder to check in with your dentist and your eye doctor, and articles on spring allergies, blood pressure, and cholesterol, and how to sign up for the American Heart Association's Healthy Hearts program. There is also a detailed article on well-child check-ups, at what age they are needed, and what to expect at each appointment. Ms. Zhang reminded committee members to spread the word to other Medi-Cal members that the CAC always welcomes new members who wish to join and make a difference.

Other mailings included the COVID vaccine flyers to members 65+ years of age, and an upcoming mailing to members who are not yet vaccinated. The Plan continues to call our vulnerable, high risk members to check in

on their welfare during COVID-19 and to help with vaccine appointments. Marketing recently completed a robo-call campaign to 103,000 members 16 years of age and older who were not yet vaccinated. Another robo-call campaign is planned for our members in the 12-15 year age range. Ms. Zhang highlighted the SCFHP website which is updated with meeting materials, member materials such as the Formulary, Provider Directory, newsletters, COVID-19 vaccine information, and a new “Medi-Cal Made Easy” landing page. Ms. Zhang concluded with a list of the events to which the Plan sent outreach materials since our March 2021 meeting. The Plan has not attended any in-person events.

Ms. Porchia-Usher asked if there are any plans to capture data on how many members get vaccinated within 1-30 days after receiving a robo-call. Ms. Zhang agrees that is a good suggestion, and Marketing is in discussion on how best to incorporate this idea into the robo-call campaigns.

Ms. Ezquerro asked if transportation to and from vaccine appointments is offered. Ms. Zhang confirmed transportation is offered at the time of appointment coordination.

#### **9. Future Agenda Items**

Ms. Porchia-Usher asked for feedback as to future agenda items. There were no suggestions at this time.

#### **10. Adjournment**

The meeting adjourned at 7:13 p.m. The next Medi-Cal Consumer Advisory Committee meeting is scheduled for Tuesday, September 14, 2021 at 6:00 p.m.

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Debra Porchia-Usher, Chairperson  
Consumer Advisory Committee



**Santa Clara County Health Authority  
 Updates to Pay Schedule  
 June 24, 2021**

<b>Job Title</b>	<b>Pay Rate</b>	<b>Minimum</b>	<b>Midpoint</b>	<b>Maximum</b>
Community Health Worker	Annually	49,655	60,827	72,000
Director, Operations	Annually	175,327	227,925	280,523
Manager, Marketing and Public Relations	Annually	107,901	137,573	167,246

**Santa Clara County Health Authority  
 Job Titles Removed from Pay Schedule  
 June 24, 2021**

<b>Job Title</b>	<b>Pay Rate</b>	<b>Minimum</b>	<b>Midpoint</b>	<b>Maximum</b>
N/A				

## Regulatory Audit Report

June 18, 2021

- **Medicare Data Validation (MDV)**

The Plan is currently undergoing the annual Medicare data validation audit. SCFHP engaged Advent Advisory Group to complete a validation of various reporting to CMS for calendar year 2020 operational activities. The audit validates data submitted for the Part D program, specifically for Appeals, Grievances, Coverage Determinations, Medication Therapy Management, and Improving Drug Utilization Review Controls. Advent's team conducted a virtual interview at the end of April to review our overall reporting process and has been reviewing our source documentation. So far, they have validated three of the four required data categories with no issues. Advent will be submitting final results to CMS by the end of June.

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**

Our 2021 annual DHCS audit, covering only Medi-Cal, occurred between March 8 and March 19, covering a review period of March 2020 through February 2021. The Plan received a preliminary audit report on June 18, which includes a total of four findings. Three of the findings relate to Utilization Management and one relates to the enrollment of transportation vendors as Medi-Cal providers. The Plan will be discussing this report with DHCS at a scheduled audit exit conference on June 25.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**

Also in March, the Plan underwent a follow-up audit of our 2019 DMHC audit. The scope of the audit was limited to the outstanding deficiencies in our 2019 audit final report, which related to delegate oversight of utilization management and providing proof of a response for post-stabilization care requests within the required timeframe. DMHC did not share any preliminary findings of the follow-up audit with the Plan. A preliminary report is expected sometime this summer.

- **Corrective Action Plans**

The Plan has been working since last Fall to implement corrective actions relating to the six findings in the final 2020 DHCS audit. All but one of the tasks included in our corrective action plans (CAPs) have been implemented. The remaining task relates to the finding that the Plan did not complete initial health assessments within the required timeframe. The task requires a reconfiguration of the primary care provider assignment process that is on track to be completed in late June.

**SCFHP DONATIONS/SPONSORSHIPS**

Organization	Event Name	FY 2020-2021		
		Check Date	Event Date	Amount
AACI	Annual Event (Gala)	TBD		\$ 5,000
Alum Rock Counseling Center	Fundraiser	5/20/2021	5/1/2021	\$ 2,500
Breathe California	Breath of Life Walk	10/16/2020	10/17/2020	\$ 1,000
California Association for Adult Day Services	Fall Conference	10/16/2020	11/17/2020	\$ 500
Chinese American Coalition for Compassionate Care	Seminar	10/16/2020	10/16/2020	\$ 1,000
Chinese for Affirmative Action	Donation	3/29/2021	3/1/2021	\$ 1,000
Community Health Awareness Council	Annual fundraiser	5/20/2021	5/5/2021	\$ 2,500
Community Health Partnership	Diaper Drive	TBD		\$ 5,000
Community Solutions	Matching Donation	4/5/2021	3/19/2021	\$ 2,500
Day Worker Center of Mountain view	Donation	11/20/2020	10/24/2020	\$ 500
Gilroy Compassion Center	Annual fundraiser	12/12/2020	11/11/2020	\$ 2,500
Goodwill Silicon Valley	Reentry Resource Center 5k	11/16/2020	10/24/2020	\$ 1,000
Grail Family Services	Building Blocks of Parenting app support	6/17/2021	6/9/2021	\$ 5,000
The Health Trust	Spring into Health Breakfast	TBD		\$ 5,000
Healthier Kids Foundation	Wine Tasting Benefit/ABC Kids	8/24/2020	9/25/2020	\$ 5,000
Indian Health Center Santa Clara	Annual Event	11/6/2020	12/5/2020	\$ 5,000
LifeMoves	Backpack Drive	9/4/2020	9/1/2020	\$ 2,000
Loaves & Fishes	40th Anniversary Event	11/2/2020	11/14/2020	\$ 2,500
March of Dimes	March for Babies	5/24/2021	5/20/2021	\$ 5,000
Momentum for Health	Annual Shining Stars Benefit	10/20/2020	10/2/2020	\$ 5,000
National Alliance on Mental Illness	NAMIWalks Silicon Valley	6/7/2021	10/9/2021	\$ 5,000
Next Door Solutions to Domestic Violence	Light up the Night	8/14/2020	10/15/2020	\$ 3,000
PACT	Leadership Luncheon	10/16/2020	10/30/2020	\$ 5,000
Parents Helping Parents	Public Benefits Program	6/7/2021	6/17/2021	\$ 2,500
Planned Parenthood	Children's Summit	4/12/2021	3/19/2021	\$ 5,000
Recovery Café	Closing the Gap Breakfast	5/20/2021	5/7/2021	\$ 2,500
Sacred Heart Community Service	Pack a Back	7/31/2020	7/30/2020	\$ 5,000
Second Harvest Food Bank	Donation	TBD		\$ 5,000
Silicon Valley Council of Non Profits	Be Our Guest Annual Luncheon	10/16/2020	10/30/2020	\$ 2,500
	Policy/Housing Summit	10/16/2020	3/9/2021	\$ 2,500
Silicon Valley Leadership Group	Silicon Valley Turkey Trot - Sponsorship	12/31/2020	11/21/2020	\$ 5,000
SOMOS Mayfair	Gracias A La Vida Annual Luncheon	TBD		\$ 2,500
Uplift Family Services	Silicon Valley Community Awards Lunch	6/7/2021	6/25/2021	\$ 5,000
Veggielution	Feast	6/7/2021	8/1/2021	\$ 5,000
VMC Foundation	Annual Fundraising Gala	5/20/2021	4/22/2021	\$ 5,000
<b>TOTAL</b>				<b>\$ 120,000</b>

# FY 2019-2020 Board Designated Funds Project Commitments

Organization	Project	Amount
Agrihood Senior Apartments	Provide permanent housing with services and supports for SCFHP members transitioning from long term care (LTC), with an estimated 44 housing units set aside for SCFHP members.	\$ 2,420,000
East Side Union High School District	East Side Access Community Wireless Project: To provide three years of maintenance costs for internet access for one neighborhood supported by the East Side Access Community Wireless Project.	\$ 150,000
Healthier Kids Foundation	My HealthFirst: Complete pilot program for student mental health screening and referrals, evaluate of the efficacy/impact, finalize workflows and forms, finalized process and plan for data recording, storage, sharing, and evaluation.	\$ 42,000
Institute on Aging	Fund Community Living Connections (CLC) program operated by IOA, to provide comprehensive community living services and supports to SCFHP members, to avoid return to SNF/LTC.	\$ 867,000
YMCA of Silicon Valley	To support the YMCA's distribution of an estimated total of 115,880 meals and snacks to children in the lowest-income neighborhoods during the summer due to the increased need during the COVID-19 crisis.	\$ 100,000
<i>Health Equity Agenda*</i>	<i>Establish and implement a health equity agenda and an index to track key health equity metrics, including the compilation of relevant health data for a manageable subset of community health priorities, analysis of information, development of an action plan, and implementation of projects based on evidence-based best practices.</i>	\$ 115,000
<i>Integrated Behavioral Health Pilot Project*</i>	<i>Develop and implement a pilot to sustainably integrate early childhood/dyadic behavioral health services into highest volume primary care clinics serving young children on Medi-Cal in Santa Clara County, to demonstrate the clinical benefit and impact of aligning reimbursement for mild and moderate mental health services with dyadic behavioral health models.</i>	\$ 500,000

\* Proposal – pending review and approval by the Santa Clara County Health Authority Governing Board

Total (excluding pending) \$ 3,579,000

Total (including pending) \$ 4,194,000



**Santa Clara Family  
Health Plan™**

# SCFHP Employee Satisfaction Survey

Governing Board Meeting – June 24, 2021

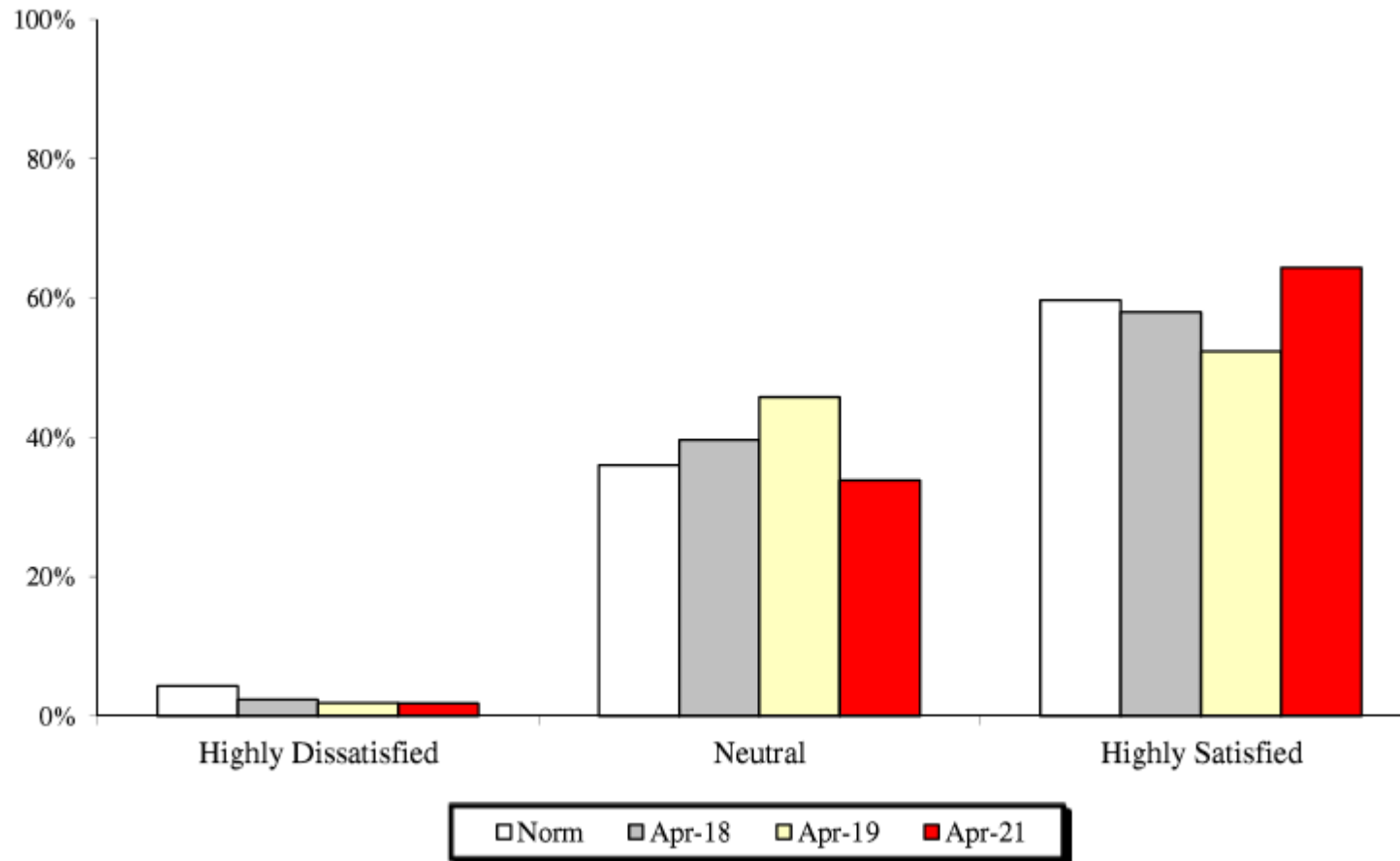
# SCFHP Employee Satisfaction Survey

April 12 – May 7, 2021

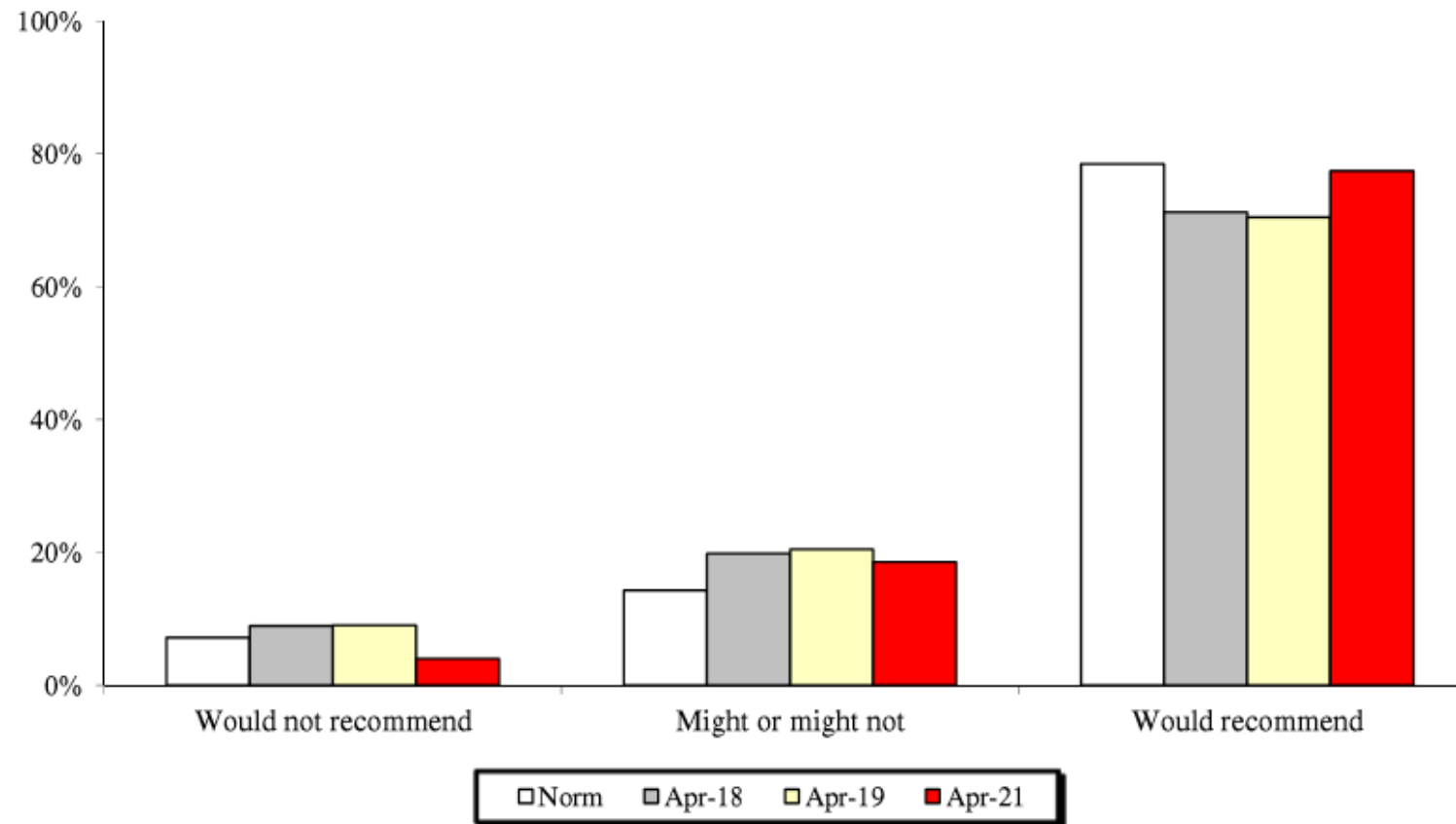
## HIGHLIGHTS

- 89% response rate (275 responses/308 employees)
- 75 agree-disagree questions (5-point agreement scale)
  - All improved compared to 2019
  - Average improvement of 7.5 percentage points
  - Approximately 2/3 of improvements were statistically significant
  - Some halo effect (likely 3-4 percentage pts) based on typically stable scores
- Most improved question categories (out of 14)
  - Teamwork and Cooperation (+10.4)
  - SCFHP Culture (+10.1)
  - Leadership and Planning (+9.1)
- Two overall ratings—both improved significantly

# Overall Satisfaction



# Willingness to Recommend SCFHP to a Friend Seeking Employment





# Key Strengths

The average agreement level of the key strengths is 89%.

- My supervisor treats me with respect
- I understand the mission and goals of SCFHP \*
- I understand how my work directly contributes to the overall success of the organization and its mission
- I know what is expected of me at work \*
- I understand how my work supports SCFHP's strategic objectives
- I understand how my work supports my department's objectives
- My physical working conditions are good
- I have never felt “pressure” from anyone at SCFHP to violate our ethics or values \*

*\* Statistically significant improvement from 2019*

# Key Opportunities for Improvement

The average agreement level of the key opportunities is 60%.

- The Executive Team does not play favorites
- People at SCFHP are held accountable for their actions \*
- There is adequate communication between departments \*
- The performance appraisal system is fair \*
- SCFHP gives enough recognition for work that's well done \*
- My salary is fair for the work that I do \*
- “Politics” at this company are kept to a minimum \*
- Everyone here “pulls their own weight” \*

*\* Statistically significant improvement from 2019*

# Next Steps

- Spend time analyzing the recently received survey results
- Identify particularly strong or weak departmental scores
- Leaders share and openly discuss results with their teams, and seek input from team members
- Focus on key items in need of improvement; work with HR and Executive leadership on an action plan
- Implement an Employee Engagement Committee with facilitation by Jim Delia
- Continue to invest in management tools to support staff
- Include employee survey activities as a standing agenda item

June 1, 2021

Bob Brownstein, Chair  
Board of Directors  
Santa Clara Family Health Plan

Christine Tomcala, CEO  
Santa Clara Family Health Plan  
ADDRESS  
San José, CA.

Please accept my resignation as a member of the Governing Board of the Santa Clara Family Health Plan effective immediately. It has been a pleasure and a meaningful experience serving in this position.

Sincerely,



Dolores Alvarado, MSW, MPH

cc: Supervisor Mike Wasserman, District One

## JANUARY

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## JUNE

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## DECEMBER

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Governing Board 12:00pm – 2:30pm	Quality Improvement Committee 6:00pm – 8:00pm
March 25	February 9
June 24	April 14
September 23	June 9
December 16	August 10
Executive/Finance Committee 11:30am – 1:30pm Jan-May 10:30am – 12:30pm Jul-Nov	October 12
	December 7
January 28	Utilization Management Committee 6:00pm – 8:00pm
February 25	
April 22	January 20
May 27	April 21
July 22	July 21
August 26	October 20
October 28	Credentialing Committee 12:15pm – 1:30pm
November 18	
Compliance Committee 1:30pm – 3:30pm	February 3
	April 7
February 25	June 2
May 27	August 4
August 26	October 6
November 18	December 1
Provider Advisory Council 12:15pm – 1:45 pm	Pharmacy & Therapeutics Committee 6:00pm-8:00pm
February 10	March 18
May 12	June 17
August 10	September 16
November 10	December 16
Consumer Advisory Committee (Medi-Cal) 6:00pm – 7:00pm	Consumer Advisory Board (CMC) 11:30am – 1:00pm
March 9	March 4
June 8	June 3
September 14	September 2
December 14	December 2



# Santa Clara Family Health Plan™

FY'20-'21 Community Engagement and Collaboration

Governing Board

June 24, 2021

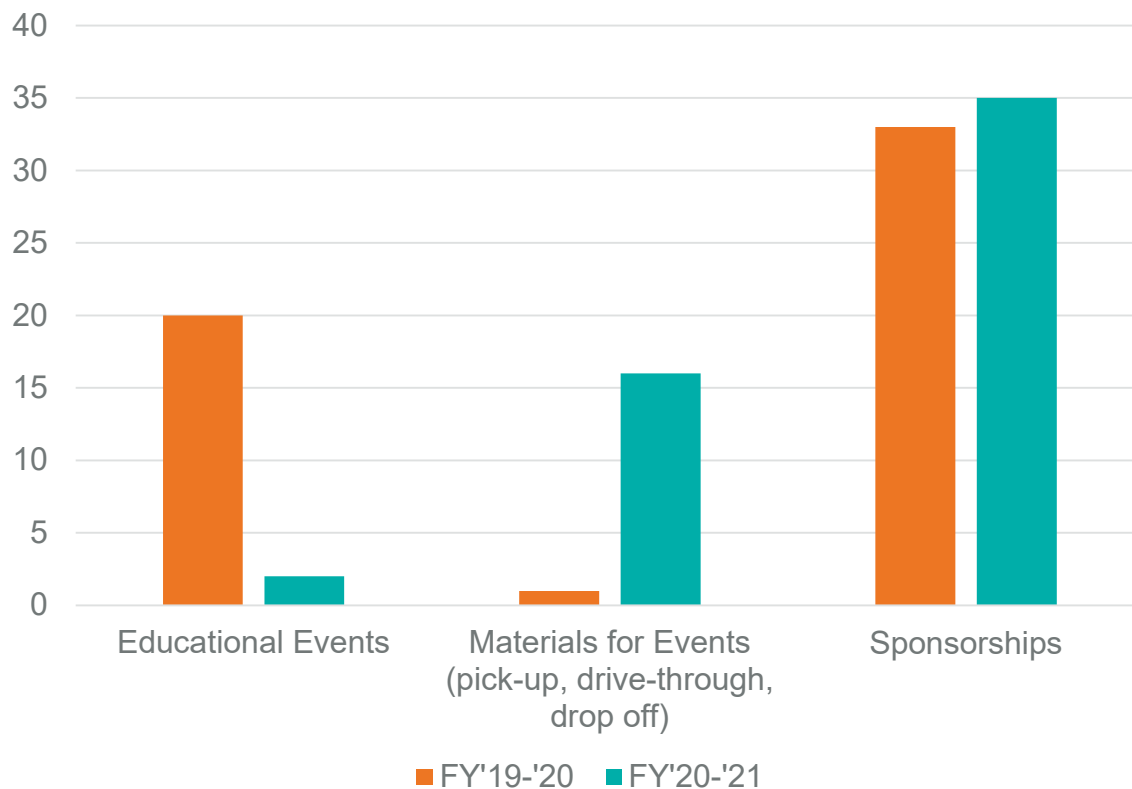
# Community Engagement and Collaboration

Community engagement, collaboration and support continued throughout the pandemic, including:

- Outreach Activities
  - Education events
  - Materials
  - In-kind donations
  - Sponsorships
  - Meetings with community partners and agencies
- Community Collaborations
  - Workgroup/association leadership
  - Workgroup/association participation
- Community Connection and Support
  - Clinics
  - Workshops
- Advocacy
  - Letters of support
- Project funding

# Outreach Activities

FY'20-'21 brought a shift to socially distanced outreach activities and support



SCFHP contributed supplies to 48 organizations, including:

- 12,285 reusable bags
- 1,500 hand sanitizers
- 2,400 flyers and brochures



# Community Collaborations

## Participation and Leadership

- ACES Connection Network Steering Committee
- Behavioral Health Integration Incentive Program
- Binational Health Week Planning Group
- Bridge to Recovery Safety Net Task Force
- Community Health Partnership Data Committee
- Community Health Partnership Initial Health Assessment Workgroup
- COVID Vaccine Stakeholder Workgroup
- Diabetes Prevention Initiative
- East San Jose PEACE Partnership
- Geriatric Team Meeting
- IHSS Advisory Board
- LGBTQ Advisory Committee
- LTSS Integration Committee
- Mujeres Empresarias Tomando Accion
- National Day of Racial Healing Planning Committee
- Office of Supportive Housing Continuum of Care
- Office of Supportive Housing Coordinated Assessment Workgroup
- Race and Health Disparities Community Board
- Santa Clara County Safety Net
- SCC SDOH Symposium Workgroup
- School Linked Services Stakeholder Meeting
- Senior Nutrition Funding
- Service Providers Network (SNP)
- Stanford/Packard Diversity, Equity & Inclusion (DE&I) Committee
- South County Collaborative
- Universal Access Care Program (UAP)
- Welcoming Week Planning Committee

# Community Connection and Support

## Clinics and Workshops

- Vaccination Clinics
  - Flu – collaborated with Anthem to hold 10 clinics
  - COVID – hosted 5 SCC Public Health Department clinics
- Workshops/Presentations/Panel Participation
  - California Health Care Foundation Bay Area Regional Market Report
  - COVID-19 Community Town Hall: Challenges and Successes of Community-Lead Vaccination Campaigns (Office of Community Engagement – Stanford School of Medicine)
  - ECM ILOS Town Hall
  - Health Plan Alliance CEO Roundtable – Return to Work
  - Kids in Common - Child & Family Health During Post COVID: A Systems Approach
  - Rethink Your Drink Workshop
  - SVCN Activate Your Impact – Health Equity Panel

# Advocacy

## Advocacy/Letters of Support for:

- AB 2164 (Rivas) – Telehealth
- American Heart Association's Healthy Heart Initiative
- Area Agency on Aging oversight
- Bay Area Community Health's HRSA P4 Challenge application
- Black Infant Health Program/Perinatal Equity Initiative expansion
- Blue Shield Vaccine Distribution oversight
- Breathe CA Children's Asthma Services
- Ending the sale of flavored tobacco in San Jose
- Healthier Kids Foundation Community Project Fund Grant
- ICAN outreach campaign for vaccine confidence, anti-Asian violence, mental health in Vietnamese community
- San Jose Tobacco Ordinances – Advocacy with Councilmember Matt Mahan on behalf of Tobacco-Free Coalition of Santa Clara County
- SB 769 (Becker) – SNF to housing
- SB 803 (Beall) – Mental health services: peer support
- Universal Developmental Screening Initiative



Santa Clara Family  
Health Plan™

# New Member Orientation Launch

Update to Governing Board

June 24, 2021

# New Member Orientations

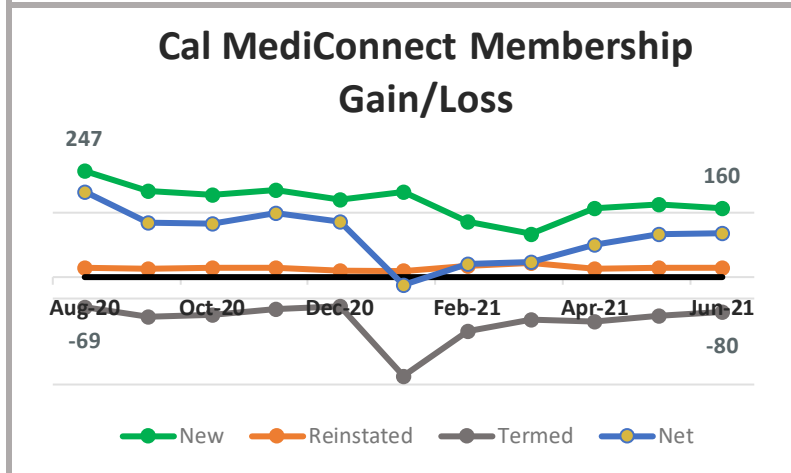
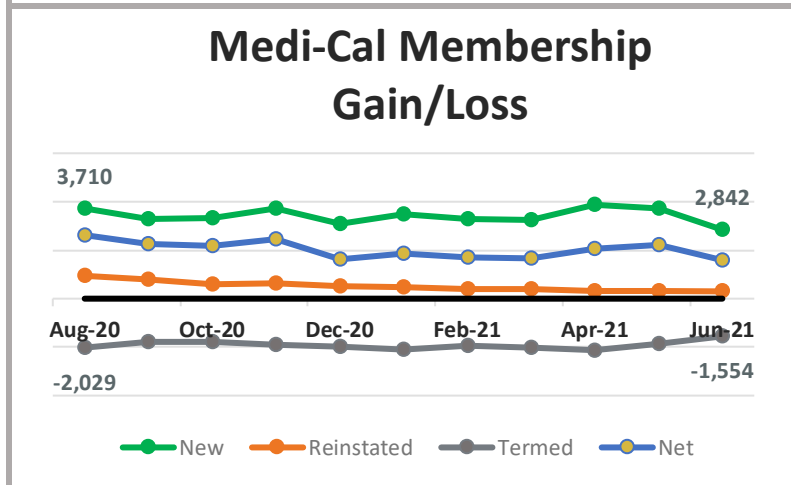
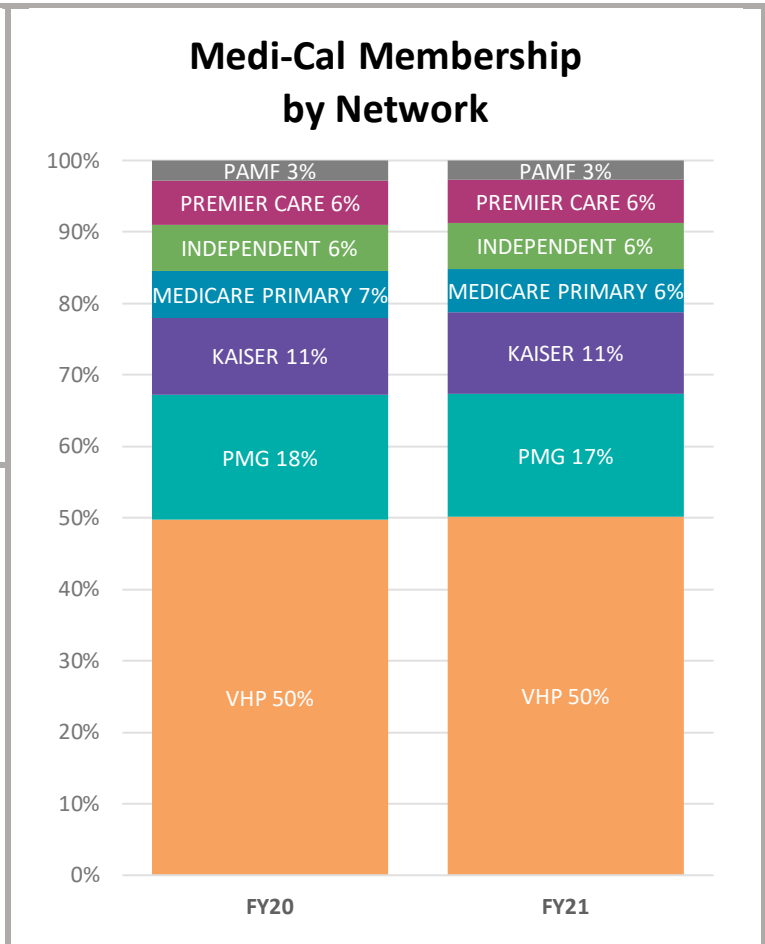
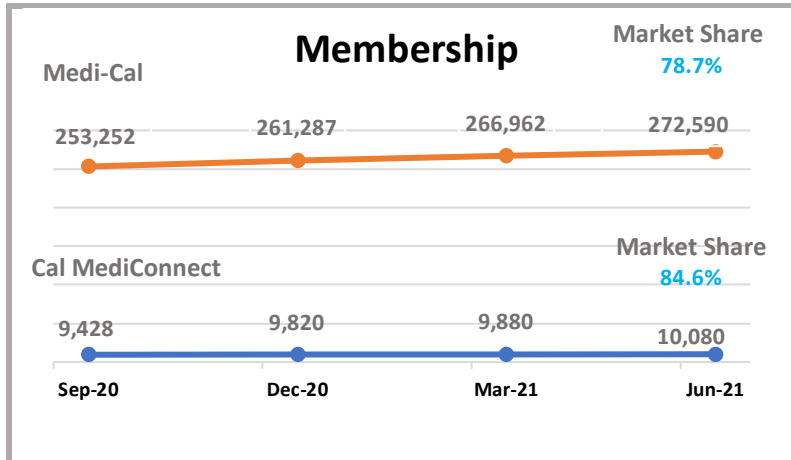
To welcome and educate new SCFHP members, improve member experience

- Launched as virtual orientations in English; over coming months will:
  - Add language options (Spanish, Vietnamese, Chinese)
  - Add in-person option
- Open to members, caregivers or other member representatives
- Deliverables include CMS and DHCS approved materials for both Medi-Cal and Cal MediConnect lines of business
  - Presentations
  - New Member Guides
  - Call scripts
  - Feedback surveys
  - Incentive program
- Key messages
  - SCFHP provides access to quality care for you and your family.
  - We are your partner in your health care, and here to help with questions about health coverage.
  - We want you to fully understand your benefits so that you can utilize them.
  - There are several ways you can contact SCFHP (phone, online portal and in-person).
- Developing processes and systems to support multiple enrollment channels
- Will continue to expand communications and publicity to grow participation



# Board Dashboard

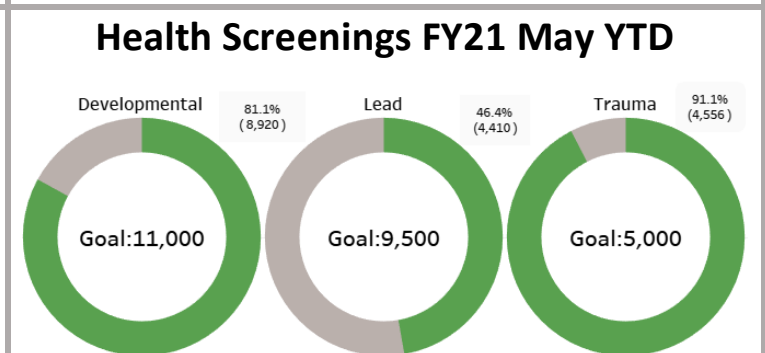
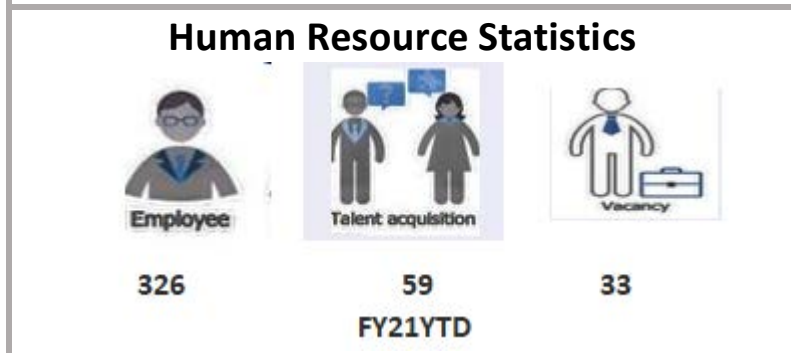
June 2021



### Financial Highlights

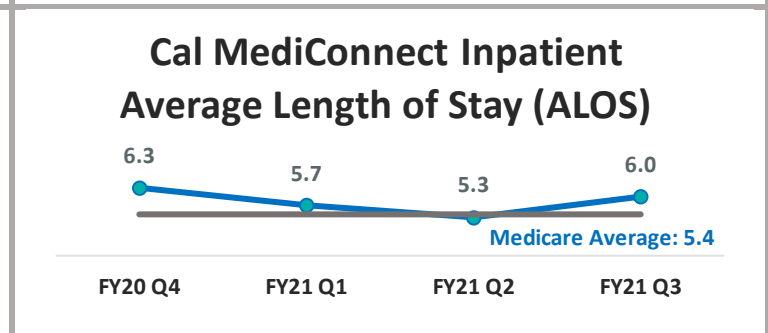
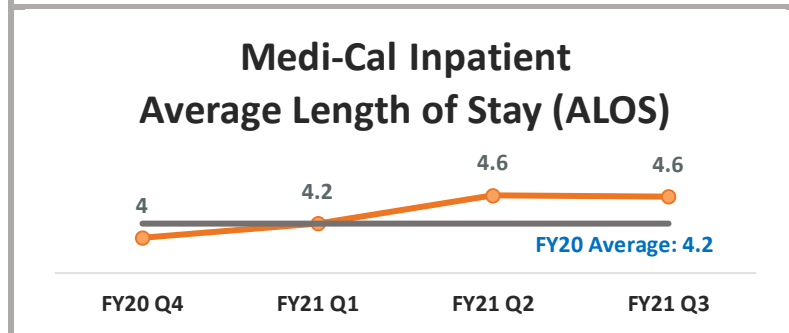
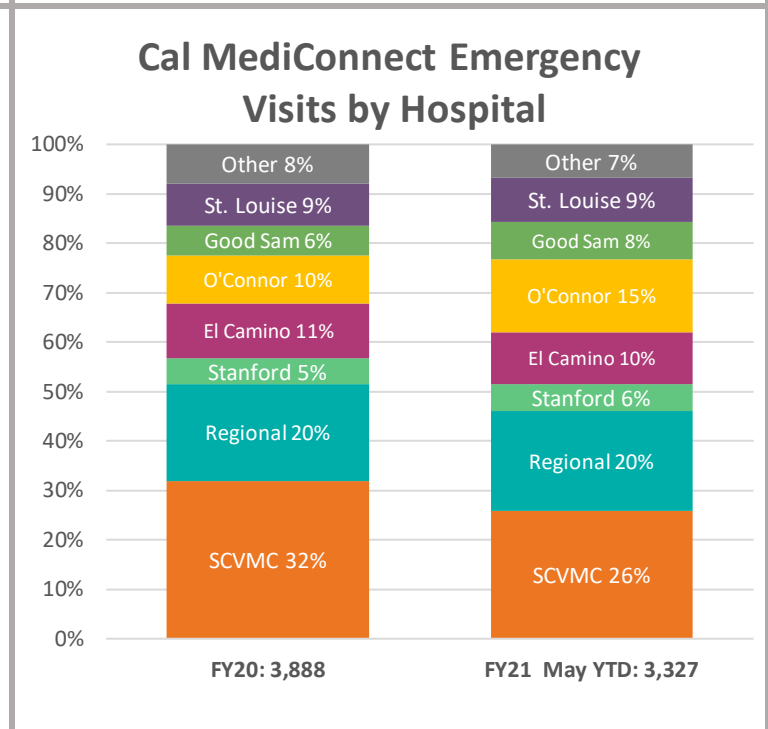
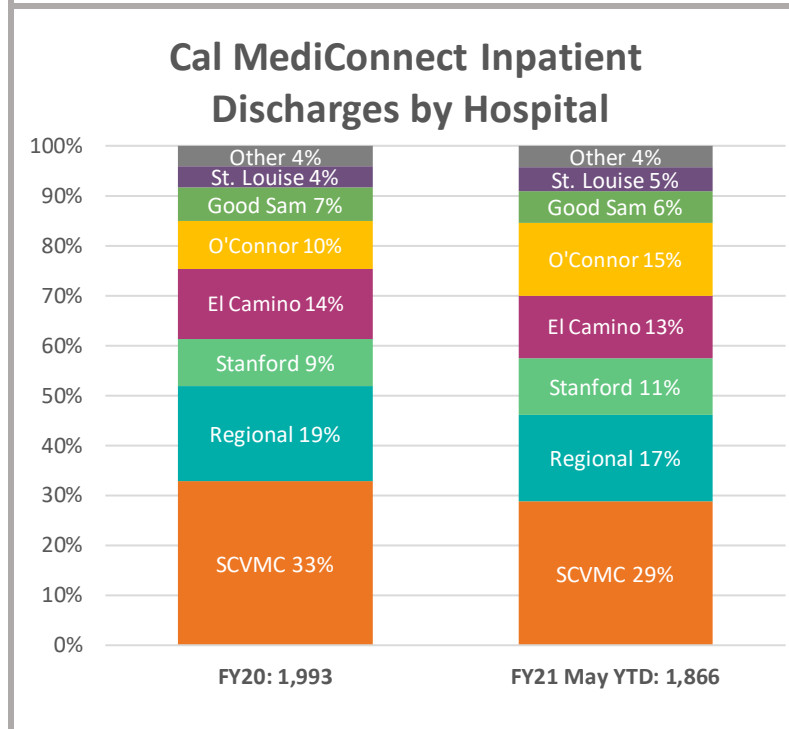
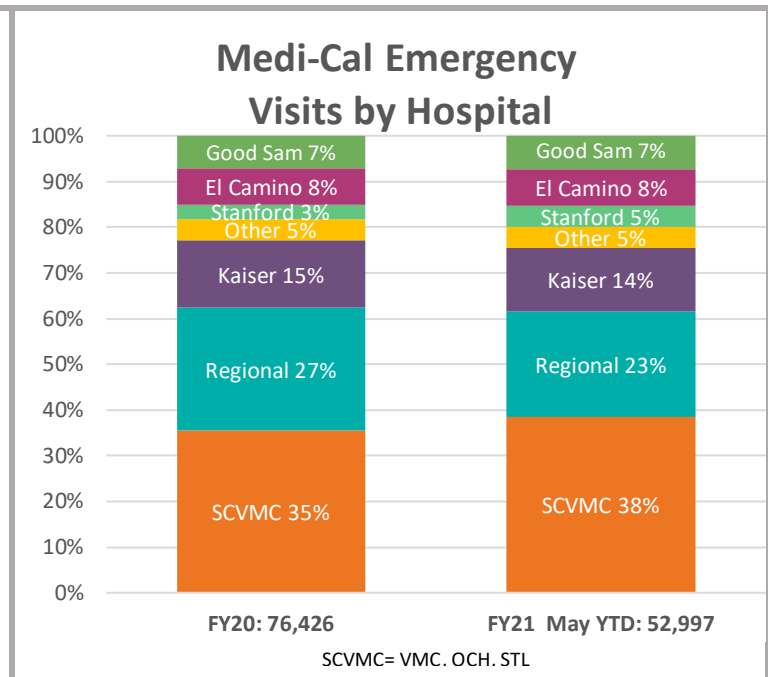
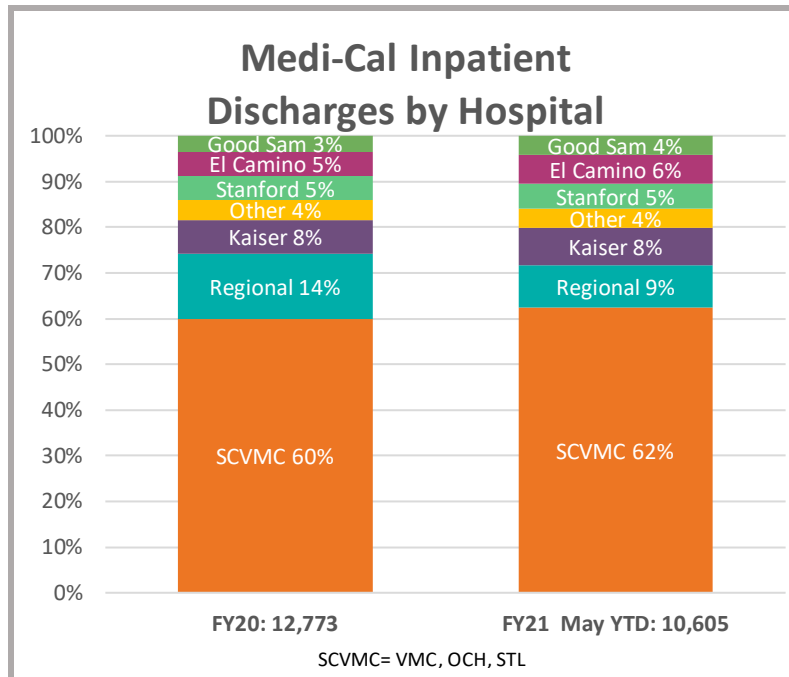
	Apr-21	YTD
Revenue	\$104.4 M	1.05 B
Medical Expense (MLR)	89.4%	92.7%
Administrative Expense	4.9%	5.2%
Net Surplus (Loss)	\$6256K	\$22.7 M

favorable variance (green)  
unfavorable variance (red)



# Board Dashboard

June 2021

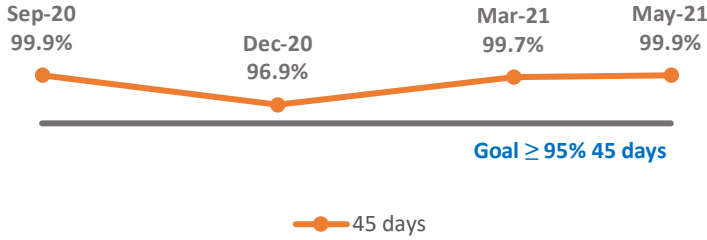


# Board Dashboard

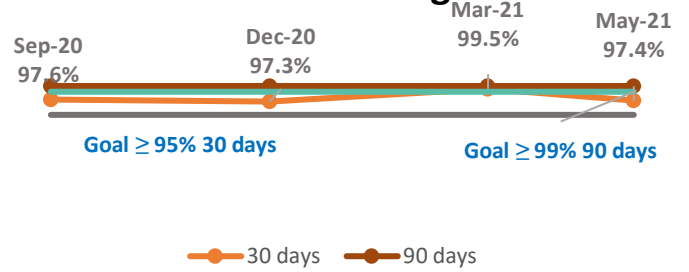
June 2021



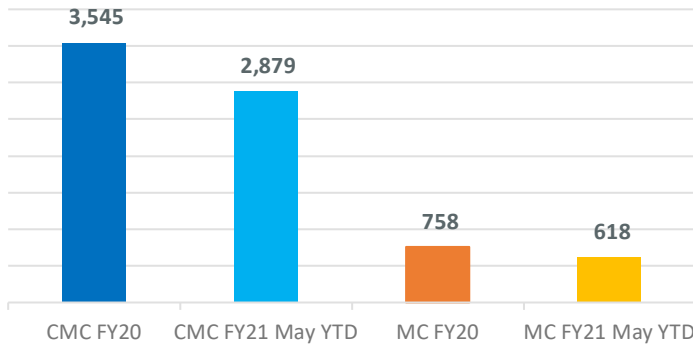
## Medi-Cal Claims Processing



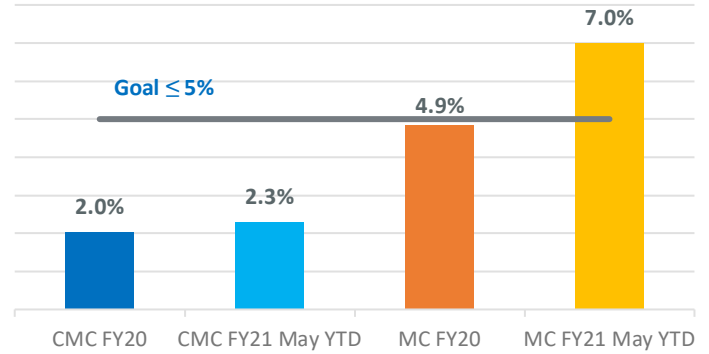
## Cal MediConnect Claims Processing



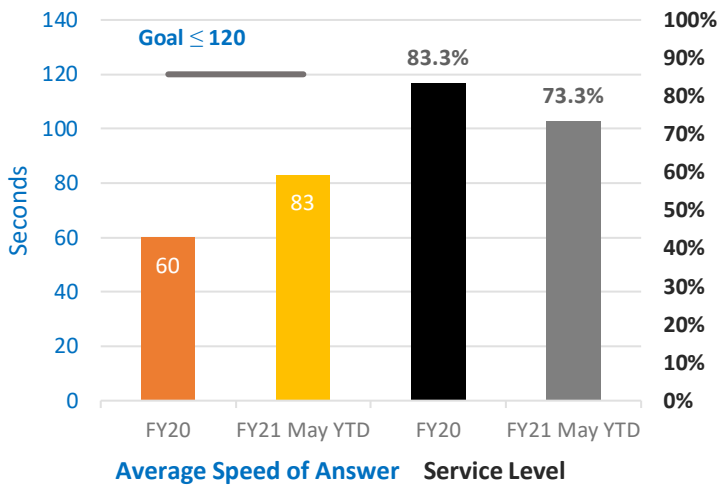
## Member Calls Handled per 1,000 Members/Year



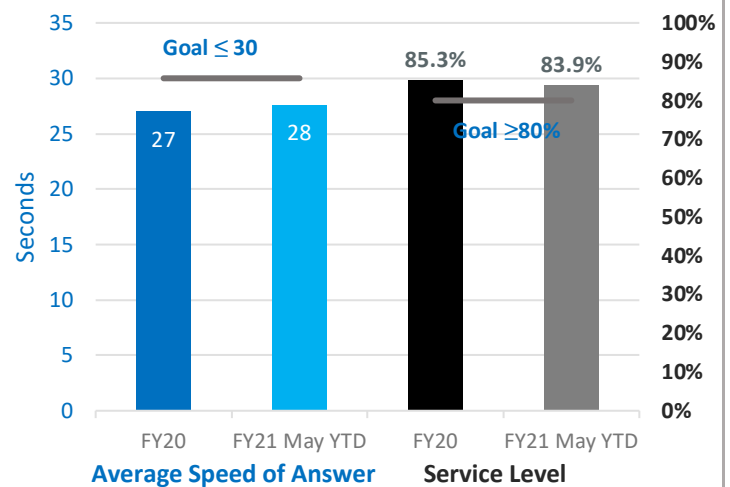
## Abandoned Call Data



## Medi-Cal Member Call Data



## Cal MediConnect Member Call Data





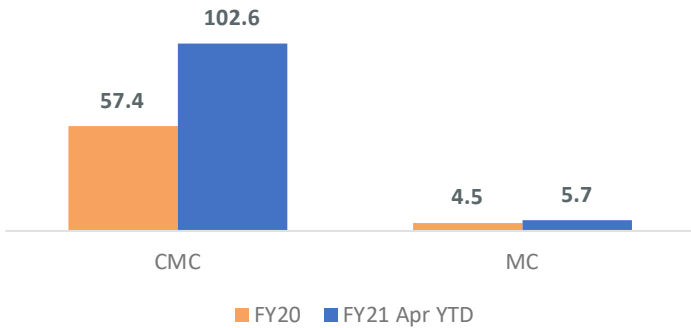
# Board Dashboard

June 2021



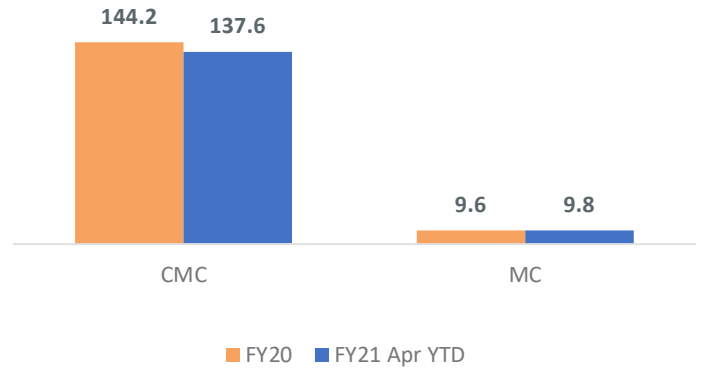
## Appeals per 1,000 Members/Year

Appeal: request to change SCFHP coverage decision

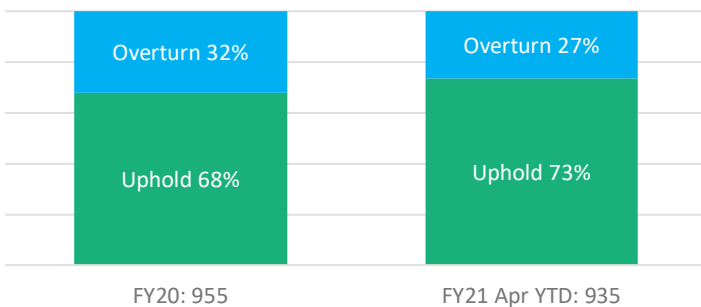


## Grievances per 1,000 Members/Year

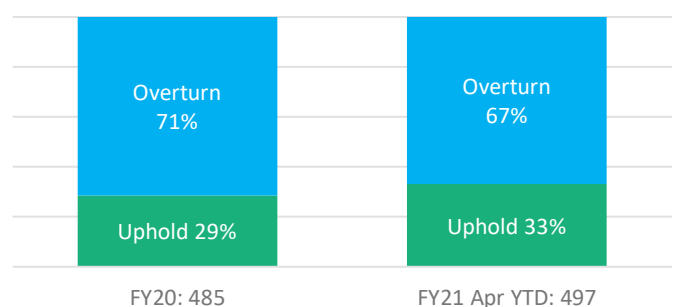
Grievance: member dissatisfaction with a service



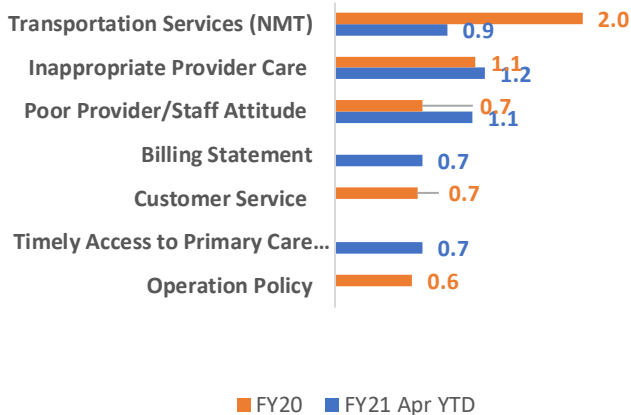
## Medi-Cal Appeals by Outcome



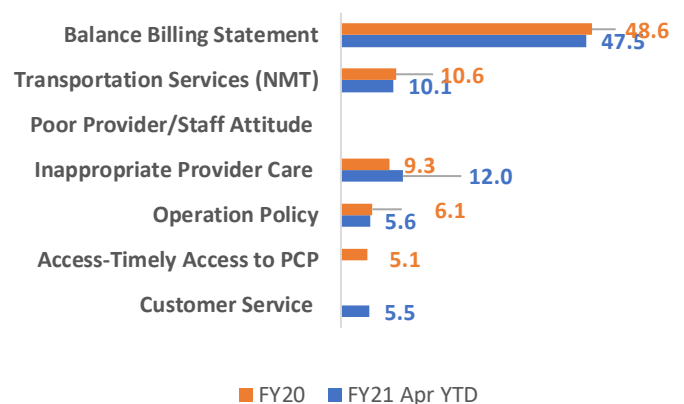
## Cal MediConnect Appeals by Outcome



## Medi-Cal Top Grievances per 1,000 Members/Year



## Cal MediConnect Top Grievances per 1,000 Members/Year



SCFHP is a local, community-based health plan dedicated to improving the health and well-being of Santa Clara County residents. Working in partnership with providers and community organizations, we serve our neighbors through our Medi-Cal and Cal MediConnect (Medicare-Medicaid Plan) health insurance plans.

## MEMBER DEMOGRAPHICS

### 272,427

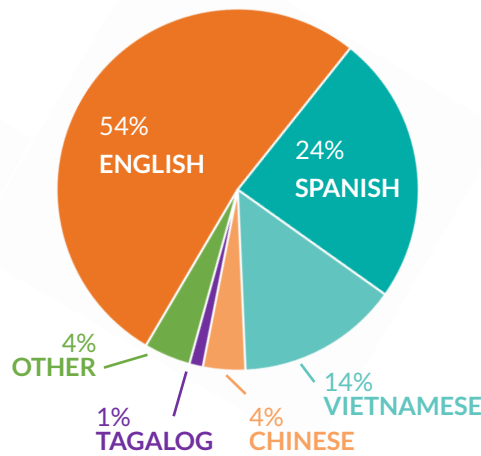
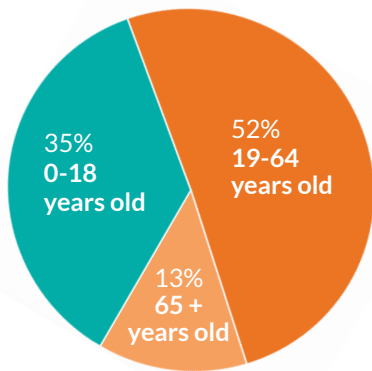
Medi-Cal Members

### 33.3%

of our Medi-Cal members are covered through ACA expansion

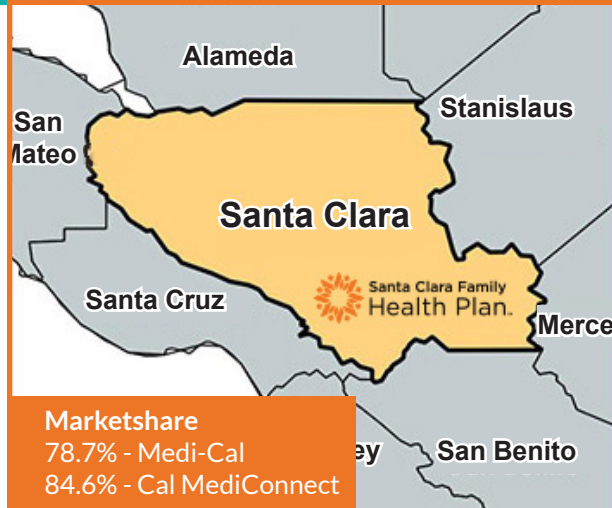
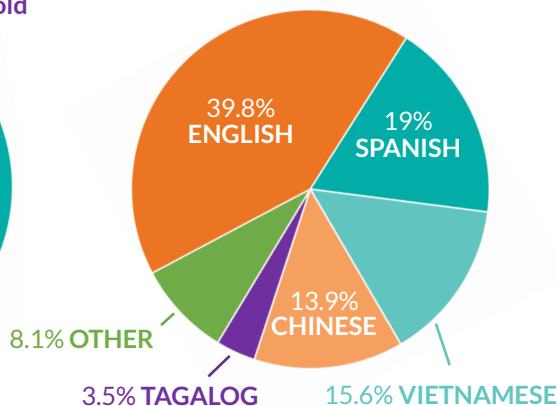
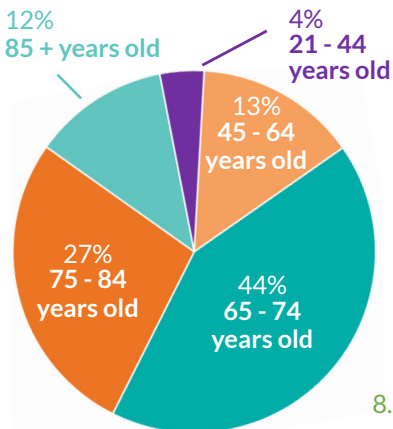
### 1.64

average # of kids enrolled with SCFHP per family



### 10,161

Cal MediConnect (Medicare-Medicaid Plan) Members



## CONTRACTED PROVIDERS

**Primary Care Physicians**  
826 Medi-Cal  
543 Cal MediConnect

**Specialists**  
4,248 Medi-Cal  
3,068 Cal MediConnect

**Ancillaries**  
836 Medi-Cal  
253 Cal MediConnect

SCFHP is contracted with **all hospitals** in Santa Clara County, giving our members access to care that is convenient for them.

### 94 ¢

of every \$1 pays for benefits and services

### 6 ¢

of every \$1 funds administration

### >\$1 B

invested in local economy each year

Budget FY 20-21



Santa Clara Family  
Health Plan™

Unaudited Financial Statements  
For The Ten Months Ended April 30, 2021

# Agenda

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# Financial Highlights



	<u>MTD</u>		<u>YTD</u>	
Revenue	\$104 M		\$1.05 B	
Medical Expense (MLR)	\$93 M	89.4%	\$972 M	92.7%
Administrative Expense (% Rev)	\$5.1 M	4.9%	\$54.1 M	5.2%
Other Income/(Expense)	\$259K		\$110K	
<b>Net Surplus (Net Loss)</b>	<b>\$6.3 M</b>		<b>\$22.7 M</b>	
Cash and Investments			\$393 M	
Receivables			\$729 M	
Total Current Assets			\$1,133 M	
Current Liabilities			\$934 M	
Current Ratio			1.21	
Tangible Net Equity			\$231 M	
% of DMHC Requirement			<b>679.3%</b>	

# Financial Highlights

<b>Net Surplus (Net Loss)</b>	<ul style="list-style-type: none"> <li>▶ Month: Surplus of \$6.3M is \$8.9M or 338.1% favorable to budget of \$2.6M loss.</li> <li>▶ YTD: Surplus of \$22.7M is \$30.5M or 389.0% favorable to budget of \$7.8M loss.</li> </ul>
<b>Enrollment</b>	<ul style="list-style-type: none"> <li>▶ Month: Membership was 278,967 (7,994 or 3.0% higher than budget of 270,973).</li> <li>▶ YTD: Member Months YTD was 2,689,731 (10,599 or 0.4% lower than budget of 2,700,330).</li> </ul>
<b>Revenue</b>	<ul style="list-style-type: none"> <li>▶ Month: \$104.4M (\$13.6M or 14.9% favorable to budget of \$90.9M).</li> <li>▶ YTD: \$1.05B (\$83.9M or 8.7% favorable to budget of \$964.5M).</li> </ul>
<b>Medical Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$93.3M (\$5.1M or 5.8% unfavorable to budget of \$88.2M).</li> <li>▶ YTD: \$971.7M (\$52.8M or 5.7% unfavorable to budget of \$918.9M).</li> </ul>
<b>Administrative Expenses</b>	<ul style="list-style-type: none"> <li>▶ Month: \$5.1M (\$457K or 8.2% favorable to budget of \$5.6M).</li> <li>▶ YTD: \$54.1M (\$1.8M or 3.3% favorable to budget of \$55.9M).</li> </ul>
<b>Tangible Net Equity</b>	<ul style="list-style-type: none"> <li>▶ TNE was \$231.3M (represents approximately two months of total expenses).</li> </ul>
<b>Capital Expenditures</b>	<ul style="list-style-type: none"> <li>▶ YTD Capital Investments of \$3.8M vs. \$6.9M annual budget, primarily Community Resource Center.</li> </ul>



Santa Clara Family  
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Detail Analyses

# Enrollment

- Total enrollment of 278,967 members is 7,994 or 3.0% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 25,092 members or 9.9%.
- Medi-Cal enrollment has been increasing since January 2020, largely due to COVID (beginning in March 2020 annual eligibility redeterminations were suspended and enrollment continues to increase).
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 10.5%, Medi-Cal Dual enrollment has increased 4.1%, and CMC enrollment has grown 10.4% also due largely to the suspension of disenrollments.

	For the Month April 2021				For Ten Months Ending April 30, 2021				Prior Year Actuals	Δ FY21 vs. FY20
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)		
Medi-Cal	269,043	261,544	7,499	2.9%	2,593,435	2,608,205	(14,770)	(0.6%)	2,354,674	10.1%
Cal Medi-Connect	9,924	9,429	495	5.2%	96,296	92,125	4,171	4.5%	83,567	15.2%
<b>Total</b>	<b>278,967</b>	<b>270,973</b>	<b>7,994</b>	<b>3.0%</b>	<b>2,689,731</b>	<b>2,700,330</b>	<b>(10,599)</b>	<b>(0.4%)</b>	<b>2,438,241</b>	<b>10.3%</b>

## Santa Clara Family Health Plan Enrollment By Network April 2021

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	33,536	12%	9,924	100%	43,460	16%
SCVHHS <sup>1</sup> , Safety Net Clinics, FQHC <sup>2</sup> Clinics	134,926	50%	-	0%	134,926	48%
Palo Alto Medical Foundation	7,277	3%	-	0%	7,277	3%
Physicians Medical Group	45,945	17%	-	0%	45,945	16%
Premier Care	15,941	6%	-	0%	15,941	6%
Kaiser	31,418	12%	-	0%	31,418	11%
<b>Total</b>	<b>269,043</b>	<b>100%</b>	<b>9,924</b>	<b>100%</b>	<b>278,967</b>	<b>100%</b>
Enrollment at June 30, 2020	244,888		8,987		253,875	
Net Δ from Beginning of FY21	9.9%		10.4%		9.9%	

<sup>1</sup> SCVHHS = Santa Clara Valley Health & Hospital System

<sup>2</sup> FQHC = Federally Qualified Health Center



# Enrollment By Aid Category

## SCFHP TRENDED ENROLLMENT BY COA YTD APRIL-2021

		2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	FYTD var	%	
<b>NON DUAL</b>	Adult (over 19)	24,051	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	5,807	22.1%	
	Child (under 19)	93,374	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	3,699	3.8%	
	Aged - Medi-Cal Only	10,801	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	11,459	11,509	302	2.7%	
	Disabled - Medi-Cal Only	10,851	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	10,811	10,772	-150	(1.4%)	
	Adult Expansion	70,458	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	13,482	18.1%	
	BCCTP	11	11	11	11	11	11	11	11	11	11	10	10	11	9	-2	(18.2%)
	Long Term Care	380	398	405	402	406	407	409	389	393	388	380	373	375	-30	(7.4%)	
	<b>Total Non-Duals</b>	<b>209,926</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>240,599</b>	<b>242,678</b>	<b>23,108</b>	<b>10.5%</b>	

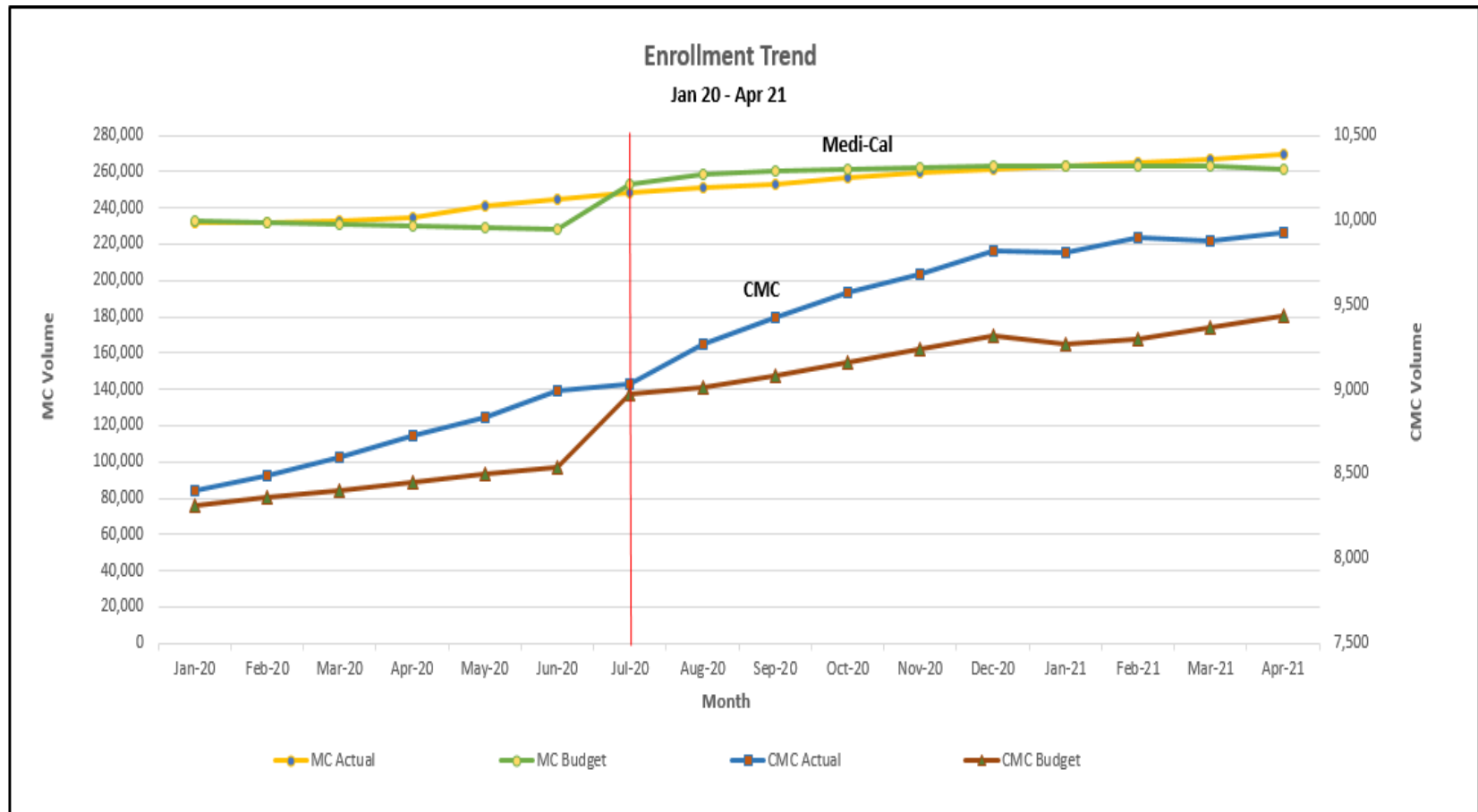
<b>DUAL</b>	Adult (21 Over)	311	320	321	327	320	337	354	353	353	352	355	361	357	36	11.2%
	SPD (21 Over)	23,443	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,168	660	2.8%
	Adult Expansion	134	190	241	261	289	358	410	498	537	590	662	742	802	561	232.8%
	Long Term Care	1,235	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	-210	(16.8%)
	<b>Total Duals</b>	<b>25,123</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>26,363</b>	<b>26,365</b>	<b>1,047</b>	<b>4.1%</b>

<b>Total Medi-Cal</b>	<b>235,049</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>	<b>269,043</b>	<b>24,155</b>	<b>9.9%</b>
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<b>CMC</b>	CMC Non-Long Term Care	8,511	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	970	11.1%
	CMC - Long Term Care	214	212	212	215	211	216	210	209	207	193	187	184	179	-33	(15.6%)
	<b>Total CMC</b>	<b>8,725</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>	<b>9,924</b>	<b>937</b>	<b>10.4%</b>

<b>Total Enrollment</b>	<b>243,774</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>276,842</b>	<b>278,967</b>	<b>25,092</b>	<b>9.9%</b>
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# Enrollment Trend

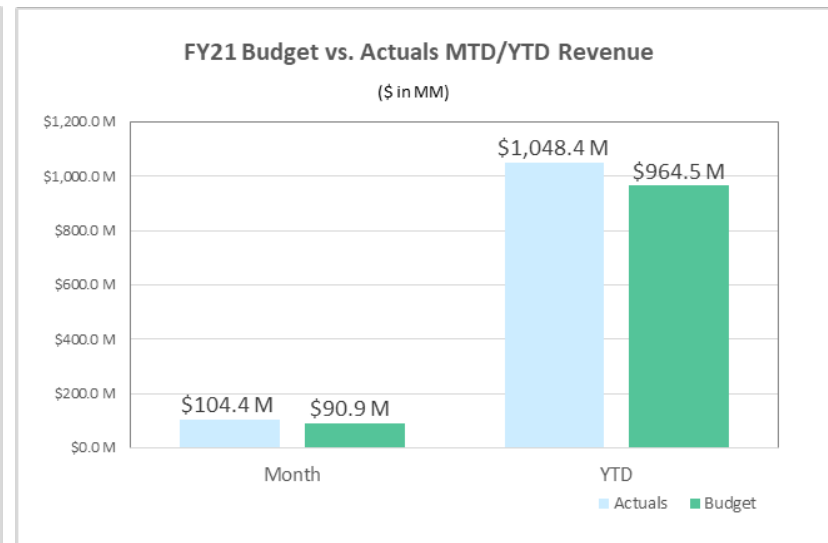
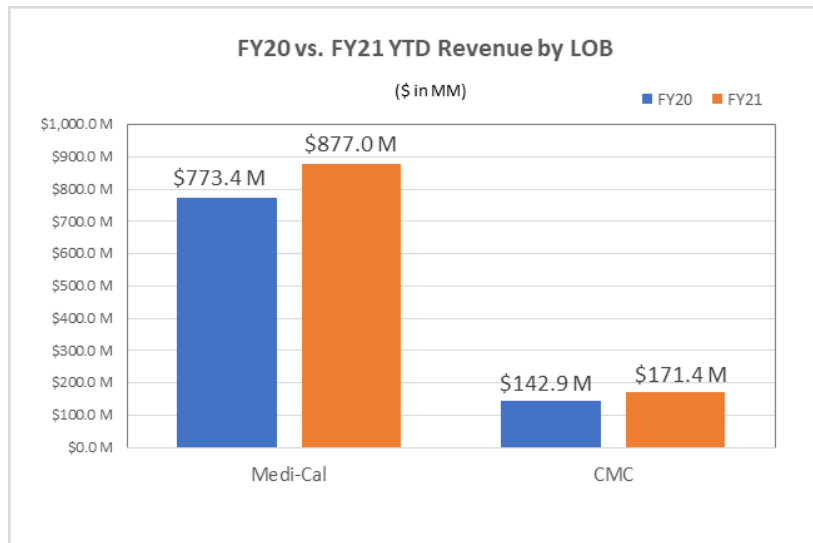


- Budgeted enrollment, represented by the green & brown lines, anticipated steep COVID enrollment growth early in the fiscal year followed by a general flattening.
- Actual enrollment, represented by the gold & blue lines, has grown steadily.

# Revenue

Current month revenue of \$104.4M was \$13.6M or 14.9% favorable to budget of \$90.9M. The current month variance was primarily due to the following:

- MCAL Non-Dual revenue was \$14.9M net favorable to budget primarily due to the pharmacy carve-out delay (with associated medical expense increase) versus budget, coupled with favorable enrollment & rate variances in the primary categories of aid.
- MCAL Dual MLTSS revenue was \$610K net unfavorable. Favorable current month enrollment and rate variances were more than offset by a revision to the estimated CY21 mix corridor accrual.
- MCAL supplemental kick revenue was \$1.5M favorable to budget due to increased utilization in the behavioral health & health homes programs plus unbudgeted Hep-C utilization.
- CMC revenue was \$2.2M unfavorable. Favorable current month enrollment and MCAL rate variances were more than offset by revisions to YTD Medicare Part C, Medicare quality withhold and MCAL mix corridor estimates.

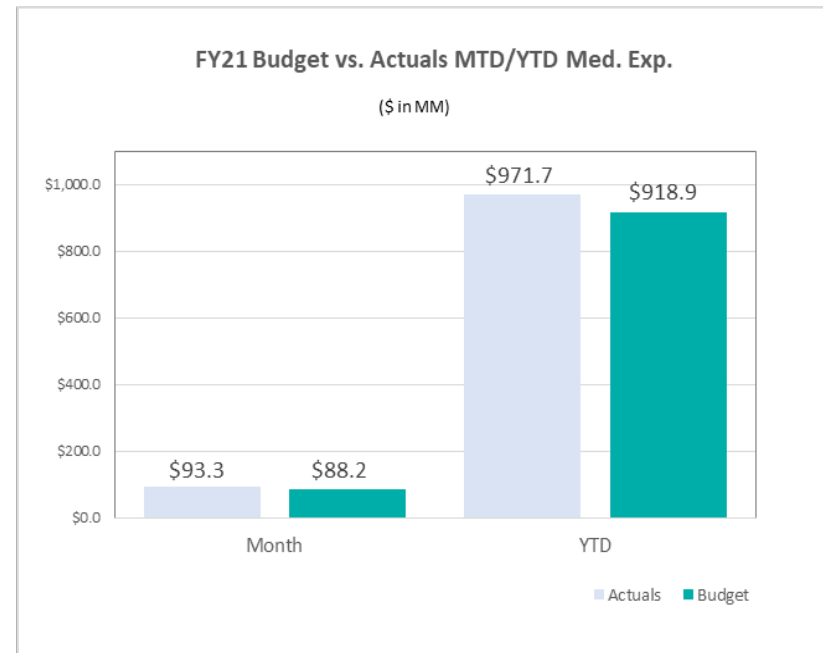
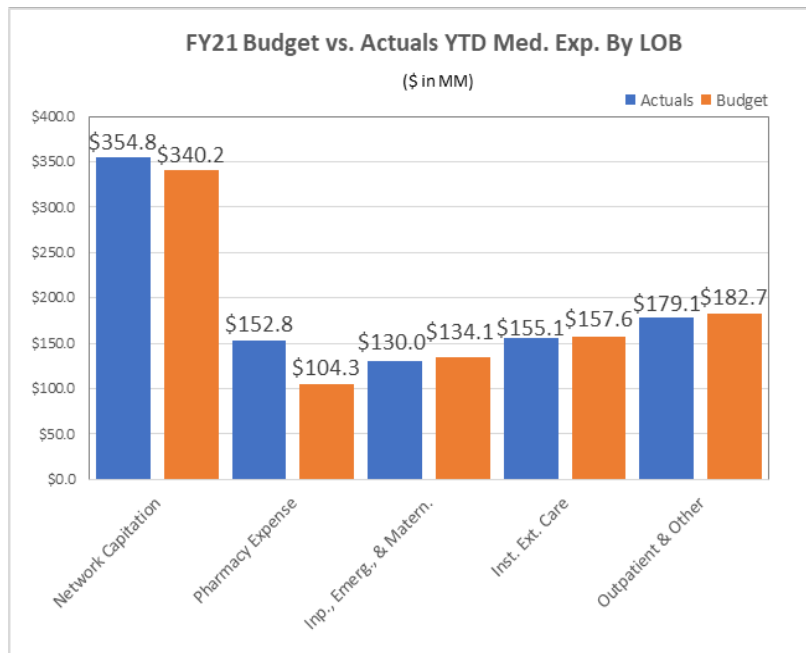


# Medical Expense

Current month medical expense of \$93.3M was \$5.1M or 5.8% unfavorable to budget of \$88.2M.

The current month variance was due largely to:

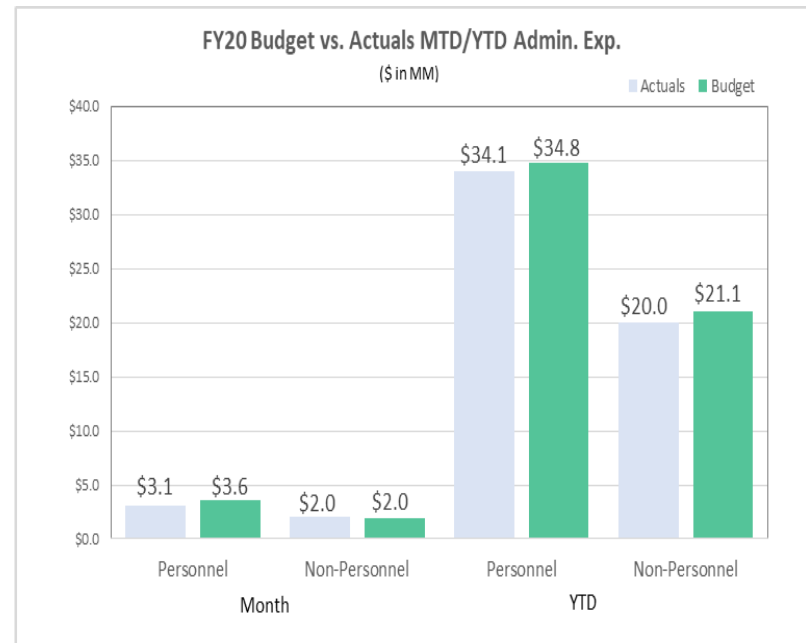
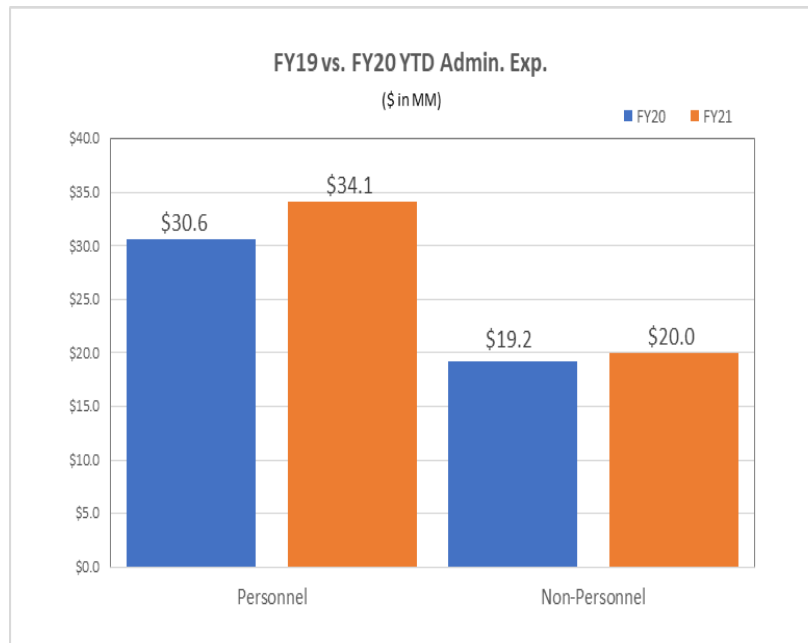
- Pharmacy expenses were \$11.9M unfavorable to budget due to postponement of the pharmacy carve-out from managed care (offset with favorable revenue variance).
- Fee-For-Service expenses reflected an \$8.4M or 18.2% favorable variance due to a general downward trend of utilization during COVID reflected in lower IBNR estimates and lower LTC enrollment & utilization.
- Capitation expense was \$1.7M or 4.8% unfavorable to budget due to higher CY21 capitation rates and increased enrollment.



# Administrative Expense

Current month expense of \$5.1M was \$457K or 8.2% favorable to budget of \$5.6M. The current month variances were primarily due to the following:

- Personnel expenses were \$511K or 14.3% favorable to budget due to lower headcount than budget, partly offset by increased retirement expense accruals.
- Non-Personnel expenses were \$53K or 2.7% favorable to budget due to timing of budgeted spending in certain larger categories of expense.



# Balance Sheet

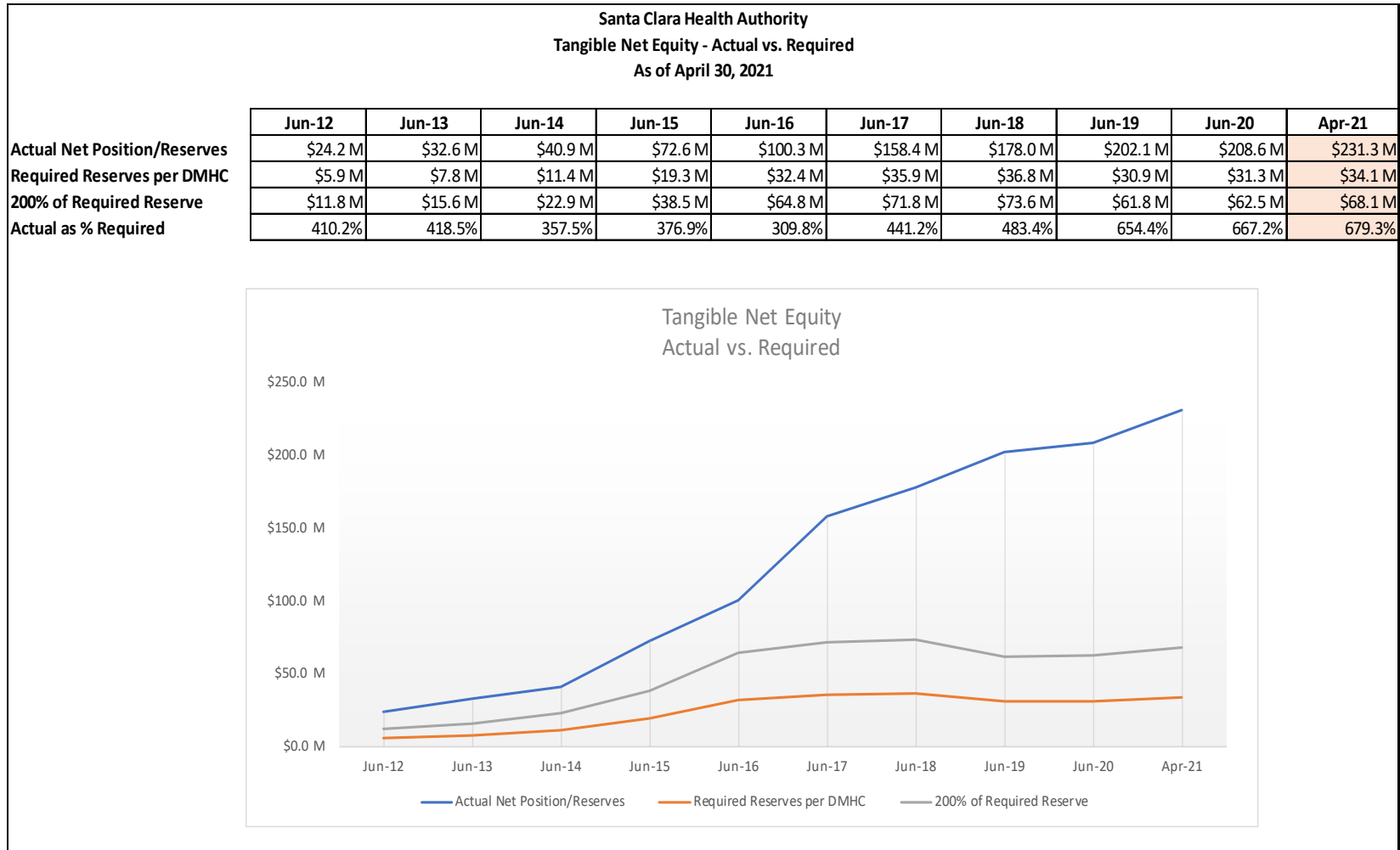
- Current assets totaled \$1.1B compared to current liabilities of \$934.2M, yielding a current ratio (Current Assets/Current Liabilities) of 1.21:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by \$59.3M compared to the cash balance as of year-end June 30, 2020 due to the timing of inflows and outflows.
- Current Cash & Equivalents components and yields were as follows:

Description	Cash & Investments	Current Yield %	Interest Income	
			Month	YTD
<b>Short-Term Investments</b>				
County of Santa Clara Comingled Pool	\$157,013,467	0.85%	\$100,000	\$1,221,175
Wells Fargo Investments	\$204,480,502	0.15%	\$32,786	\$261,252
	<u>\$361,493,968</u>		<u>\$132,786</u>	<u>\$1,482,428</u>
<b>Cash &amp; Equivalents</b>				
Bank of the West Money Market	\$79,106	0.10%	\$297	\$13,420
Wells Fargo Bank Accounts	\$31,394,862	0.01%	\$391	\$5,327
	<u>\$31,473,968</u>		<u>\$689</u>	<u>\$18,746</u>
<b>Assets Pledged to DMHC</b>				
Restricted Cash	\$325,000	0.18%	\$132	\$1,238
<b>Petty Cash</b>				
	\$500	0.00%	\$0	\$0
<b>Month-End Balance</b>	<u><b>\$393,293,437</b></u>		<u><b>\$133,607</b></u>	<u><b>\$1,502,412</b></u>

- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- Overall cash and investment yield is lower than budget (0.42% actual vs. 1.4% budgeted).

# Tangible Net Equity

- TNE was \$231.3M - representing approximately two months of the Plan's total expenses.



# Reserves Analysis

SCFHP RESERVES ANALYSIS APRIL 2021				
Financial Reserve Target #1: Tangible Net Equity				
	Board Funds Committed	Approved Projects	Funds Expended	Balance
<b>Unrestricted Net Assets</b>				<b>\$186,443,965 *</b>
Board Designated Funds (Note 1):				
Special Project Funding for CBOs	\$4,000,000	\$961,743	\$662,727	\$3,337,274
Innovation & COVID-19 Fund	\$16,000,000	\$4,690,000	\$2,169,999	\$13,830,001
Subtotal	\$20,000,000	\$5,651,743	\$2,832,726	\$17,167,275
Net Book Value of Fixed Assets				\$27,379,755
Restricted Under Knox-Keene Agreement				\$325,000
<b>Total Tangible Net Equity (TNE)</b>				<b>\$231,315,994</b>
Current Required TNE				\$34,054,052
TNE %				679.3%
<b>SCFHP Target TNE Range:</b>				
350% of Required TNE (Low)				\$119,189,181
500% of Required TNE (High)				\$170,270,259
<b>Total TNE Above/(Below) SCFHP Low Target</b>				<b>\$112,126,812</b>
<b>Total TNE Above/(Below) High Target</b>				<b>\$61,045,735</b>
Financial Reserve Target #2: Liquidity				
Cash & Investments				\$393,293,437
Less Pass-Through Liabilities:				
Hospital Directed Payments				(179,964,789)
MCO Tax Payable to State of CA				(9,216,954)
Whole Person Care / Prop 56				(52,715,488)
Other Pass-Through Liabilities (Note 2)				(97,476,858)
<b>Total Pass-Through Liabilities</b>				<b>(339,374,089)</b>
Net Cash Available to SCFHP				<u>53,919,348</u>
SCFHP Target Liquidity (Note 3)				
45 Days of Total Operating Expense				(140,646,188)
60 Days of Total Operating Expense				(187,528,250)
Liquidity Above/(Below) SCFHP Low Target				<u>(86,726,840)</u>
Liquidity Above/(Below) High Target				<u><b>-\$133,608,903</b></u>

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

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

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

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



# Capital Expenditures

- Majority of the capital variances are Community Resource Center, hardware, software, and building improvements due to timing of certain projects.

Expenditure	YTD Actual	Annual Budget
Community Resource Center	\$2,841,628	\$3,507,100
Hardware	\$295,652	\$1,282,500
Software	\$181,703	\$1,194,374
Building Improvements	\$470,620	\$866,500
Furniture & Equipment	\$0	\$28,000
<b>TOTAL</b>	<b>\$3,789,603</b>	<b>\$6,878,474</b>



**Santa Clara Family  
Health Plan™**

Financial Statements

# Income Statement



## Santa Clara County Health Authority INCOME STATEMENT For Ten Months Ending April 30, 2021

	Apr-2021		% of		Apr-2021		% of		Current Month Variance		YTD Apr-2021		% of		YTD Apr-2021		% of		YTD Variance		
	Actuals	Rev	Budget	Rev	\$	%	Actuals	Rev	Budget	Rev	\$	%	Actuals	Rev	Budget	Rev	\$	%			
<b>REVENUES</b>																					
MEDI-CAL	\$ 89,929,003	86.1%	\$ 74,188,547	81.6%	\$ 15,740,456	21.2%	\$ 876,984,367	83.7%	\$ 802,190,632	83.2%	\$ 74,793,734	9.3%									
CMC MEDI-CAL	2,906,257	2.8%	2,928,333	3.2%	(22,076)	-0.8%	37,401,602	3.6%	29,281,348	3.0%	8,120,255	27.7%									
CMC MEDICARE	11,605,027	11.1%	13,770,866	15.2%	(2,165,839)	-15.7%	133,999,419	12.8%	133,061,797	13.8%	937,622	0.7%									
TOTAL CMC	14,511,285	13.9%	16,699,199	18.4%	(2,187,915)	-13.1%	171,401,021	16.3%	162,343,145	16.8%	9,057,877	5.6%									
<b>TOTAL REVENUE</b>	<b>\$ 104,440,287</b>	<b>100.0%</b>	<b>\$ 90,887,746</b>	<b>100.0%</b>	<b>\$ 13,552,541</b>	<b>14.9%</b>	<b>\$ 1,048,385,388</b>	<b>100.0%</b>	<b>\$ 964,533,777</b>	<b>100.0%</b>	<b>\$ 83,851,611</b>	<b>8.7%</b>									
<b>MEDICAL EXPENSES</b>																					
MEDI-CAL	\$ 78,662,778	75.3%	\$ 72,552,875	79.8%	\$ (6,109,903)	-8.4%	\$ 816,441,128	77.9%	\$ 765,700,284	79.4%	\$ (50,740,844)	-6.6%									
CMC MEDI-CAL	2,335,951	2.2%	3,048,564	3.4%	712,612	23.4%	28,907,360	2.8%	30,188,941	3.1%	1,281,580	4.2%									
CMC MEDICARE	12,342,567	11.8%	12,602,510	13.9%	259,943	2.1%	126,376,301	12.1%	123,046,032	12.8%	(3,330,269)	-2.7%									
TOTAL CMC	14,678,519	14.1%	15,651,074	17.2%	972,555	6.2%	155,283,661	14.8%	153,234,972	15.9%	(2,048,689)	-1.3%									
HEALTHY KIDS	0	0.0%	0	0.0%	0	0.0%	7,303	0.0%	0	0.0%	(7,303)	0.0%									
<b>TOTAL MEDICAL EXPENSES</b>	<b>\$ 93,341,296</b>	<b>89.4%</b>	<b>\$ 88,203,949</b>	<b>97.0%</b>	<b>\$ (5,137,347)</b>	<b>-5.8%</b>	<b>\$ 971,732,092</b>	<b>92.7%</b>	<b>\$ 918,935,256</b>	<b>95.3%</b>	<b>\$ (52,796,836)</b>	<b>-5.7%</b>									
<b>MEDICAL OPERATING MARGIN</b>	<b>\$ 11,098,991</b>	<b>10.6%</b>	<b>\$ 2,683,797</b>	<b>3.0%</b>	<b>\$ 8,415,194</b>	<b>313.6%</b>	<b>\$ 76,653,296</b>	<b>7.3%</b>	<b>\$ 45,598,521</b>	<b>4.7%</b>	<b>\$ 31,054,775</b>	<b>68.1%</b>									
<b>ADMINISTRATIVE EXPENSE</b>																					
SALARIES AND BENEFITS	\$ 3,071,195	2.9%	\$ 3,581,753	3.9%	\$ 510,558	14.3%	\$ 34,079,191	3.3%	\$ 34,821,237	3.6%	\$ 742,046	2.1%									
RENTS AND UTILITIES	47,167	0.0%	43,275	0.0%	(3,892)	-9.0%	405,543	0.0%	379,835	0.0%	(25,709)	-6.8%									
PRINTING AND ADVERTISING	38,624	0.0%	77,429	0.1%	38,805	50.1%	216,943	0.0%	745,517	0.1%	528,573	70.9%									
INFORMATION SYSTEMS	275,303	0.3%	354,989	0.4%	79,686	22.4%	2,761,728	0.3%	3,423,889	0.4%	662,161	19.3%									
PROF FEES/CONSULTING/TEMP STAFFING	1,026,839	1.0%	871,217	1.0%	(155,622)	-17.9%	9,567,978	0.9%	9,481,941	1.0%	(86,037)	-0.9%									
DEPRECIATION/INSURANCE/EQUIPMENT	367,730	0.4%	382,265	0.4%	14,535	3.8%	3,582,646	0.3%	3,629,069	0.4%	46,424	1.3%									
OFFICE SUPPLIES/POSTAGE/TELEPHONE	41,661	0.0%	66,006	0.1%	24,346	36.9%	662,938	0.1%	651,698	0.1%	(11,240)	-1.7%									
MEETINGS/TRAVEL/DUES	82,582	0.1%	103,449	0.1%	20,867	20.2%	821,372	0.1%	1,092,191	0.1%	270,819	24.8%									
OTHER	151,745	0.1%	79,792	0.1%	(71,953)	-90.2%	1,990,238	0.2%	1,702,020	0.2%	(288,218)	-16.9%									
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<b>\$ 5,102,846</b>	<b>4.9%</b>	<b>\$ 5,560,176</b>	<b>6.1%</b>	<b>\$ 457,330</b>	<b>8.2%</b>	<b>\$ 54,088,578</b>	<b>5.2%</b>	<b>\$ 55,927,397</b>	<b>5.8%</b>	<b>\$ 1,838,820</b>	<b>3.3%</b>									
<b>OPERATING SURPLUS (LOSS)</b>	<b>\$ 5,996,145</b>	<b>5.7%</b>	<b>\$ (2,876,379)</b>	<b>-3.2%</b>	<b>\$ 8,872,524</b>	<b>308.5%</b>	<b>\$ 22,564,718</b>	<b>2.2%</b>	<b>\$ (10,328,877)</b>	<b>-1.1%</b>	<b>\$ 32,893,595</b>	<b>318.5%</b>									
GASB 75 - POST EMPLOYMENT BENEFITS EXPENSE	\$ 65,750	0.1%	\$ 60,000	0.1%	\$ (5,750)	-9.6%	\$ 785,721	0.1%	\$ 600,000	0.1%	\$ (185,721)	-31.0%									
GASB 68 - UNFUNDED PENSION LIABILITY	(156,500)	-0.1%	75,000	0.1%	231,500	308.7%	1,602,458	0.2%	750,000	0.1%	(852,458)	-113.7%									
<b>NON-OPERATING EXPENSES</b>	<b>\$ (90,750)</b>	<b>-0.1%</b>	<b>\$ 135,000</b>	<b>0.1%</b>	<b>\$ 225,750</b>	<b>167.2%</b>	<b>\$ 2,388,179</b>	<b>0.2%</b>	<b>\$ 1,350,000</b>	<b>0.1%</b>	<b>\$ (1,038,179)</b>	<b>-76.9%</b>									
INTEREST & INVESTMENT INCOME	\$ 133,607	0.1%	\$ 350,000	0.4%	\$ (216,393)	-61.8%	\$ 1,502,412	0.1%	\$ 3,500,000	0.4%	\$ (1,997,588)	-57.1%									
OTHER INCOME	35,100	0.0%	33,668	0.0%	1,432	4.3%	996,256	0.1%	333,592	0.0%	662,665	198.6%									
<b>NON-OPERATING INCOME</b>	<b>\$ 168,706</b>	<b>0.2%</b>	<b>\$ 383,668</b>	<b>0.4%</b>	<b>\$ (214,962)</b>	<b>-56.0%</b>	<b>\$ 2,498,668</b>	<b>0.2%</b>	<b>\$ 3,833,592</b>	<b>0.4%</b>	<b>\$ (1,334,924)</b>	<b>-34.8%</b>									
<b>NET NON-OPERATING ACTIVITIES</b>	<b>\$ 259,456</b>	<b>0.2%</b>	<b>\$ 248,668</b>	<b>0.3%</b>	<b>\$ 10,788</b>	<b>4.3%</b>	<b>\$ 110,489</b>	<b>0.0%</b>	<b>\$ 2,483,592</b>	<b>0.3%</b>	<b>\$ (2,373,103)</b>	<b>-95.6%</b>									
<b>NET SURPLUS (LOSS)</b>	<b>\$ 6,255,601</b>	<b>6.0%</b>	<b>\$ (2,627,711)</b>	<b>-2.9%</b>	<b>\$ 8,883,312</b>	<b>338.1%</b>	<b>\$ 22,675,207</b>	<b>2.2%</b>	<b>\$ (7,845,285)</b>	<b>-0.8%</b>	<b>\$ 30,520,492</b>	<b>389.0%</b>									

# Balance Sheet



**SANTA CLARA COUNTY HEALTH AUTHORITY**  
As of April 30, 2021

	Apr-2021	Mar-2021	Feb-2021	Apr-2020
<b>Assets</b>				
<b>Current Assets</b>				
Cash and Investments	393,293,437	520,024,777	362,000,143	373,998,823
Receivables	729,385,339	507,477,386	650,794,128	512,264,590
Prepaid Expenses and Other Current Assets	10,329,799	9,506,927	8,901,299	10,805,210
<b>Total Current Assets</b>	<b>1,133,008,575</b>	<b>1,037,009,089</b>	<b>1,021,695,570</b>	<b>897,068,624</b>
<b>Long Term Assets</b>				
Property and Equipment	51,175,489	51,142,872	51,070,144	46,874,600
Accumulated Depreciation	(23,795,734)	(23,463,932)	(23,133,032)	(20,234,109)
Total Long Term Assets	27,379,755	27,678,940	27,937,112	26,640,491
<b>Total Assets</b>	<b>1,160,388,330</b>	<b>1,064,688,028</b>	<b>1,049,632,682</b>	<b>923,709,114</b>
<b>Deferred Outflow of Resources</b>				
	<b>8,402,260</b>	<b>8,402,260</b>	<b>8,402,260</b>	<b>9,237,609</b>
<b>Total Assets &amp; Deferred Outflows</b>	<b>1,168,790,590</b>	<b>1,073,090,288</b>	<b>1,058,034,942</b>	<b>932,946,723</b>
<b>Liabilities and Net Assets:</b>				
<b>Current Liabilities</b>				
Trade Payables	6,233,361	6,086,219	8,087,827	11,118,630
Deferred Rent	48,928	48,757	48,585	0
Employee Benefits	3,158,835	3,097,436	3,002,306	2,013,844
Retirement Obligation per GASB 75	2,899,618	2,833,868	2,768,118	3,288,233
Deferred Revenue - Medicare	13,231,624	0	0	262,932
Whole Person Care / Prop 56	52,715,488	49,776,444	49,144,350	35,440,767
Payable to Hospitals (SB90)	103,805	104,014	20,688	0
Payable to Hospitals (SB208)	179,860,984	124,936,215	124,936,215	0
Pass-Throughs Payable	43,742,187	330,470	330,470	39,857,332
Due to Santa Clara County Valley Health Plan and Kaiser	29,440,619	29,732,966	29,466,215	32,843,615
MCO Tax Payable - State Board of Equalization	9,216,954	27,447,737	18,230,783	32,410,280
Due to DHCS	53,734,670	53,630,663	52,760,437	38,041,327
Liability for In Home Support Services (IHSS)	419,268,582	419,268,582	419,268,582	416,092,527
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
Medical Cost Reserves	112,260,630	119,021,715	117,508,759	105,190,703
<b>Total Current Liabilities</b>	<b>934,210,311</b>	<b>844,609,111</b>	<b>833,867,361</b>	<b>724,854,213</b>
<b>Non-Current Liabilities</b>				
Net Pension Liability GASB 68	1,602,458	1,758,957.68	1,915,458	709,914
<b>Total Non-Current Liabilities</b>	<b>1,602,458</b>	<b>1,758,957.68</b>	<b>1,915,458</b>	<b>709,914</b>
<b>Total Liabilities</b>	<b>935,812,769</b>	<b>846,368,069</b>	<b>835,782,819</b>	<b>725,564,127</b>
<b>Deferred Inflow of Resources</b>				
	<b>1,661,827</b>	<b>1,661,827</b>	<b>1,661,827</b>	<b>2,994,548</b>
<b>Net Assets</b>				
Board Designated Fund: Special Project Funding for CBOs	3,337,274	3,337,274	3,337,274	3,459,274
Board Designated Fund: Innovation & COVID-19 Fund	13,830,001	13,830,001	13,830,001	13,950,001
Invested in Capital Assets (NBV)	27,379,755	27,678,940	27,937,112	26,640,491
Restricted under Knox-Keene agreement	325,000	425,000	425,000	305,350
Unrestricted Net Equity	163,768,758	163,369,573	163,111,401	157,770,638
Current YTD Income (Loss)	22,675,207	16,419,606	11,949,509	2,262,295
<b>Total Net Assets / Reserves</b>	<b>231,315,994</b>	<b>225,060,393</b>	<b>220,590,296</b>	<b>204,388,048</b>
<b>Total Liabilities, Deferred Inflows and Net Assets</b>	<b>1,168,790,590</b>	<b>1,073,090,288</b>	<b>1,058,034,942</b>	<b>932,946,723</b>

# Cash Flow Statement



	<u>Apr-2021</u>	<u>Year-to-date</u>
Cash Flows from Operating Activities		
Premiums Received	(135,594,442)	1,087,898,454
Medical Expenses Paid	(100,394,729)	(952,081,069)
Administrative Expenses Paid	109,121,741	(75,192,482)
<b>Net Cash from Operating Activities</b>	<b>(126,867,429)</b>	<b>60,624,903</b>
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	(32,617)	(3,789,603)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	168,706	2,498,668
<b>Net Increase/(Decrease) in Cash &amp; Cash Equivalents</b>	<b>(126,731,340)</b>	<b>59,333,967</b>
Cash & Investments (Beginning)	520,024,777	333,959,470
Cash & Investments (Ending)	<b>393,293,437</b>	<b>393,293,437</b>
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Income/(Loss)	6,086,895	20,176,539
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	331,802	3,058,936
Changes in Operating Assets/Liabilities		
Premiums Receivable	(221,907,954)	81,621,377
Prepays & Other Assets	(822,873)	(466,100)
Accounts Payable & Accrued Liabilities	114,781,408	(22,911,019)
State Payable	(18,126,776)	(42,108,311)
IGT, HQAF & Other Provider Payables	(292,347)	(5,504,456)
Net Pension Liability	(156,500)	1,602,458
Medical Cost Reserves & PDR	(6,761,085)	25,155,479
<b>Total Adjustments</b>	<b>(132,954,324)</b>	<b>40,448,364</b>
<b>Net Cash from Operating Activities</b>	<b>(126,867,429)</b>	<b>60,624,903</b>

# Statement of Operations by Line of Business - YTD



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

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
<b>P&amp;L (ALLOCATED BASIS)</b>					
REVENUE	\$876,984,367	\$37,401,602	\$133,999,419	\$171,401,021	<b>\$1,048,385,388</b>
<b>MEDICAL EXPENSE</b>	<b>\$816,441,128</b>	<b>\$28,907,360</b>	<b>\$126,376,301</b>	<b>\$155,283,661</b>	<b>\$971,732,092</b>
(MLR)	93.1%	77.3%	94.3%	90.6%	92.7%
<b>GROSS MARGIN</b>	<b>\$60,543,239</b>	<b>\$8,494,242</b>	<b>\$7,623,118</b>	<b>\$16,117,360</b>	<b>\$76,653,296</b>
<b>ADMINISTRATIVE EXPENSE</b>	<b>\$45,245,611</b>	<b>\$1,929,633</b>	<b>\$6,913,334</b>	<b>\$8,842,967</b>	<b>\$54,088,578</b>
(% of Revenue Allocation)					
<b>OPERATING INCOME/(LOSS)</b>	<b>\$15,297,628</b>	<b>\$6,564,609</b>	<b>\$709,784</b>	<b>\$7,274,393</b>	<b>\$22,564,718</b>
(% of Revenue Allocation)					
<b>OTHER INCOME/(EXPENSE)</b>	<b>\$92,425</b>	<b>\$3,942</b>	<b>\$14,122</b>	<b>\$18,064</b>	<b>\$110,489</b>
(% of Revenue Allocation)					
<b>NET INCOME/(LOSS)</b>	<b>\$15,390,053</b>	<b>\$6,568,550</b>	<b>\$723,907</b>	<b>\$7,292,457</b>	<b>\$22,675,207</b>
<b>PMPM (ALLOCATED BASIS)</b>					
REVENUE	\$338.16	\$388.40	\$1,391.54	\$1,779.94	<b>\$389.77</b>
MEDICAL EXPENSES	\$314.81	\$300.19	\$1,312.37	\$1,612.57	<b>\$361.27</b>
GROSS MARGIN	\$23.34	\$88.21	\$79.16	\$167.37	<b>\$28.50</b>
ADMINISTRATIVE EXPENSES	\$17.45	\$20.04	\$71.79	\$91.83	<b>\$20.11</b>
OPERATING INCOME/(LOSS)	\$5.90	\$68.17	\$7.37	\$75.54	<b>\$8.39</b>
OTHER INCOME/(EXPENSE)	\$0.04	\$0.04	\$0.15	\$0.19	<b>\$0.04</b>
NET INCOME/(LOSS)	\$5.93	\$68.21	\$7.52	\$75.73	<b>\$8.43</b>
<b>ALLOCATION BASIS:</b>					
MEMBER MONTHS - YTD	2,593,435	96,296	96,296	96,296	2,689,731
REVENUE BY LOB	83.7%	3.6%	12.8%	16.3%	100.0%



Santa Clara Family  
Health Plan™

Appendix

# Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD MAY-2021

		2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	FYTD var	%
<b>NON DUAL</b>	Adult (over 19)	25,253	26,299	27,066	27,877	28,269	29,181	29,835	30,327	30,750	31,307	31,711	32,106	32,577	6,278	23.9%
	Child (under 19)	95,145	96,173	96,605	97,359	97,629	98,409	98,930	99,012	99,172	99,377	99,557	99,872	100,245	4,072	4.2%
	Aged - Medi-Cal Only	11,044	11,207	11,227	11,178	11,229	11,263	11,328	11,385	11,463	11,451	11,459	11,509	11,535	328	2.9%
	Disabled - Medi-Cal Only	10,902	10,922	10,944	10,910	10,839	10,875	10,830	10,849	10,877	10,847	10,811	10,772	10,747	-175	(1.6%)
	Adult Expansion	72,546	74,553	76,262	77,701	79,263	80,654	82,060	83,250	84,477	85,477	86,677	88,035	89,361	14,808	19.9%
	BCCTP	11	11	11	11	11	11	11	11	10	10	11	9	9	-2	(18.2%)
	Long Term Care	398	405	402	406	407	409	389	393	388	380	373	375	367	-38	(9.4%)
	<b>Total Non-Duals</b>	<b>215,299</b>	<b>219,570</b>	<b>222,517</b>	<b>225,442</b>	<b>227,647</b>	<b>230,802</b>	<b>233,383</b>	<b>235,227</b>	<b>237,137</b>	<b>238,849</b>	<b>240,599</b>	<b>242,678</b>	<b>244,841</b>	<b>25,271</b>	<b>11.5%</b>

<b>DUAL</b>	Adult (21 Over)	320	321	327	320	337	354	353	353	352	355	361	357	365	44	13.7%
	SPD (21 Over)	23,595	23,508	23,641	23,686	23,654	23,687	23,760	23,988	23,899	24,155	24,206	24,168	24,146	638	2.7%
	Adult Expansion	190	241	261	289	358	410	498	537	590	662	742	802	863	622	258.1%
	Long Term Care	1,252	1,248	1,261	1,267	1,256	1,237	1,208	1,182	1,115	1,074	1,054	1,038	1,031	-217	(17.4%)
	<b>Total Duals</b>	<b>25,357</b>	<b>25,318</b>	<b>25,490</b>	<b>25,562</b>	<b>25,605</b>	<b>25,688</b>	<b>25,819</b>	<b>26,060</b>	<b>25,956</b>	<b>26,246</b>	<b>26,363</b>	<b>26,365</b>	<b>26,405</b>	<b>1,087</b>	<b>4.3%</b>

<b>Total Medi-Cal</b>	<b>240,656</b>	<b>244,888</b>	<b>248,007</b>	<b>251,004</b>	<b>253,252</b>	<b>256,490</b>	<b>259,202</b>	<b>261,287</b>	<b>263,093</b>	<b>265,095</b>	<b>266,962</b>	<b>269,043</b>	<b>271,246</b>	<b>26,358</b>	<b>10.8%</b>
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<b>CMC</b>	CMC Non-Long Term Care	8,625	8,775	8,814	9,055	9,212	9,360	9,470	9,613	9,614	9,706	9,696	9,745	9,809	1,034	11.8%
	CMC - Long Term Care	212	212	215	211	216	210	209	207	193	187	184	179	180	-32	(15.1%)
	<b>Total CMC</b>	<b>8,837</b>	<b>8,987</b>	<b>9,029</b>	<b>9,266</b>	<b>9,428</b>	<b>9,570</b>	<b>9,679</b>	<b>9,820</b>	<b>9,807</b>	<b>9,893</b>	<b>9,880</b>	<b>9,924</b>	<b>9,989</b>	<b>1,002</b>	<b>11.1%</b>

<b>Total Enrollment</b>	<b>249,493</b>	<b>253,875</b>	<b>257,036</b>	<b>260,270</b>	<b>262,680</b>	<b>266,060</b>	<b>268,881</b>	<b>271,107</b>	<b>272,900</b>	<b>274,988</b>	<b>276,842</b>	<b>278,967</b>	<b>281,235</b>	<b>27,360</b>	<b>10.8%</b>
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# Santa Clara Family Health Plan™

Fiscal Year 2021-2022  
Proposed Operating & Capital Budgets

Governing Board Meeting of June 24, 2021

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# FY22 Budget – General Context

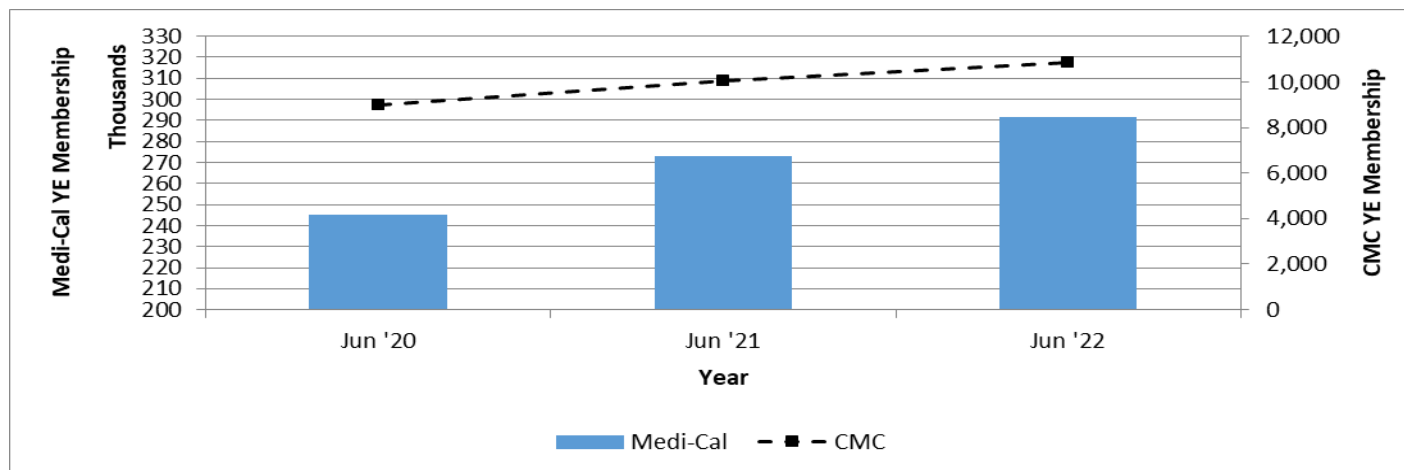
- **COVID:**
  - SCFHP still faces many unknowns as we emerge from the COVID pandemic.
  - Many areas of our budget may yet be affected.
- **State Budget:**
  - New Cal AIM programs: Enhanced Case Management (ECM), In Lieu of Services (ILOS) & major organ transplants commence in Medi-Cal in Jan-22.
  - CA state budget reinstated Prop 56 funds permanently.
  - Preparations have begun toward transition of CMC to D-SNP in Jan-23
- **SCFHP Budget:**
  - Implementation of New Cal AIM programs
  - Implementation of strategic initiatives and other projects.
  - Pharmacy presumed to continue in managed care for the entire fiscal year.
  - Mid-year budget reforecast will be reviewed with the Board.

# Major Changes & Updates

- **FY21 Significant Changes:**
  - Increased COVID enrollment was projected to return to normal by Dec-20.
  - Medi-Cal Risk adjustment was frozen at 25% plan-specific and 75% Countywide average.
  - DHCS provided Bridge period rates for Jul-20 through Dec-20 & calendar year rates effective Jan-21.
  - Pharmacy was to be carved out effective Apr-21, but continues.
  - CY21 CCI rates received were higher than anticipated.
  - Budgeted FY21 net loss of \$14M.
- **FY22 Updates:**
  - Enrollment is expected to increase through Dec-21 and fall thereafter as redeterminations resume.
  - 22,000 new Medi-Cal managed care mandatory members enrolled effective Jan-22.
  - COVID crisis is beginning to wind down & FFS utilization expected to rebound.
  - Budgeted FY22 net surplus of \$8.6M.

# Enrollment – Membership Assumptions

- **Medi-Cal Line of Business:**
  - FY22 budget assumes enrollment grows through Dec-21 and falls over CY22 due to the resumption of redeterminations.
  - New mandatory former FFS population merges into MCAL effective Jan-22.
  - Total MCAL membership is expected to increase from projected FYE 21 of 272,870 to 291,765 at FYE 22 (net increase of 6.9%).
- **Cal MediConnect Line of Business:**
  - As with MCAL, CMC enrollment grows and falls with redeterminations.
  - With continued outreach, CMC membership is expected to increase from the projected FYE 21 of 10,035 to 10,870 members at FYE 22 (net increase of 8.3%).



# Enrollment – Member Month Summary

	Jun 21	Jun 22	Variance	
	Projected	Budget	Increase/ (Decrease)	%
<b>NON DUALS</b>				
Adult Expansion	90,277	101,431	11,154	12.4%
Adult/Family (under 19)	100,097	104,862	4,765	4.8%
Adult/Family (over 19)	32,923	36,029	3,106	9.4%
SPD	22,285	22,669	384	1.7%
Long Term Care	400	400	0	0.0%
<b>Non-Dual Subtotal</b>	<b>245,982</b>	<b>265,391</b>	<b>19,409</b>	<b>7.9%</b>
<b>DUALS</b>				
Adult Expansion	985	1,015	30	3.0%
Adult/Family (21 over)	369	385	16	4.3%
SPD	24,359	23,799	(560)	(2.3%)
Long Term Care	1,175	1,175	0	0.0%
<b>Dual Subtotal</b>	<b>26,888</b>	<b>26,374</b>	<b>(514)</b>	<b>(1.9%)</b>
<b>Total Medi-Cal</b>	<b>272,870</b>	<b>291,765</b>	<b>18,895</b>	<b>6.9%</b>
<b>Cal MediConnect</b>	<b>10,035</b>	<b>10,870</b>	<b>835</b>	<b>8.3%</b>
<b>TOTAL ENROLLMENT</b>	<b>282,905</b>	<b>302,635</b>	<b>19,730</b>	<b>7.0%</b>

# Enrollment – Member Months

	Actual Member Months			Proj.	Budget
	FY18	FY19	FY20	FY21	FY22
Medi-Cal	3,073,184	2,904,840	2,829,691	3,137,551	3,472,434
<i>Annual Growth</i>	-4.5%	-5.5%	-2.6%	10.9%	10.7%
Cal MediConnect	88,970	92,838	101,391	116,320	126,920
<i>Annual Growth</i>	-3.7%	4.3%	9.2%	14.7%	9.1%
Healthy Kids	34,294	40,083	10,528	-	-
<b>Total</b>	<b>3,196,448</b>	<b>3,037,761</b>	<b>2,941,610</b>	<b>3,253,871</b>	<b>3,599,354</b>
<i>Annual Growth</i>	-4.5%	-5.0%	-3.2%	10.6%	10.6%
Average Covered Lives	266,371	253,147	245,134	271,156	299,946

# Revenue Assumptions

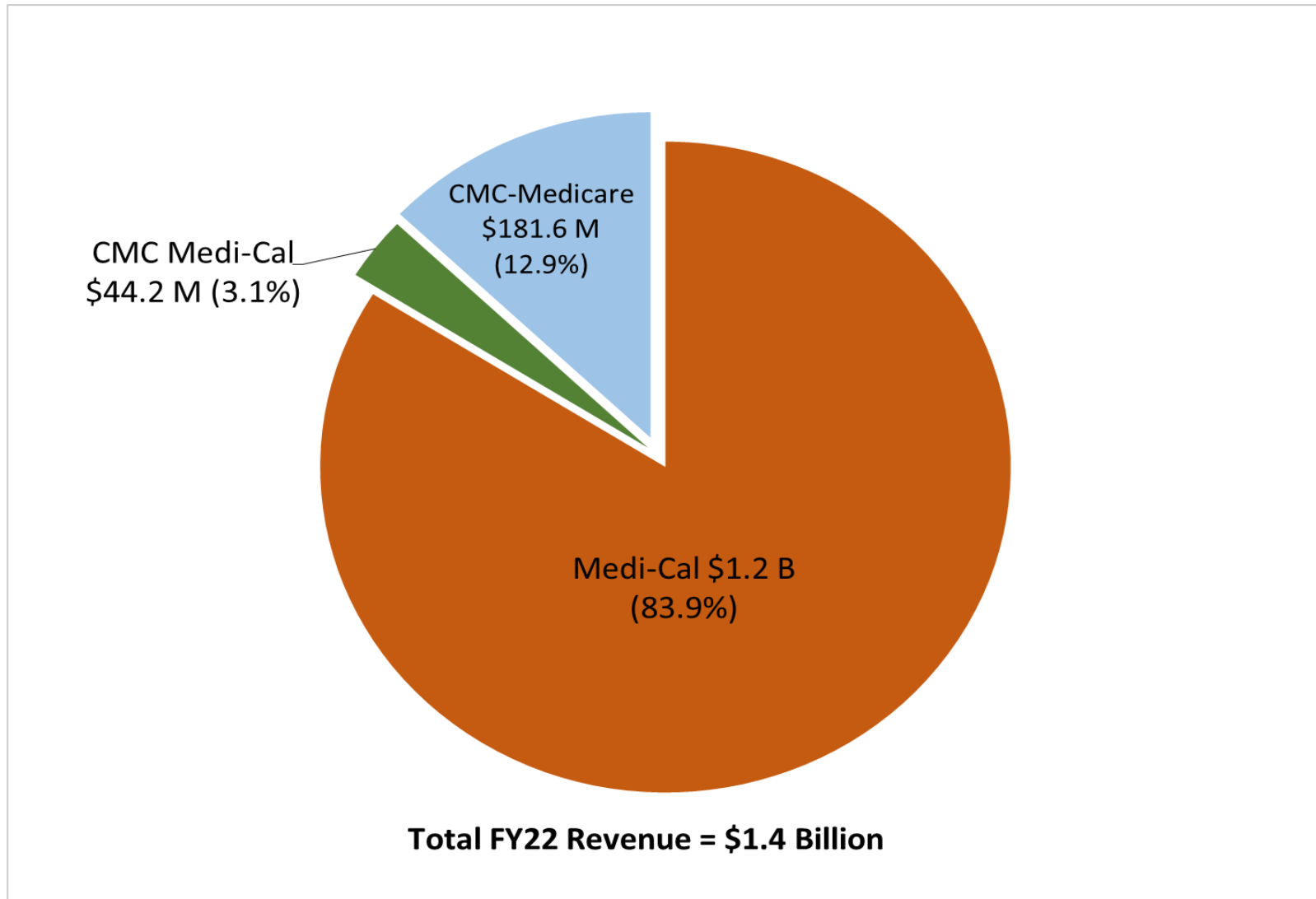
- Revenue is expected to increase from projected FY21 of \$1.262 billion to \$1.404 billion for FY22 due to a combination of factors:
- Enrollment:
  - Projected Medi-Cal enrollment increases 6.9% while projected CMC enrollment increases 8.3%.
  - Projected MC enrollment continues to grow in first half of FY22 and gradually decreases in second half.
  - Additional OHC members roll into Medi-Cal program.
- Rates:
  - Medi-Cal Non-Dual & MLTSS CY21 Rates:
    - Includes pharmacy benefits for calendar year.
    - Risk adjustment at 25% plan-specific and 75% Countywide average.
    - Rates reflected an average 3.8% increase compared to Bridge Period.
  - Medi-Cal Non-Dual & MLTSS CY22 Rates:
    - CY22 rates will not be finalized until December 2021.
    - Rates reflect an estimated 1.6% reduction.
    - ECM increment added. No additional revenue for ILOS.



# Revenue Assumptions (continued)

- Cal MediConnect Medi-Cal Rates:
  - CY21 – increased by 4.5%
  - CY22 – estimated decrease by 8.3% including 1% QWH and 5% conservatism.
- Cal MediConnect Medicare Rates:
  - CY21: Based on actual PMPM for Jan-June 2021 less 1% net quality withhold.
  - CY22: Based on the CY22 draft rates from Medicare and Jan-21 to Apr-21 risk score.

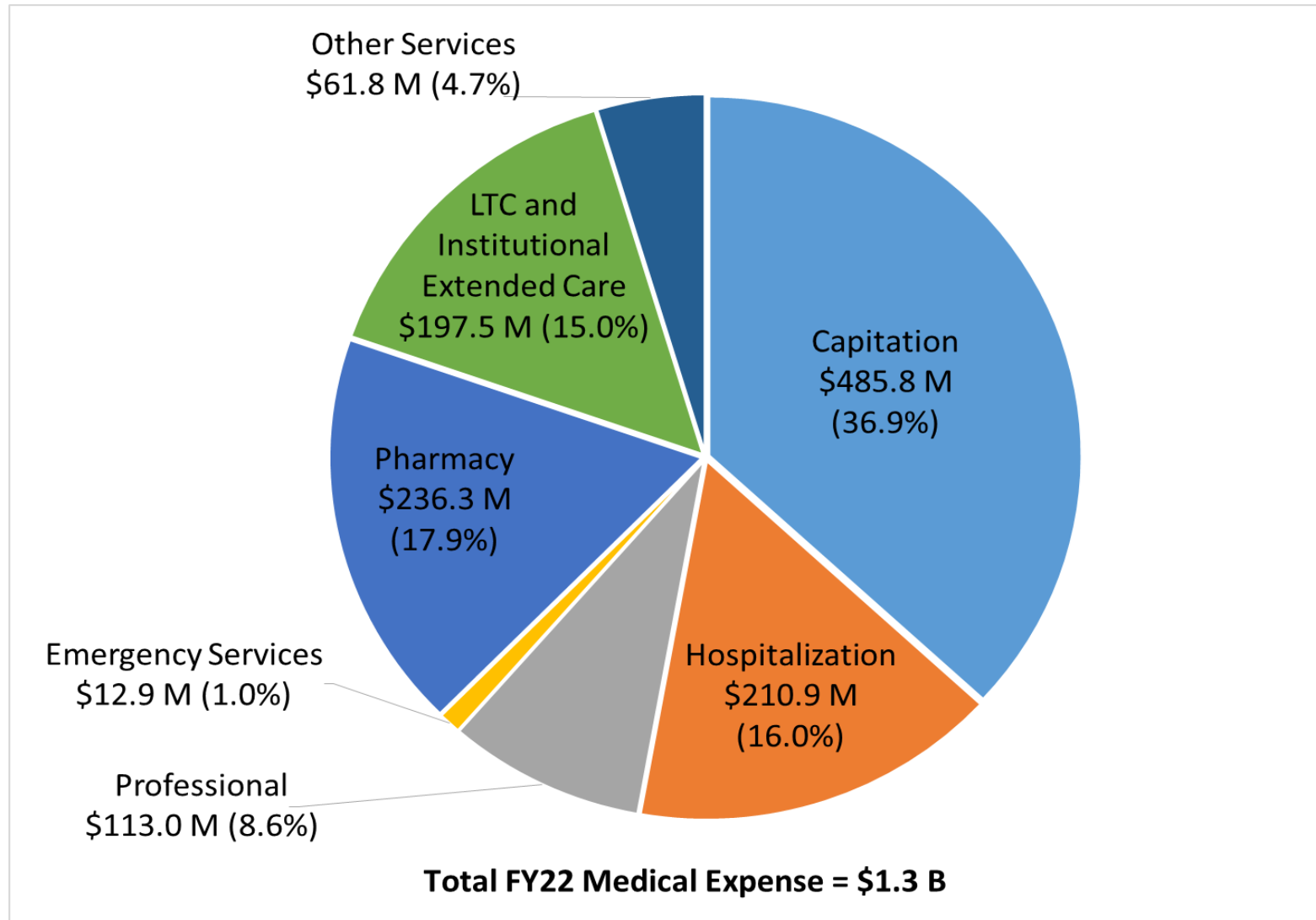
# Revenue Composition



# Medical Expense Assumptions

- Medical expenses are expected to increase from projected FY21 of \$1.169 billion to \$1.318 billion.
- Several methods were utilized in the development of medical expense projections. Projections were primarily based on trends calculated from historical experience and known contract changes.
- FY22 medical expenses are projected to be 93.9% of FY22 budgeted revenue (compared to 92.6% projected for FY21)
  - Enrollment increases/decreases.
  - Fee-For-Service (FFS) rates increased 1%-6% due to increased post-COVID utilization and unit costs.
  - Capitation rates are due to provider contracts adjustments.
  - Non-Dual Long-Term Care member months are assumed flat.
  - Pharmacy benefit expense projected to be continued for the full fiscal year.

# Medical Expense Composition



# Administrative Expense Analysis

	FY21 Forecast		FY22 Budget	
Revenue	\$1,262,385,388		\$1,403,506,647	
Member Months	3,253,871		3,599,354	
FTEs (current + open @ FYE)	376		419	
	EXPENSE	PMPM	EXPENSE	PMPM
Salaries & Benefits	\$41,243,580	\$12.68	\$50,197,619	\$13.95
Rents & Utilities	\$499,878	\$0.15	\$504,800	\$0.14
Depreciation / Insurance / Equipment	\$4,318,106	\$1.33	\$4,709,000	\$1.31
Prof Fees / Consulting / Temp Staffing	\$11,621,656	\$3.57	\$13,474,461	\$3.74
Printing & Advertising	\$294,192	\$0.09	\$1,292,500	\$0.36
Information Systems	\$3,312,335	\$1.02	\$5,166,860	\$1.44
OfficeSupplies / Postage / Telephone	\$746,259	\$0.23	\$748,007	\$0.21
Meetings / Travel / Dues	\$986,536	\$0.30	\$1,640,679	\$0.46
Other Expenses	\$2,293,728	\$0.70	\$1,202,280	\$0.33
Total Administrative Expenses	\$65,316,270	\$20.07	\$78,936,205	\$21.93
<i>Administrative Ratio</i>	5.2%		5.6%	

FY21 Forecast represents ten months of actual expense and two months of estimate.

# Administrative Expense Assumptions

- **Personnel Expense:**
  - Costs are greater than projected FY21 by \$13.6 million or 20.9%.
  - FY21 staffing includes 322 current FTEs and 54 open positions.
  - FY22 budget adds 43 new positions (11%) due to new programs, strategic initiatives, increased workload and additional compliance requirements:
    - 20 Health Service positions, largely additional Case Management and Quality Improvement.
    - 9 Operations positions.
    - 5 Marketing and Medicare Outreach positions.
    - 5 Finance positions.
    - 4 Information Technology positions.

# Administrative Expense Assumptions (cont.)

- **Non-Personnel Expense:**

Annual costs are increasing \$4.7 million over projected FY21 due to new initiatives and reduced FY21 spending during COVID.

- **Professional / Consulting / Temp Staff** increases for new programs (D-SNP, Cal AIM, ECM, ILOS - \$1.85M).
- **Information Systems** increases due to efficiency, compliance, security, and quality (\$1.85M).
- **Printing & Advertising** increases for brand awareness, new programs, regulatory requirements, and enrollment growth (\$1.0M).
- **Depreciation / Insurance Expense** increases on newly-acquired assets, including Community Resource Center and additional software (\$400K).
- **Assessment, Dues, & Other** decrease largely due to increased DMHC annual assessment based on enrollment growth and deferred expenditures because of COVID (\$400K).

# Consolidated Budget

	FY21 Forecast		FY22 Budget	
	Total \$	PMPM	Total \$	PMPM
Enrollment	3,253,871		3,599,354	
Revenues	\$1,262,385,388	\$387.96	\$1,403,506,647	\$389.93
Health Care Expenses	\$1,169,332,092	\$359.37	\$1,318,259,025	\$366.25
Gross Margin	\$93,053,296	\$28.60	\$85,247,623	\$23.68
Administrative Expenses	\$65,316,270	\$20.07	\$78,936,205	\$21.93
Non Operating Income	\$629,402	\$0.19	\$2,314,366	\$0.64
Net Surplus	\$28,366,427	\$8.72	\$8,625,783	\$2.40
Medical Loss Ratio	92.6%		93.9%	
Administrative Ratio	5.2%		5.6%	
Net Surplus %	2.2%		0.6%	



# FY22 Budget by Line of Business



	Medi-Cal		CMC-Medi-Cal		CMC-Medicare		Total CMC		Consolidated
	Totals	PMPM	Totals	PMPM	Totals	PMPM	Totals	PMPM	Totals
<b>Member Months</b>	3,472,434		126,920		126,920		126,920		<b>3,599,354</b>
<b>Premium Revenue</b>	<b>\$ 1,177,729,434</b>	\$ 339.17	<b>\$ 44,183,885</b>	\$ 348.12	<b>\$ 181,593,328</b>	\$ 1,430.77	<b>\$ 225,777,213</b>	\$ 1,778.89	<b>\$ 1,403,506,647</b>
<b>Medical Expenses:</b>									
Capitation	\$ 485,822,531	\$ 0.41	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	<b>\$ 485,822,531</b>
Hospitalization	\$ 123,421,766	\$ 35.54	\$ 5,386,599	\$ 42.44	\$ 82,080,455	\$ 646.71	\$ 87,467,054	\$ 689.15	<b>\$ 210,888,820</b>
Professional	\$ 85,985,091	\$ 24.76	\$ 7,908,233	\$ 62.31	\$ 19,097,870	\$ 150.47	\$ 27,006,103	\$ 212.78	<b>\$ 112,991,194</b>
Emergency Services	\$ 8,950,908	\$ 2.58	\$ 403,739	\$ 3.18	\$ 3,555,560	\$ 28.01	\$ 3,959,299	\$ 31.20	<b>\$ 12,910,208</b>
Pharmacy	\$ 180,409,139	\$ 51.95	\$ -	\$ -	\$ 55,925,644	\$ 440.64	\$ 55,925,644	\$ 440.64	<b>\$ 236,334,783</b>
LTC and Institutional Extended Care	\$ 163,204,126	\$ 47.00	\$ 21,440,074	\$ 168.93	\$ 12,892,853	\$ 101.58	\$ 34,332,927	\$ 270.51	<b>\$ 197,537,053</b>
Other	\$ 58,069,906	\$ 16.72	\$ 1,891,579	\$ 14.90	\$ 1,812,952	\$ 14.28	\$ 3,704,531	\$ 29.19	<b>\$ 61,774,437</b>
<b>Total Medical Expenses</b>	<b>\$ 1,105,863,467</b>	\$ 318.47	<b>\$ 37,030,224</b>	\$ 291.76	<b>\$ 175,365,334</b>	\$ 1,381.70	<b>\$ 212,395,557</b>	\$ 1,673.46	<b>\$ 1,318,259,025</b>
<b>MLR</b>	93.9%		83.8%		96.6%		94.1%		93.9%
<b>Gross Margin</b>	<b>\$ 71,865,967</b>	\$ 20.70	<b>\$ 7,153,661</b>	\$ 56.36	<b>\$ 6,227,995</b>	\$ 49.07	<b>\$ 13,381,656</b>	\$ 105.43	<b>\$ 85,247,623</b>
<b>Administrative Expenses</b>	\$ 65,393,693	\$ 18.83	\$ 2,464,937	\$ 19.42	\$ 11,077,576	\$ 87.28	\$ 13,542,513	\$ 106.70	<b>\$ 78,936,205</b>
<b>ALR</b>	5.6%		5.6%		5.6%		5.6%		5.6%
<b>Other Income</b>	\$ 1,942,062	\$ 0.56	\$ 72,859	\$ 0.57	\$ 299,445	\$ 2.36	\$ 372,304	\$ 2.93	<b>\$ 2,314,366</b>
<b>Net Surplus (Deficit) \$</b>	<b>\$ 8,414,336</b>	\$ 2.42	<b>\$ 4,761,583</b>	\$ 37.52	<b>\$ (4,550,136)</b>	\$ (35.85)	<b>\$ 211,447</b>	\$ 1.67	<b>\$ 8,625,783</b>
<b>Net Surplus (Deficit) %</b>	0.7%		10.8%		-2.5%		0.1%		0.6%

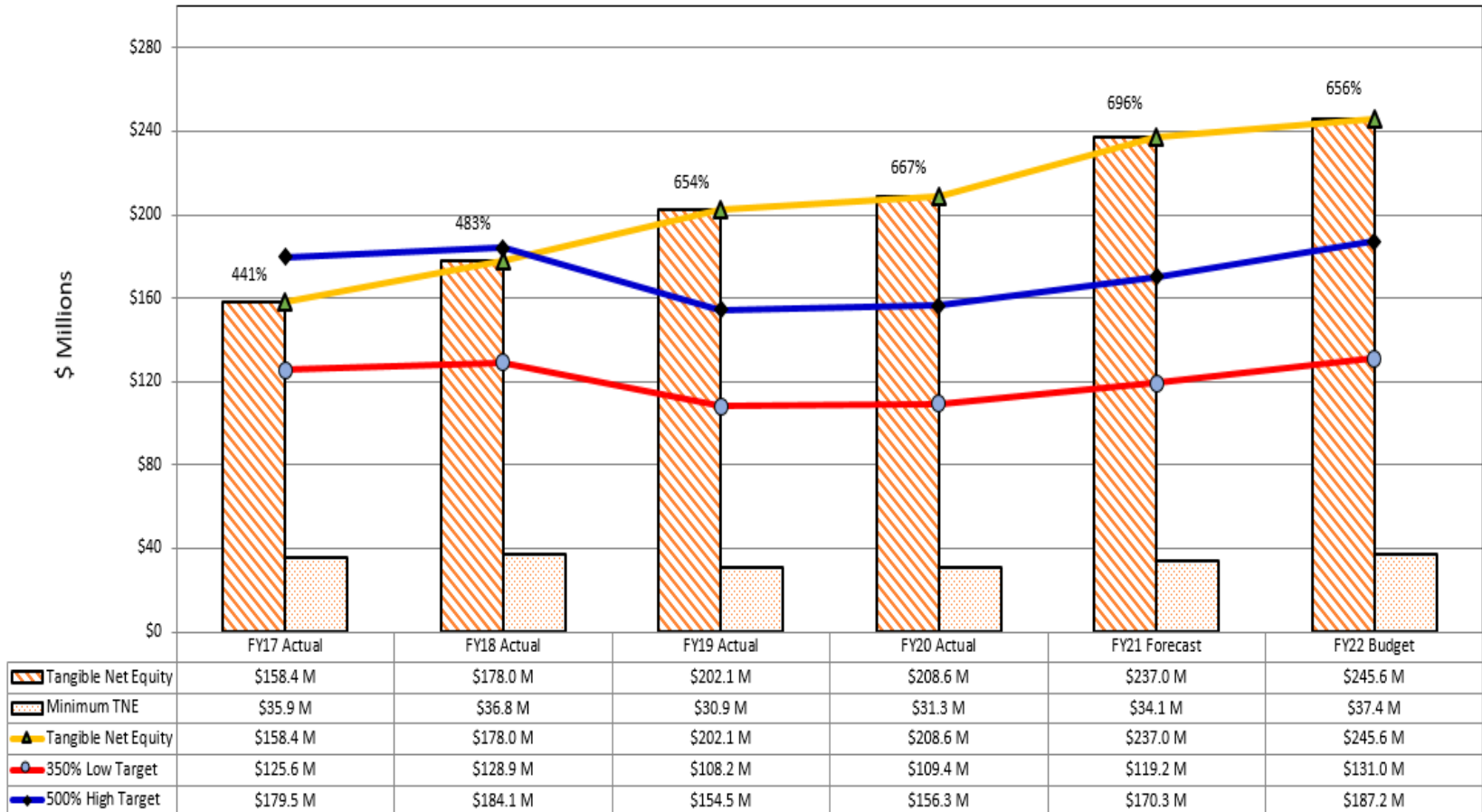
# Medi-Cal Line of Business - Overview

- Revenue of \$1.178 billion, an increase of \$120.7M or 11.4% over FY21.
  - 3,472,434 member months, an increase of 10.7%.
  - Medi-Cal rates are projected to decrease by 1.6%.
- Medical Expense of \$1.106 billion, an increase of \$122.9M or 12.5% over FY21.
  - Capitation payments based on expected rates, enrollment growth and network distribution.
  - FFS costs based on historic claim experience adjusted for different utilization trends between COVID vs. normal year utilization and contracted rates.
  - Unit cost trends reflect increase of 1.0 – 6.0% for various categories of service.
- Administrative Expense of \$71.9 million.
  - Allocated by line of business based on premium revenue.
  - Admin cost as a percentage of revenue = 5.6%.

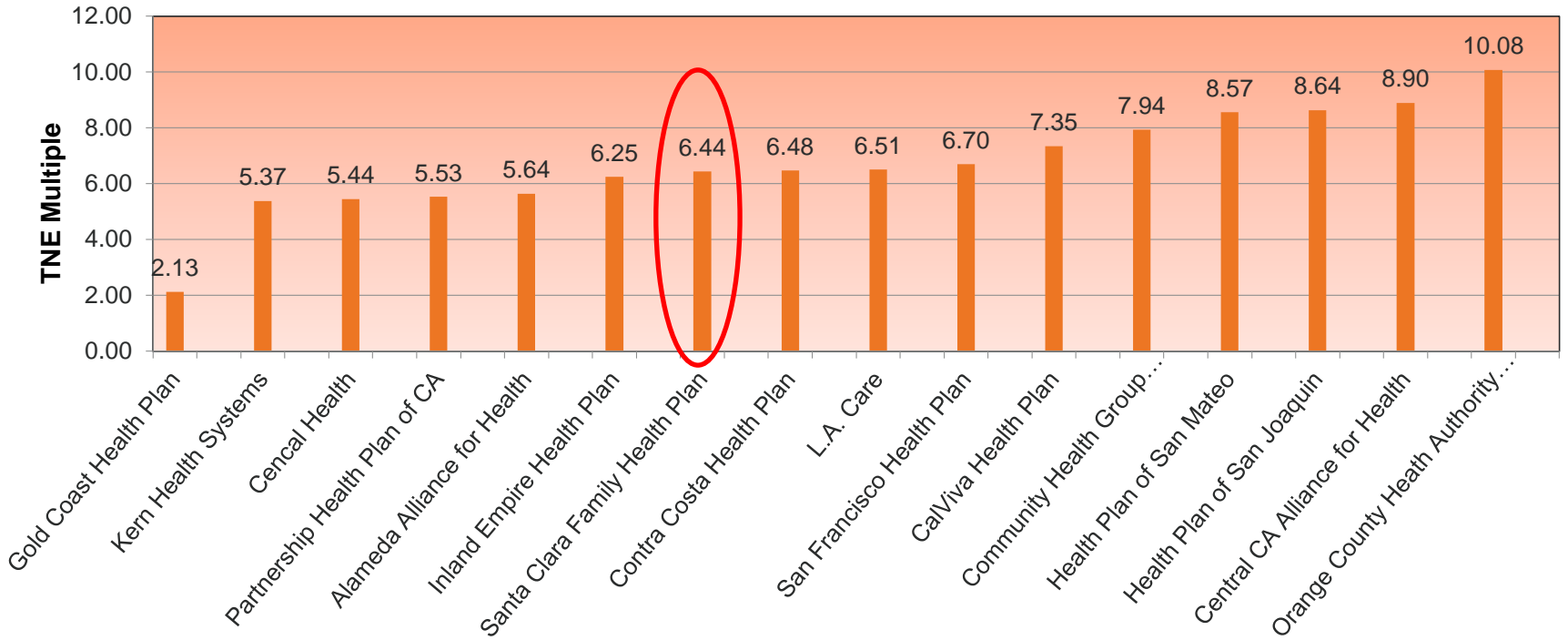
# Cal MediConnect Line of Business - Overview Santa Clara Family Health Plan.

- Revenue of \$225.8 million, an increase of \$20.4 million or 9.9% over FY21.
  - 126,920 projected member months, an increase of 9.1%.
  - Medi-Cal revenue blending based on projected membership mix and CY21 DHCS rates.
  - Medicare revenue based on Jan – Apr 21 risk score and Medicare rates with anticipated CMS savings and quality withhold targets included.
- Medical Expense of \$212.4 million, an increase of \$26.0 million or 14.0% over FY21.
  - FFS costs based on historic claim experience adjusted for utilization trends and contracted rates and increasing Medicare fee schedule.
  - Unit cost trends reflect increases of 1.0 - 6.0% for various categories of service
  - Pharmacy costs increase 5.0 – 7.0% based on current unit cost and utilization trends.
- Administrative Expense of \$13.5 million.
  - Allocated by line of business based on premium revenue.
  - Admin cost as a percentage of revenue = 5.6%.

# Tangible Net Equity



# Tangible Net Equity - Local Plans at 03/31/21



# Key Opportunities Risks & Unknowns

- **Potential Upside Opportunities:**
  - Improved utilization management
  - Provider contracting opportunities
  - Enhanced coordination of benefits and third-party recoupments
  - Close monitoring of administrative expenses
- **Potential Downside Costs:**
  - Increased non-COVID acuity resulting from hiatus in care
  - New initiatives - DSNP, CaAIM, ECM, and ILOS programs
  - Additional Board-Designated expenditures:
    - Estimate \$3M distribution
- **Major Unknowns:**
  - COVID (favorable/unfavorable)
  - Emerging enrollment trends
  - Additional impacts of State Budget (favorable/unfavorable)

# FY22 Capital Budget Summary

Description	Amount (\$)
COMPUTER SOFTWARE	\$ 1,896,874
COMPUTER HARDWARE	\$ 1,060,000
FURNITURE & EQUIPMENT	\$ 179,101
FACILITIES - MAIN OFFICE	\$ 62,000
FACILITIES - COMMUNITY RESOURCE CENTER	\$ 55,800
<b>TOTAL FY21 CAPITAL ASSETS</b>	<b>\$ 3,253,775</b>

# Capital Budget – Key Components

## **Major IT Requests:**

Computer Software of \$1.9M includes: (1) QNXT enhancements of \$495K, (2) Cognizant NetworX pricer of \$377K, (3) FHIR solution of \$120K, (4) provider & member portal enhancements of \$120K, (5) security enhancements of \$120K, (6) Fraud, Waste, & Abuse tool of \$100K, and (7) various process improvement software totaling \$565K.

Computer Hardware of \$1.1M includes: (1) data center storage expansion of \$600K, (2) server & backup enhancements of \$260K, and (3) desktop computer hardware of \$200K.

## **Major Facilities Requests:**

Main Office enhancements include (1) video cameras & microphones for Boardroom and conference rooms of \$79K, (2) general contingency of \$100K and (3) general building improvements of \$90K and CRC tenant improvements of \$56K.



# Capital Budget – Detail



Description	Amount (\$)
Trizetto Elements - Enrollment and financial reconciliation. Online application tool.	\$ 495,000
Security enhancement and Evolve producer management, onboarding.	\$ 385,000
Cognizant - NetworX Pricer, Modeler, and Modeler Analytics tool.	\$ 376,874
Optum Payment System - Claim Pricers, Claim Editing, and FHIR Payer to Payer solutions	\$ 320,000
HealthX - Portal enhancements. Provider Directory, IVR enhancement, UX/UI modications.	\$ 120,000
Essette - CalAIM, ILOS, and ECM modification and software development.	\$ 100,000
Fraud Shield - Fraud Waste & Abuse software. Identify potential cases and create visuals data trend.	\$ 100,000
<b>COMPUTER SOFTWARE</b>	<b>\$ 1,896,874</b>
Primary data center storage expansion to support new project and initiatives	\$ 600,000
Server & Backup Enhancements to increase capacity, improve redundancy and recovery capabilities	\$ 260,000
Computer and phone hardware (desktop, laptop, phone)	\$ 200,000
<b>COMPUTER HARDWARE</b>	<b>\$ 1,060,000</b>
Conference room video camera and microphones. Boardroom audio enhancement. Main office contingency plan	\$ 179,101
<b>FURNITURE &amp; EQUIPMENT</b>	<b>\$ 179,101</b>
Automatic locks for exterior doors and building improvements	\$ 62,000
<b>FACILITIES - MAIN OFFICE</b>	<b>\$ 62,000</b>
Building Tenant Improvements	\$ 55,800
<b>FACILITIES - COMMUNITY RESOURCE CENTER</b>	<b>\$ 55,800</b>
<b>TOTAL FY22 CAPITAL ASSETS</b>	<b>\$ 3,253,775</b>

## POLICY

<b>Policy Title:</b>	<b>Innovation Fund</b>		<b>Policy No.:</b>	GO.03 v1
<b>Replaces Policy Title (if applicable):</b>	N/A		<b>Replaces Policy No. (if applicable):</b>	N/A
<b>Issuing Department:</b>	Governance & Org Structure		<b>Policy Review Frequency:</b>	Periodically as warranted
<b>Lines of Business (check all that apply):</b>	<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Kids	<input type="checkbox"/> CMC	

### I. Purpose

To establish an innovation fund for strategic initiatives determined by SCFHP to be high priority investments.

### II. Policy

SCFHP has established a Board Designated Fund to allow the Plan to identify and fund potential high value strategic investments. The amount of reserves available for this Designated Fund will be based on a portion of the amount available, if any, over the Board-designated maximum Tangible Net Equity (TNE), subject to the Plan exceeding the Board-established liquidity target range, determined annually after release of the audited financial statements and as recommended by management in consideration of current and anticipated financial challenges.

It is SCFHP's policy to make investments in keeping with the following principles:

1. Focus investments on identified gaps in serving our members, potential members and providers to better meet member health needs, consistent with SCFHP's mission.
2. Fund initiatives that enable SCFHP to address evolving state and federal health care policy and regulatory expectations.
3. Work in collaboration with organizations in the community, as appropriate for the initiative.
4. Strategic investments may span multiple years.

The Executive/Finance Committee may approve innovation fund investments up to \$250,000. Project funding over \$250,000 must be approved by the Governing Board.

### III. References

1. Tangible Net Equity Policy
2. Liquidity Policy

**IV. Approval/Revision History**

First Level Approval		Second Level Approval		Third Level Approval
[Manager/Director Name] [Title]		[Compliance Name] Title]		[Executive Name] [Title]
Date		Date		Date
Version Number	Original/ Reviewed/ Revised	Reviewing Committee (if applicable)	Committee Action/Date (Recommended or Approved)	Board Action/Date (Approved or Ratified)
v1	Original			

## Santa Clara County Health Authority Board Designated Innovation Fund Request Summary

<b>Organization Name:</b>	Healthy Equity Agenda Steering Committee (Community Health Partnership, The Health Trust, Santa Clara Family Health Plan, Working Partnerships USA, and the Behavioral Health Contractors Association)
<b>Project Name:</b>	Healthy Equity Agenda
<b>Fiscal Sponsor Contact Name and Title:</b>	Dolores Alvarado, CEO, Community Health Partnership
<b>Requested Amount:</b>	\$115,000
<b>Time Period for Project Expenditures:</b>	July 2021 – June 2022
<b>Proposal Submitted to:</b>	Governing Board
<b>Date Proposal Submitted for Review:</b>	May 26, 2021

### Summary of Proposal:

The COVID-19 pandemic has laid bare deep racial and ethnic health disparities in Santa Clara County and across the Country. This project proposes to formalize a Steering Committee which can launch a comprehensive Santa Clara County plan to address systemic racial health disparities, build health equity in our community, and mitigate the loss of life that may come with future pandemics and natural disasters. The Steering Committee includes Community Health Partnership, The Health Trust (THT), Santa Clara Family Health Plan (SCFHP), Working Partnerships USA, and the Behavioral Health Contractors Association. Rather than multiple disparate projects managed by uncoordinated community groups, the Steering Committee proposes a unified, bold, multi-year plan to guide our collective work to reduce health disparities in our County. SCFHP, THT, and the County of Santa Clara are each being asked to contribute \$115,000 toward the project budget of \$345,000.

### Summary of Projected Outcome/Impact:

The Steering Committee will utilize funding to establish and implement a health equity agenda and an index to track key health equity metrics. This initiative includes the compilation of relevant health data for a manageable subset of community health priorities, analysis of the information, development of an action plan, and implementation of projects based on evidence-based best practices. The Steering Committee may also prepare recommendations for public policies that advance health equity, primarily at the County level. The Steering Committee's goal is to see quantifiable reductions in both racial health disparities and long-term health care costs, with a commitment to tracking progress in short-term deliverables and long-term health outcomes.

## **Health Equity Agenda Proposal**

June 2021

Behavioral Health Contractors Association | Community Health Partnership|  
Santa Clara Family Health Plan | The Health Trust | Working Partnerships USA

### **REQUEST**

The Community Health Partnership, The Health Trust, the Santa Clara Family Health Plan, Working Partnerships USA, and the Behavioral Health Contractors Association (“Steering Committee”) respectfully request \$115,000 in FY22 to establish and implement a health equity agenda, including a set of projects to address local health disparities and an index to track key health equity metrics. This investment will be matched by the Santa Clara Family Health Plan and The Health Trust, pending their respective boards’ review and approval. The projects will build upon evidence-based and cost-effective best practices.

### **BACKGROUND**

The COVID-19 pandemic has laid bare deep racial and ethnic health disparities in Santa Clara County and across the Country. Locally, it has had a disproportionately negative impact on the health of Black, Latinx, and low-income communities - particularly in East San Jose, Gilroy, and pockets throughout the County. Further, this pandemic underscored economic instability for many residents in these same communities.

As multiple stakeholders rightly focus on the urgent and immediate public health issues directly related to COVID-19, the Steering Committee also sees this as the time to launch a more comprehensive Santa Clara County plan to address systemic racial health disparities, build health equity in our community, and mitigate the loss of life that may come with future pandemics and natural disasters. Rather than multiple disparate projects managed by uncoordinated community groups, we propose a unified, bold, multi-year plan to guide our collective work to reduce health disparities in our County.

This project includes the formalization of the Steering Committee, the compilation of relevant health data for a manageable subset of community health priorities, analysis of the information, development of an action plan, and implementation of projects based on evidence-based best practices. The Steering Committee might also prepare recommendations for public policies that advance health equity, primarily at the County level. The Steering Committee’s goal is to see quantifiable reductions in both racial health disparities and long-term health care costs, with a commitment to tracking progress in short-term deliverables and long-term health outcomes.

The Steering Committee, and the project as a whole, will utilize a “both-and” approach when it comes to (a) addressing upstream social determinants of health AND downstream health outcomes, and (b) addressing community-level health measures and individual health outcomes.

## **DISCUSSION**

Before the COVID-19 pandemic, the leading causes of death in Santa Clara County were: cancer, heart disease, cerebrovascular disease, unintentional injuries, diabetes, hypertension, chronic lower respiratory disease, influenza and pneumonia, chronic liver disease, and cirrhosis, and suicide. And while the loss of life due to COVID-19 realigned the leading causes of death in our County, we also know that many of these conditions played a role in County residents' increased risk for COVID-19 illness and death. Furthermore, the more progressive a disease is, the more costly the care for both the individual and the County. By prioritizing prevention in underserved communities, we can increase equity in our community and decrease costly treatment from our County health care systems.

The Steering Committee will facilitate a phased approach to the creation of a Santa Clara County health equity plan, inviting input from a broader network of stakeholders (patients, healthcare workers, community-based organizations, health plans, Santa Clara County's Race and Health Disparities Community Board, health systems, government) as appropriate. This work will include partnering with other organizations looking to directly address post-COVID-19 inequities.

Phase 1: The Steering Committee, with potential consultant support, will identify a set of 10-15 metrics that tie to major racial health disparities in Santa Clara County and can show measurable improvement over two five-year plans, such as uncontrolled diabetes, hypertension, heart disease, suicides and suicide attempts, chronic lower respiratory disease, and HIV viral suppression. These metrics can also include data on wherein early detection can play a role in outcome and treatment costs, such as cancer, hepatitis B, and hepatitis C. The intent is to identify existing, readily available data sets that can be disaggregated by race/ethnicity, age, gender, and geography, rather than engage in new data collection. For example, the Steering Committee could segment a national behavioral health data set for Santa Clara County. These data sets will be utilized to establish baselines from which the Steering Committee can track measurable progress both short and long term.

The Steering Committee will seek input from community health center patients and additional stakeholders before finalizing the set of metrics, likely through focus groups and/or surveys. The Steering Committee will ensure equitable participation by including gift cards and other incentives to allow for work loss or childcare. The Steering Committee will focus on a comprehensive understanding of not just poor health outcomes, but also the driving factors behind these outcomes. The metrics will be presented in a user-friendly, streamlined Health Equity Index, free and available to the public via a website. While intended audiences for the index will include community-based organizations, policy advocates, and policymakers, the index will be intuitive enough for those without a public health or public administration background to navigate. The Steering Committee will also note gaps in data and potentially make recommendations for future data collection.

Phase 2: The Steering Committee, with potential consultant support, will provide analysis on the causes for existing health disparities in the data. With input from additional stakeholders and peer-reviewed best practices, the Steering Committee will develop a plan with projects and

timelines to reduce these health disparities. If peer-reviewed best practices are not available the Steering Committee will consider innovative ideas and allocate time for a pilot program. Recognizing that reduction in health disparities may require massive resources, the steering committee will seek to set achievable five-year objectives, based on evidence-based and cost-effective strategies.

Phase 3: Using the data and plan as a publicly shared platform, the Steering Committee will develop and champion appropriate policy recommendations. While most of the recommendations will likely center on the County of Santa Clara, some recommendations might be more applicable to city or state government solutions.

Examples of evidence-based recommendations include the following:

- To address diabetes mortality rates: the Steering Committee may recommend life-saving insulin home-delivered to all eligible Medi-Cal and uninsured residents, regardless of ability to pay. Diabetic case managers can proactively call residents to help them better manage blood sugar, increase life expectancy, and decrease costly diabetes-related treatment for neuropathy or kidney issues.
- To increase equity in cancer mitigation, progression, and treatment: the Steering Committee might recommend multilingual, culturally sensitive patient navigators at County hospitals and clinics to increase routine cancer screening to increase life expectancy and decrease costly care for advanced cancers.
- To increase equity in diabetes prevention, progression, and treatment: the Steering Committee may recommend an expansion of the Spanish-language Diabetes Prevention Programs in East San Jose, with paid YMCA memberships and exercise prescriptions for eligible Medi-Cal members.
- To decrease mortality due to unintentional accidents: the Steering Committee may recommend multi-component fall prevention programs to limit devastating falls for older adults or champion automated speed enforcement cameras to lessen speed-related traffic collisions.
- To improve asthma management and treatment: the Steering Committee may recommend healthy home environment assessments completed by multilingual, culturally-sensitive Community Health Workers who may, depending upon their analysis, recommend improved ventilation, or low-emission vacuums, or air filters, or allergen-proof pillow and mattress coverings, or neighborhood policies to limit diesel particulate matter.

Phase 4: The Steering Committee, with potential consultant support, will track and share progress annually in reducing the identified health disparities. The steering committee will work in partnership with the County of Santa Clara Public Health Department and the Behavioral Health Services Department to sustain this work long-term.

## **BUDGET**

The Community Health Partnership will house the funding for this project.

Personnel (consultant and/or staff)	\$250,000
Website development and maintenance	\$50,000
Administrative overhead (15%)	\$45,000
Total	\$345,000



June 16, 2021

The Honorable Cindy Chavez  
Board of Supervisors  
County of Santa Clara  
70 W. Hedding Street, 10th Floor  
San Jose, CA 95110

RE: Health Equity Proposal on the 6/22/21 Board of Supervisors' Agenda

Dear Supervisor Chavez and Members of the Board of Supervisors:

The Community Health Partnership, The Health Trust, the Santa Clara Family Health Plan, Working Partnerships USA, and the Behavioral Health Contractors Association are thankful for your leadership and all of the County staff's efforts as we have navigated through the COVID-19 pandemic, especially the County's focus on health equity. While we are not yet past COVID-19, it is imperative that we begin planning for a future that best serves all our County residents rather than returning to our previous "normal" that was leaving many behind. As the Steering Committee behind the Health Equity Agenda proposal, we respectfully request your support for the Health Equity Proposal on the 6/22/21 Board of Supervisors agenda.

The COVID-19 pandemic disproportionately impacted our Black and Latino communities, both through the burden of the disease and its economic fallout. These same communities were disproportionately impacted by health inequities prior to the pandemic, often experiencing poor health outcomes due to racist or oppressive systems and policies. As health service providers, advocates, and researchers, we believe there is no better time than now to focus on eliminating the very inequities that allowed COVID-19 to run rampant through these communities.

In consideration of this belief, The Health Trust and the Santa Clara Family Health Plan, pending board approvals, plan to match the County's one-time funding of \$115,000 to establish a health equity agenda that will determine key health equity metrics and address local health disparities. The project, with Community Health Partnership acting as the fiscal sponsor, seeks to assist the County's efforts in identifying and addressing health disparities in a multi-phased and data-driven approach with a focus on transparency and community involvement.

We welcome your support and continued collaboration on both this and future initiatives to address health inequity in Santa Clara County. Please do not hesitate to contact us if we might be of assistance.

Sincerely,

Dolores Alvarado  
Chief Executive Officer  
Community Health Partnership

Bob Brownstein  
Strategic Advisor  
Working Partnerships USA

Elisa Koff-Ginsborg  
Executive Director  
Behavioral Health Contractors' Association

Michele Lew  
Chief Executive Officer  
The Health Trust

Christine Tomcala  
Chief Executive Officer  
Santa Clara Family Health Plan

County of Santa Clara  
Board of Supervisors  
Supervisorial District Two  
Supervisor Cindy Chavez



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106743

**DATE:** June 22, 2021  
**TO:** Board of Supervisors  
**FROM:** Cindy Chavez, Supervisor  
**SUBJECT:** Health Equity Agenda

**RECOMMENDED ACTION**

Approve referral to Administration and County Counsel to report to the Board in August 2021 with options for consideration relating to allocating \$115,000 to support the establishment of a health equity agenda that will determine key health equity metrics and address local health disparities. (Chavez)

**FISCAL IMPLICATIONS**

There is a one-time cost to Santa Clara County of \$115,000, which is expected to be matched equally both by Santa Clara Family Health Plan (SCFHP) and the Health Trust, for a total initial program budget of \$345,000. The appropriate source of the \$115,000 county investment will be determined by the Administration based on the potential applicability of State or federal resources given the project's fidelity with the County's ongoing efforts to address health disparities.

The County's investment in this program should be conditional on the equal support by SCFHP and the Health Trust.

**REASONS FOR RECOMMENDATION**

Santa Clara County is fortunate to have many strong health-focused and community organizations that have served invaluable roles during the COVID response, and who are now transitioning to confront the inequities and disparities made even more starkly evident during the pandemic.

Five such organizations are Working Partnership, the Health Trust, SCFHP, the Behavioral Health Contractors Association, and the Community Health Partnership. These organizations have developed a Health Equity Agenda Proposal that will support the County's overall recovery efforts to address the fundamental inequities and related health disparities present in our County.

Before the COVID-19 pandemic, the leading causes of death in Santa Clara County were cancer, heart disease, cerebrovascular disease, unintentional injuries, diabetes, hypertension, chronic lower respiratory disease, influenza and pneumonia, chronic liver disease, and cirrhosis, and suicide. And while the loss of life due to COVID-19 realigned the leading causes of death in the County, many of these conditions played a role in County residents' increased risk for COVID-19 illness and death.

Furthermore, the more progressive a disease is, the more costly the care for both the individual and the County. By prioritizing prevention in underserved communities, we can increase equity in our community and decrease costly treatment from our County health care systems.

This project, which will be organizationally and fiscally housed within the Community Health Partnership, and equally funded by the County of Santa Clara, SCFHP, and the Health Trust will bolster the County's current and intended efforts to identify and address health disparities through transparent data driven approaches.

As described in the attached proposal, the program will proceed through four phases:

- Phase One – Identification of meaningful and valid metrics by which to measure and report health equity.
- Phase Two – Identification of root causes of health disparities in the community and determination of proven interventions and projects tailored to our community to increase the related equity metrics and health outcomes.
- Phase Three – Developing and championing appropriate policy recommendations. Examples included in the proposal recognize the importance of individuals with diabetes accessing insulin, the improved health outcomes for individuals with cancer being assisted by patient navigators, and the value of community health workers assessing and intervening to improve air quality in the homes of individuals with asthma and respiratory problems.
- Phase Four – Tracking and sharing equity metrics data and information in partnership with the County of Santa Clara Public Health Department.

## **BACKGROUND**

The COVID-19 pandemic has laid bare deep racial and ethnic health disparities in Santa Clara County and across the Country. Locally, it has had a disproportionately negative impact on the health of Black, Latinx, and low-income communities - particularly in East San Jose, Gilroy, and pockets throughout the County. Further, this pandemic underscored economic instability for many residents in these same communities.

As multiple stakeholders rightly focus on the urgent and immediate public health issues directly related to COVID-19, the Steering Committee that submitted the attached proposal also sees this as the time to launch a more comprehensive Santa Clara County plan to address systemic racial health disparities, build health equity in our community, and mitigate the loss of life that may come with future pandemics and natural disasters. The Steering Committee, and the project as a whole, will utilize a “both-and” approach when it comes to (a) addressing

upstream social determinants of health AND downstream health outcomes, and (b) addressing community-level health measures and individual health outcomes.

**ATTACHMENTS:**

- Correspondence from Dolores Alvarado, Chief Executive Officer, Community Health Partnership relating to Health Equity Index Project (PDF)

## Santa Clara County Health Authority Board Designated Innovation Fund Request Summary

<b>Organization Name:</b>	FIRST 5 Santa Clara County
<b>Project Name:</b>	Integrated Behavioral Health Pilot Project
<b>Contact Name and Title:</b>	Jolene Smith, CEO, FIRST 5 Santa Clara County
<b>Requested Amount:</b>	\$500,000 (\$250,000 per year for two years)
<b>Time Period for Project Expenditures:</b>	July 1, 2021 – June 30, 2023
<b>Proposal Submitted to:</b>	Governing Board
<b>Date Proposal Submitted for Review:</b>	June 2, 2021

### Summary of Proposal:

FIRST 5 Santa Clara County (FIRST 5), in partnership with the University of California-San Francisco (UCSF) and the California Children’s Trust will develop and implement an integrated behavioral health pilot project. The intent of the pilot is to sustainably integrate early childhood/dyadic behavioral health services into 7 to 10 of the highest volume primary care clinics serving young children on Medi-Cal in Santa Clara County. The two-year demonstration and technical assistance project will demonstrate the clinical benefit and impact of aligning reimbursement for mild and moderate mental health services with dyadic behavioral health models in primary care medical homes. FIRST 5 will subcontract with UCSF to provide technical assistance on the design, development, implementation, capacity strengthening, evaluation, and fiscal sustainability of project. Funding from SCFHP will contribute to estimated pilot project total budget of \$1,368,302 over two years.

### Summary of Projected Outcome/Impact:

The pilot will demonstrate the scalable and sustainable reimbursement and clinical delivery models for dyadic models of care in pediatric and family medicine primary care settings. FIRST 5 and its partners expect the pilot to set new standards and expectations for early childhood behavioral health services in primary care by way of expanding payment to support this work.



The First 5 years.  
Make them count.

June 2, 2021

Christine Tomcala, CEO  
Santa Clara Family Health Plan  
6201 San Ignacio Avenue  
San Jose, CA 95119

Dear Ms. Tomcala:

FIRST Santa Clara County (FIRST 5), in partnership with the University of California-San Francisco (UCSF) and the California Children's Trust, is pleased to submit the attached proposal to the Santa Clara Family Health Plan. This two-year demonstration and technical assistance project with a select cohort of high volume pediatric and family medicine clinics in Santa Clara County (i.e., Valley Medical Center and community health clinics) will demonstrate the clinical benefit and impact of aligning reimbursement for mild and moderate mental health services with dyadic behavioral health models in primary care medical homes.

**FIRST 5 Santa Clara County (FIRST 5) formally requests Santa Clara Family Health Plan's partnership and investment in an integrated behavioral health pilot project by providing a two-year grant of \$500,000 (\$250,000 per year) to FIRST 5.** The goal of this pilot project is to sustainably integrate early childhood/dyadic behavioral health services into 7 to 10 of the highest volume primary care clinics serving young children on Medi-Cal in Santa Clara County. Funding through this grant will contribute to the estimated pilot project total budget of \$1,368,302 over two years (\$684,151 per year). FIRST 5 will subcontract with UC San Francisco to provide technical assistance on the design, development, implementation, capacity strengthening, evaluation, and fiscal sustainability of this project. In addition, FIRST 5 will continue to raise funds as well as utilize FIRST 5's own funds to meet the budget requirements for this project, which is anticipated to start in the upcoming Fiscal Year 21/22

In addition, this pilot project is part of the attached **Board of Supervisors Referral** that was approved in November 2020. This referral directs County Administration to build on and expand the Universal Developmental Screening Initiative, in partnership with FIRST 5 Santa Clara County, to explore three key goals:

1. Include Adverse Childhood Experiences (ACEs) screenings for children into routine well-child visits.
2. Establish integrated supports for mental, behavioral and social-emotional wellness into obstetric/gynecologic, pediatric and/or family practice clinics for children and their parents or caregivers when needs are identified through ACEs or developmental screenings.
3. Extend models of screening, support services, and billing beyond VMC clinics to community clinic partners or private health care systems, **in partnership with local health plans.**

The pilot will demonstrate scalable and sustainable reimbursement and clinical delivery models for dyadic models of care in pediatric and family medicine primary care settings. Partnering with the Santa Clara Family Health Plan, FIRST 5 and its partners will set new standards and expectations for early childhood behavioral health services in primary care by way of expanding payment to support this work.

In Governor Newsom's May Revise documents that were shared publicly last week, a new dyadic behavioral health mild/moderate benefit that the Technical Assistance Team at UCSF co-constructed with DHCS was recommended for funding, with a target implementation date of July 2022. The proposed benefit would provide a full sustainability pathway via billing/reimbursement for the early childhood/dyadic integrated behavioral health services we propose to build in Santa Clara County. The language of the announcement reads as follows:

*Dyadic Services Benefit in Medi-Cal – This is a new statewide benefit that provides integrated physical and behavioral health screening and services to the whole family. This model of care has been proven to improve access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting, and maternal mental health. The budget includes \$200 million total funds (\$100 million General Fund) ongoing.*

Concurrent state level advocacy in partnership with health plan partners will be focused on supporting implementation of the new Department of Health Care Services' (DHCS) guidance to ensure the coding and billing practices detailed here are formally added to the state's guidance for mild and moderate mental health services delivered by Managed Care Organizations (MCOs).

This two-year demonstration project crosswalks encounter data for dyadic models to CPT or Z codes. The UCSF TA Team has developed a TA model to support clinics with developing workflows and billing strategies to successfully implement evidence-based dyadic behavioral health services. The TA model was developed in partnership with the HealthySteps National Office at Zero to Three and has been implemented in San Francisco City and County and also in the Denver Metro Area by partners at the University of Colorado.

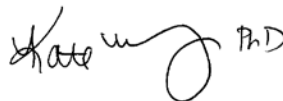
This work has taken on new relevance amidst the COVID-19 pandemic and associated mental health epidemic. Primary care providers have been busier than usual doing their best to meet the high level of family-based and dyadic behavioral health and social needs that have arisen for the population they serve. Supporting them by capacitating an integrated behavioral health workforce will go a long way in better meeting the needs of their patients and reducing the high risk of burnout that is especially prevalent during this time.

We are grateful for the partnership of our health plan partners in the design and development of this proposal and believe it has far-reaching implications for improving care to children, families and the surrounding community.

In Partnership,



Jolene Smith, CEO  
FIRST 5 Santa Clara County



Kate Margolis, PhD  
Assistant Professor of Psychiatry and Pediatrics, UCSF  
Associate Director of Primary Care Behavioral Health, Pediatrics  
Zuckerberg San Francisco General Hospital & Trauma Center

**Attachments:**

1. *Integrated Behavioral Health Funding Proposal*
2. *Board of Supervisors Referral to Expand Universal Developmental Screening Initiative*





**Proposal to Santa Clara Family Health Plan:  
Transforming Child Health with Early Childhood Behavioral Health Integration in Primary Care  
June 2, 2021**

**REQUEST:**

FIRST 5 Santa Clara County (FIRST 5) formally requests Santa Clara Family Health Plan's partnership and investment in an integrated behavioral health pilot project by providing a two-year grant of \$500,000 (\$250,000 per year) to FIRST 5. The goal of this pilot project is to sustainably integrate early childhood/dyadic behavioral health services into 7 to 10 of the highest volume primary care clinics serving young children on Medi-Cal in Santa Clara County. Funding through this grant will contribute to the estimated pilot project total budget of \$1,368,302 over two years (\$684,151 per year). FIRST 5 will subcontract with UC San Francisco to provide technical assistance on the design, development, implementation, capacity strengthening, evaluation, and fiscal sustainability of this project. In addition, FIRST 5 will continue to raise funds as well as utilize FIRST 5's own funds to meet the budget requirements for this project, which is anticipated to start in the upcoming Fiscal Year 21/22.

FIRST 5 also requests that Santa Clara Family Health Plan support the success of this integrated behavioral health pilot project by: (1) ensuring that codes are input into billing infrastructure and paying the claims associated with the mild to moderate benefit, as further detailed below; (2) tracking claims data and engaging in quality improvement processes to improve and increase billing practices of providers; and (3) championing the effort with local systems and stakeholders.

**BENEFIT TO SANTA CLARA FAMILY HEALTH PLAN:**

Santa Clara County is the 6th most populous county in California with a population of 1,927,852 with 441,591 children; 28,455 of whom are in poverty. Also, 22% of children in the county are enrolled in Medi-Cal with 49,961 children who are Medi-Cal eligible, yet only 10,545 of these children are receiving specialty mental health services. Dashboard data from 2011-2014 show that children who are 0-5 years old access specialty mental health services at a 3% rate on average.

Dyadic models of care (Healthy Steps and others) have demonstrated impact on compliance and quality metrics for Medi-Cal Managed Care Organizations. Demonstrated improvement in Bright Futures adherence and Healthcare Effectiveness Data and Information Set (HEDIS) measures are specific and relevant expectations for this demonstration. Examples of metrics that dyadic models have evidence to improve that are relevant to Santa Clara County, include adherence to well child visits (children in Santa Clara County (SCC) have a 53% rate of adherence to receiving one annual well child visit) and improvements in other health metrics, such as vision (SCC has a 21% adherence rate), blood lead screening (SCC has a 41% adherence rate), and vaccination rates.

In addition, increased utilization of the Mild to Moderate Mental Health benefit has demonstrated cost effectiveness for reducing other high cost health plan benefits, and the opportunity to expand co-located care coordination and case management will help leverage other efforts in Santa Clara focused on children and families. Critically, Dyadic models are a specifically referenced in the Governor's Fiscal Year 21-22 Budget with a proposal to expand billing codes and reimbursement opportunities.

Finally, dyadic models are consistent with the focus of the Whole Child entered reforms proposed in CalAIM. CalAIM proposes increased focus on screening, risk assessment, and care coordination for children and families. Achieving these ambitious reforms necessitates creative ways to leverage the opportunity and periodicity of pediatric primary care and family practice settings.

But of course, the real benefit to Dyadic care is patient centered care and the untapped opportunity to reach caregivers during the 12 well child visits in the first three years of life. This is a unique opportunity to address the social determinants of health, promote behavioral health integration, and ease access for adults who face barriers to accessing care in other settings. This is especially critical in the setting of 42% of households in Santa Clara County having between one and three Adverse Childhood Experiences (ACEs), which is at the designated “at risk” domain.

#### **CLIENT, CLINIC, AND SYSTEMS-LEVEL OUTCOMES:**

The proposed project will produce a scalable and sustainable technical assistance model for Santa Clara County primary care practices that serve Medi-Cal patients and seek to implement early childhood integrated behavioral health models. At the end of the two-year period, the project will achieve the following outcomes. Each participating clinic will:

- Improve the capacity of its medical providers to identify, assess, triage, and treat social-emotional and developmental concerns of infants and toddlers.
- Increase the number of child and family developmental, behavioral, and social-emotional screenings and consultations for acute problems, consistent with evidence-based models of early childhood behavioral health.
- Increase the number of preventive and health promotion consultations, external connections to early intervention services, and connections to dyadic behavioral health services.
- Improve care coordination, systems navigation, and the dissemination of positive parenting guidance, information, and resources.
- Increase billing claims generated to the mild to moderate behavioral health benefit for children ages 0-5, demonstrating that clinics can capture revenue for dyadic services, providing a path to long-term sustainability.

This project will also demonstrate the value of integrated primary care-based early childhood behavioral health services through patient and provider satisfaction, and through return on investment evaluation. The project will thus inform ongoing advocacy efforts to achieve meaningful payment reform for dyadic behavioral health services. **The project is well aligned with Whole Child centered reforms proposed in CalAIM as well as current Santa Clara County priorities and initiatives, including (but not limited to): (1) Santa Clara County Board of Supervisors’ Universal Developmental Screening Initiative and recent Board Referral to extend models of screening, support services, and billing beyond Valley Medical Clinics to community clinic partners or private health care systems, in partnership with local health plans; (2) Help Me Grow/KidConnections Network of Care; and (3) ACEs Screening with Connection to Early Intervention Services.** Santa Clara Family Health Plan thus has the opportunity to be recognized for their leadership in better addressing the health and welfare of children and families.

## **PROJECT DETAIL**

### **NEEDS STATEMENT**

Early childhood is when a young person is most susceptible to their social and physical environment; it is a time of both risk and opportunity that sets the trajectory for the rest of a person's life. The need for family- and community-centered care is particularly critical during pregnancy and the first five years of life, when the architecture of the brain is established and neural connections grow at the fastest rate of a person's lifetime. With an average of 12-13 visits in the first three years of life, pediatric primary care and family medicine settings offer an unparalleled opportunity to provide early social emotional support and intervention. The American Academy of Pediatrics recognizes these possibilities in their Bright Futures Guidelines. Yet the guidelines are difficult to completely implement within the traditional structure of the well child visit, which lasts an average of only 12-17 minutes. Here in California, the 2019 DHCS State Auditor's report confirmed this difficulty by highlighting the high rate at which primary care sites fall short on their preventive care deliverables, with California ranking 43<sup>rd</sup> in the nation in conducting timely behavioral, social, and developmental screening.

Decades of research in the field of early childhood development points to dyadic models of infant/early childhood mental health care—including HealthySteps, Developmental Understanding and Legal Collaboration for Everyone (DULCE), Child Parent Psychotherapy, and Parent Child Interaction Therapy—as being the most effective form of social emotional intervention to address both preventative and acute needs during infancy and early childhood. The frequency with which families with children birth to five years old access primary care means that the mild to moderate, non-specialty mental health system is uniquely positioned to provide much needed behavioral health care to young children and their caregivers. However, statistics show that children ages birth to five are the age group least likely to access this benefit. This is likely due to diagnosis-driven payment models and a limited workforce with expertise in identification and treatment of infant and early childhood social emotional concerns.

Furthermore, these challenges manifest in the context of overall disparities in accessing pediatric services, as noted by the California Children's Trust, which reports that children currently represent 42% of Medi-Cal enrollees but only 14% of all expenditures. The collective failure to connect children to behavioral health services is especially troubling given recent striking increases in ED utilization for self-injury (104% increase), pediatric mental health inpatient days (50%), suicide (70%), and the self-reporting of children through the California Healthy Kids Survey (61% increase in mental health needs). Combined with the increase in health and social disparities facing our BIPOC communities in light of the COVID pandemic, these factors have created an increased urgency to strengthen our systems of care to better meet the needs of infants, young children, and their caregivers. Fortunately, the State's current focus on ACEs and early childhood mental health along with recent Department of Health Care Services (DHCS) payment reforms have created new pathways to prioritizing services to better meet the needs of this population.

### **METHODOLOGY**

In response to these challenges, FIRST 5 seeks to develop sustainable, high quality, primary care-based early childhood integrated behavioral health services that leverage the mild to moderate behavioral health benefit. The proposed pilot would support the transformation of primary care practice to recognize the continuum of needs for young children and their families by implementing a robust, team-based response tailored to the variety of early childhood developmental, behavioral, physical, and social health needs that present in clinics.

The UCSF Technical Assistance Team proposes to implement a two-year pilot project with FIRST 5, Santa Clara Family Health Plan, Valley Health Plan, Anthem, County of Santa Clara Health System (i.e., Valley

Medical Center and Behavioral Health Services Department), and Community Health Partnership. The proposed technical assistance model will consist of the following phases:

Phase 1: Engagement, Assessment, and Model Development (*ongoing*)

- ✓ Conduct stakeholder engagement and advocacy
- ✓ Complete multi-system landscape assessment
- ✓ Outreach to health plans
- ✓ Develop technical assistance model and select target sites

Participating sites will receive support for, including but not limited to, integrated behavioral health model onboarding (e.g. HealthySteps), training, and implementation efforts.

Phase 2: Site and Systems Specific Technical Assistance (*Fiscal Years 2021-23*)

- ✓ Improve workforce capacity through training and continuing medical education
- ✓ Support clinical service delivery
- ✓ Provide sustainability support
- ✓ Conduct learning collaboratives

To support implementation and tracking, the partners will assess the capacity building needs of all site staff and medical team members and provide or arrange ongoing consultation and training. Behavioral health clinicians will have the opportunity to participate in intensive infant/early childhood behavioral health training and reflective supervision, which will be provided in collaboration with local resources (i.e., Child Parent Psychotherapy-trained supervisors) and UCSF partners (i.e., modules through the Child Trauma Research Program). Behavioral health clinicians will also be supported in seeking infant and early childhood mental health endorsement through the California Association for Infant Mental Health.

Phase 3: Research and Evaluation (*Fiscal Years 2021-23*)

- ✓ Develop countywide metrics
- ✓ Identify an infrastructure for countywide reporting
- ✓ Conduct data collection and analysis
- ✓ Draft an evaluation report and disseminate findings

In addition to site engagement and workforce capacity building, the TA team will partner with stakeholders to support sustainable implementation of integrated behavioral health services. Implementation of the identified model will be supported by a scaffolded, data driven approach, ensuring the uptake of progress in a transformative, sustainable manner. The TA team will simultaneously work with site, county, and health plan leadership to identify trackable billing and reimbursement strategies that can inform service sustainability. Working with additional state and national partners, the pilot will develop revenue models and return on investment analyses.

***(See Appendix A for additional detail on the proposed model of technical assistance and budget.)***

## SYSTEMS IMPACT: FROM BARRIERS TO BENEFITS

Under current practice and guidance, both Mental Health Plan Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Managed Care Organization (MCO) Mild to Moderate reimbursement is misaligned with dyadic models. Despite the demonstrated evidence of the importance and effectiveness of these models in improving health outcomes for children and their caregivers, a combination of the narrow state definition of the mild-to-moderate benefit, narrow diagnostic criteria, confusion regarding assignment of an identified patient, numerous contracting and administrative barriers, and challenges arising from primary care physician (PCP) assignment have stymied scalable models of dyadic care in high-volume safety net clinics.

The proposed pilot will demonstrate that partnership between managed care plan leadership and clinical leadership can overcome these barriers. Our aim is first and foremost to improve the lives of children and their caregivers, and secondly to change practice statewide and demonstrate solutions of system-wide and national interest. Among the many anticipated durable benefits of the proposed pilot are the following:

**Benefit: Improved Metrics** Dyadic behavioral health models of care, such as HealthySteps, have decades of evidence delivering on child development and family outcomes that align with Santa Clara County MCO metrics. For example, HealthySteps' success in improving well-child visit and immunization adherence aligns with the current QIP metric targeting 6 well-child visits attended by age 15 months. Additionally, the ways in which dyadic models elevate early childhood issues and transform practice have a concrete impact on improving rates of developmental and ACEs screening.

**Benefit: Improved Coordination and Access to Care** Dyadic models such as DULCE and HealthySteps offer the potential to reach families during well-child visit in order to reduce the total cost of care for the family unit through promotion of preventive and routine healthcare. The model ensures the provision of brief behavioral health interventions (including for maternal depression) for families during well-child visits, referrals for substance abuse, family planning, and successful participation in early intervention. HealthySteps places a very heavy emphasis on closed loop referrals. The HealthySteps Specialist works with other clinic- and community-based resources to ensure families are linked with services and actually receive those services. Furthermore, the model has the potential to link caregivers to adult services on the same day those concerns are identified through the well child visits. In Medicaid expansion states where children are often enrolled in the same plan as their caregivers, MCOs can benefit from dyadic service delivery to bring down the total cost of care for the entire family.

**Benefit: Reaching High Utilizing Caregivers** According to the HealthySteps National Office, there is a growing interest by Medicaid MCOs in thinking more about team-based care and the benefits of programs like HealthySteps that not only provide critical services to young children but also reach their caregivers in the safe and positively regarded setting of pediatric care. Well child visits are an opportunity to address issues for which parents/caregivers may not otherwise seek care, oftentimes due to the lack of a primary care provider or stigma associated with their concerns. An MCO in Washington, D.C., ran claims data for families being served in HealthySteps and found that participating parents were often the most difficult to reach, had frequent ER visits and behavioral health crises, had substance abuse issues, and were dealing with very significant social needs. We know that while these adults may not seek care for their own concerns, they will take their children to well-child visits.

The pilot will provide state and national policy makers, health system leaders, and advocates with essential information and experience to inform the scaling and sustainability of this vital approach.

## SUSTAINABILITY

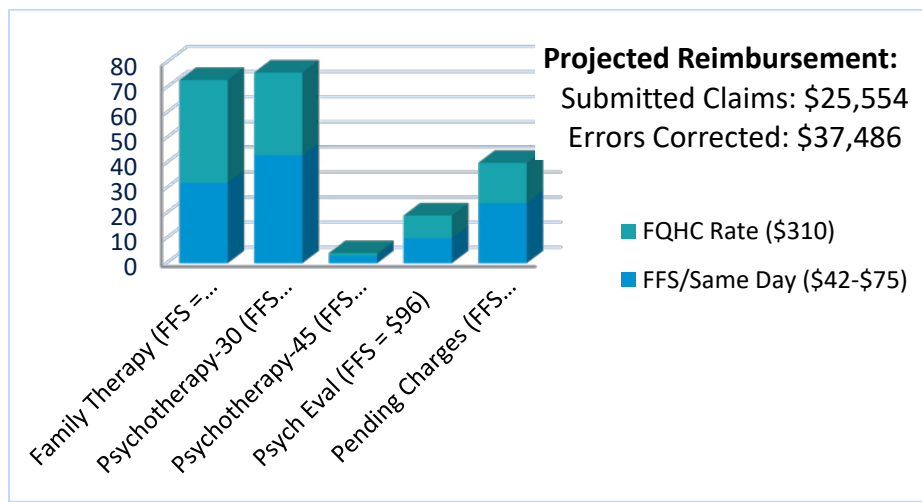
The UCSF Technical Assistance Team will work with county stakeholders to identify local partners to whom eventual TA needs may be transitioned at the end of the proposed pilot. For example, partnerships should be established with local infant mental health clinical programs to establish ongoing reflective supervision/consultation to behavioral health practitioners. Additionally, we will look at leveraging higher education academic programs to include more early childhood mental health content in their curricula. This would provide the opportunity to collaborate with master's level counseling/social work training programs, that already teach about integrated behavioral health, to include specific infant/early childhood behavioral health material. Sites may also consider building a practicum training program as a mechanism for creating a pipeline for a sustainable workforce in this area.

The proposed pilot will be implemented simultaneously with the statewide rollout of the new Family Therapy Benefit. The Benefit opens Z codes and redefines Medical Necessity criteria. There is no cap on the number of family therapy visits billed with ICD-10 code Z65.9 in place of a mental health diagnosis code. However, for children without a specified risk factor who are suspected of having a mental health disorder, no diagnosis is required until after the fifth visit.

Billing through the family therapy benefit is already underway at San Francisco General Hospital Children's Health Center, in partnership with San Francisco Health Plan. That early stage pilot projects the following billing revenue in 2021 Q1:

**650 Encounters > 261 Appointments (40%) > 213 Billable Visits (33%) > 73 Family Therapy Visits (11%)**

**\* Family Therapy accounted for 34% of all billable visits \***



**\*Note: Of the 213 billable claims, those that were correctly submitted are projected to garner \$25,554 in reimbursement. After erroneous claims (i.e. diagnoses entered incorrectly or the wrong payer was billed, etc.) are corrected, the total claims revenue is projected to be \$37,486 for Q1 2021. This amount is projected to cover approximately 75% of a behavioral health clinician staffing costs.**

**APPENDIX A: DETAILED DESCRIPTION OF TECHNICAL ASSISTANCE TO BE PROVIDED TO CLINICS**

**Proposed Scope of Work**

The proposed areas of focus for technical assistance services are as follows:

- I. Engagement, Assessment, and Model Development**
  - a. Conduct stakeholder engagement and advocacy
  - b. Complete multi-system landscape assessment
  - c. Outreach to health plans
  - d. Develop technical assistance model and select target sites
  
- II. Site and Systems Specific Technical Assistance**
  - a. Improve workforce capacity through training and continuing medical education
  - b. Support clinical service delivery
  - c. Provide sustainability support
  - d. Conduct learning collaboratives
  
- III. Research and Evaluation**
  - a. Develop countywide metrics
  - b. Identify an infrastructure for countywide reporting
  - c. Conduct data collection and analysis
  - d. Draft an evaluation report and disseminate findings

<b>I. Engagement, Assessment, and Model Development</b>			
<b>Proposed Service</b>	<b>Scope of Service</b>	<b>Example Activities/Deliverables</b>	<b>Phase</b>
<b><i>Conduct stakeholder engagement and advocacy</i></b>	Present on dyadic behavioral health service models to county leadership and local stakeholders to leverage interest and partnership in developing a sustainable model of care that crosses systems to meet the needs of infants, young children, and their caregivers.	<ul style="list-style-type: none"> <li>- Present dyadic BH sustainability and scaling options/models to FIRST 5 Commissioners</li> <li>- Present to county behavioral health service providers</li> <li>- Present to health plans and other identified stakeholders</li> <li>- Summarize feedback from county leaders and stakeholders</li> </ul>	Phase 1
<b><i>Complete multi-system landscape assessment</i></b>	Assess readiness of community, sites, and health plans to adopt dyadic integrated behavioral health model(s) and select/finalize model approach.	<ul style="list-style-type: none"> <li>- Draft county landscape assessment (or interpret existing assessments and identify gaps for further assessment)</li> <li>- Finalize model recommendation and approach</li> </ul>	Phase 1

<b>I. Engagement, Assessment, and Model Development</b>			
<b>Proposed Service</b>	<b>Scope of Service</b>	<b>Example Activities/Deliverables</b>	<b>Phase</b>
<b><i>Outreach to health plans</i></b>	Meet with health plan leadership to communicate updates on project efforts and identify opportunities to partner on piloting a sustainability plan. Partner with health plans to stand up infrastructure for service reimbursement.	<ul style="list-style-type: none"> <li>- Assess health plan readiness to reimburse for services</li> <li>- Serve as liaison between health plans that are engaged in dyadic billing pilots, such as with the San Francisco pilot through Anthem and San Francisco Health Plan.</li> <li>- Design and develop quality and incentive strategies as part of sustainability options</li> <li>- Support technical infrastructure building &amp; tracking mechanisms for services at the plan level</li> <li>- Liaise with DHCS as needed</li> </ul>	Phase 1-2
<b><i>Develop technical assistance (TA) model and select target sites</i></b>	Collaborate with FIRST 5 to develop initial TA model to begin July 2021.	<ul style="list-style-type: none"> <li>- Develop training and TA plan from findings of landscape assessment</li> <li>- Develop and facilitate process to identify initial target sites</li> <li>- Collaborate with FIRST 5 to review and select sites</li> </ul>	Phase 1
<b><i>Implement Technical Assistance Model with Selected Sites</i></b>	Implement pilot training and TA model with initial cohort of selected clinics. Implement a continuous feedback process to adapt TA strategies and goals to fit within county and clinic needs. Create a plan for transitioning site support back to the county for ongoing TA needs after contract ends.	<ul style="list-style-type: none"> <li>- Build off of initial TA plan and make necessary adjustments for Y2</li> <li>- Create plan to transition TA back to county after Y2</li> </ul>	Phase 2



<b>II. Site and Systems Specific Technical Assistance</b>			
<b>Proposed Service</b>	<b>Scope of Service</b>	<b>Example Deliverables</b>	<b>Phase</b>
<b>Conduct learning collaboratives</b>	Facilitate a learning collaborative with cohorts of sites participating in uptake of dyadic BH services that focuses on shared goal setting, sharing of strategies, and building a collective impact.	<ul style="list-style-type: none"> <li>- Host and facilitate Kick-Off meetings including initial workforce capacity building measures (i.e., HealthySteps Institute if this is the selected model)</li> <li>- Prepare quarterly progress reports on shared progress of cohort</li> <li>- Facilitate quarterly collaborative meetings</li> <li>- Facilitate monthly site leadership meetings</li> </ul>	Phase 2-3
<b>Improve workforce capacity through training</b>	Provide education and training to support sites' medical teams' capacity to identify, assess, and intervene on early childhood, dyadic, and family mental health needs effectively in the primary care setting. <i>(This will occur concurrently with the below section, beginning with general concepts, theory, and benefits – with the idea to build site and leadership buy-in – and then capacity building will become more specific and targeted as the clinical team ramps up and practice needs are determined.)</i>	<ul style="list-style-type: none"> <li>- Facilitate shadowing at San Francisco site</li> <li>- Provide weekly TA to behavioral health clinicians</li> <li>- Conduct regular reflective supervision to behavioral health clinicians</li> <li>- Facilitate monthly meetings with leadership team</li> <li>- Identify training opportunities</li> <li>- Review duty statements and job descriptions; support staff onboarding</li> <li>- Develop competencies for all disciplines working on integrated team</li> <li>- Assist with Infant &amp; Early Childhood Mental Health endorsement process (for interested clinicians)*</li> <li>- Training modules provided by UCSF Child Trauma Research Program**</li> </ul>	Phase 2-3
<b>Support clinical service delivery</b>	Support implementation of a sustainable, team-based, evidence-based clinical model that promotes infant and early childhood mental health and development, buffers toxic stress, and mitigates intergenerational trauma. Clinical services should include screening, triage, assessment, intervention, and referral/follow up. Operational supports should include supporting building the technology infrastructure and supporting site workflows.	<ul style="list-style-type: none"> <li>- Conduct monthly meetings to support clinical implementation</li> <li>- Review individual site assessments of current operations, staffing, clinical need</li> <li>- Develop implementation plan</li> <li>- Develop quality improvement strategy and provide analysis support</li> <li>- Outline requirements for billing infrastructure design &amp; tracking support</li> <li>- Create toolkit with resources for the electronic health record</li> </ul>	Phase 2-3

<b>II. Site and Systems Specific Technical Assistance</b>			
<b>Proposed Service</b>	<b>Scope of Service</b>	<b>Example Deliverables</b>	<b>Phase</b>
<b><i>Provide sustainability support</i></b>	Identify diverse billing and coding incentive strategies to cover cost of early childhood integrated behavioral health services. Support infrastructure development within each clinical site, health system, and health plan to support the uptake of billing/coding.	<ul style="list-style-type: none"> <li>- Review sustainability options &amp; select pilot sustainability strategy**</li> <li>- Develop evaluation and tracking mechanisms for service utilization and billing</li> </ul>	Phase 2-3

***\* Infant & Early Childhood Mental Health Endorsement has an associated cost that is beyond the scope of this proposed budget.***

***\*\*UCSF Training Modules has an associated cost that is beyond the scope of this proposed budget.***

***\*\*More than one viable sustainability strategy may be available.***

<b>III. Research and Evaluation</b>			
<b>Proposed Service</b>	<b>Scope of Service</b>	<b>Example Deliverables</b>	<b>Phase</b>
<b><i>Develop countywide metrics</i></b>	Develop countywide shared system of metrics that encompasses service utilization and financial targets. Work with health plans to identify metrics that link to sustainability.	<ul style="list-style-type: none"> <li>- Align early childhood quality improvement metrics with dyadic BH targets at each clinic</li> <li>- Create metrics representing the variety of TA domains</li> <li>- Disseminate shared metrics and plan for data collection</li> </ul>	Phase 2
<b><i>Identify an infrastructure for countywide reporting</i></b>	Support clinics with reporting on identified metrics that leverage medical record technology, facilitate quality improvement assessment, and reduce the burden of data entry on providers.	<ul style="list-style-type: none"> <li>- Conduct gap analysis of data reporting infrastructure within county and sites</li> <li>- Align quality improvement strategies with shared metrics</li> <li>- Support site efforts to report on shared metrics</li> </ul>	Phase 2
<b><i>Conduct data collection and analysis</i></b>	Train providers on data service documentation and establish a system to monitor fidelity of data reporting. Create workflow for data abstraction and regular reporting.	<ul style="list-style-type: none"> <li>- Conduct provider training</li> <li>- Establish fidelity tracking system on billing and coding requirements</li> <li>- Create plan for each site to abstract EMR data to support data reporting</li> </ul>	Phase 2

III. Research and Evaluation			
Proposed Service	Scope of Service	Example Deliverables	Phase
<b>Draft an evaluation report and disseminate findings</b>	Conduct ongoing evaluation of TA process and identify outcomes to inform practice improvement and disseminate to stakeholders.	<ul style="list-style-type: none"> <li>- Produce quarterly reports of relevant operations, services, and claims data to develop targeted TA</li> <li>- Produce quarterly reports from cohort of sites using shared metrics</li> </ul>	Phase 2
	Create annual evaluations and final report focusing on evaluation of TA and established metrics. Partner with FIRST 5 to disseminate findings to stakeholders.	<ul style="list-style-type: none"> <li>- Annual reports of ROI if using HealthySteps model</li> <li>- If using the HealthySteps model, conduct business case to assess return on investment for providing prevention and health promotion services for young children and families served in primary care (*additional cost to implement HealthySteps model)</li> </ul>	Phase 3

### Proposed Annual Project Budget

The following table describes the proposed annual budget for this two-year pilot project.

Project Phases 2 and 3: July 1, 2021 – June 30, 2023	Annual Subtotal
<b>UCSF Technical Assistance Project Team</b>	<b>Salary &amp; Benefits</b>
Manager of Practice Improvement (.40 FTE) <ul style="list-style-type: none"> <li>• <i>Project management, staff supervision, practice improvement strategic consultant, clinical financing and coding support, and systems liaison</i></li> </ul>	\$72,960
Medicaid Financing Consultant <ul style="list-style-type: none"> <li>• <i>Engagement and advocacy with stakeholders, such as policy makers and health plans, to develop and implement sustainability strategies</i></li> </ul>	\$50,000
3 ECMH Clinical Consultants (1.5 FTE) <ul style="list-style-type: none"> <li>• <i>Direct technical assistance and coaching to clinic staff, including reflective supervision and training and clinical model implementation support</i></li> </ul>	\$208,050
Data Manager/Administrative Coordinator (1.0 FTE) <ul style="list-style-type: none"> <li>• <i>Informatics, data training, management, and analysis; QI consultant &amp; administrative coordination.</i></li> </ul>	\$102,200
Postdoctoral Research Fellow (1.0 FTE) <ul style="list-style-type: none"> <li>• <i>Develop materials and trainings, data analysis and reporting, gathering evidence support and national examples to inform site decision making, and data infrastructure design</i></li> </ul>	\$69,300
UCSF Administrative Contract Support (.05 FTE) <ul style="list-style-type: none"> <li>• <i>Managing contracts, such as through financing and invoicing</i></li> </ul>	\$8,760
<b>Other Costs</b>	
Materials (software, graphic support, etc.)	\$15,000
UCSF Indirect Costs (~30%) <ul style="list-style-type: none"> <li>• <i>Facilities and administrative costs to support the UCSF research enterprise, and vary depending on contract type</i></li> </ul>	\$157,881
<b>Annual Total</b>	<b>\$684,151</b>

County of Santa Clara  
Board of Supervisors  
Supervisorial District Four  
Supervisor Susan Ellenberg



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103730

**DATE:** November 17, 2020

**TO:** Board of Supervisors

**FROM:** Susan Ellenberg, Supervisor

**SUBJECT:** Expansion of the Universal Developmental Screening Initiative

**RECOMMENDED ACTION**

Approve referral to Administration to report to the Board with options for consideration relating to expanding the Universal Developmental Screening Initiative in the Santa Clara County Health and Hospital System in partnership with FIRST 5 Santa Clara County and community health system partners. (Ellenberg)

**REASONS FOR RECOMMENDATION**

Santa Clara County has a history of innovation and leadership in serving the needs of children through our Health and Hospital System including expanding access to care, utilizing trauma informed practices, and leveraging partnerships for early intervention services. The adoption of the Universal Developmental Screening Initiative by the Board of Supervisors in 2013 was a key step in improving early identification of developmental and social-emotional needs of young children to improve their long-term health, educational and behavioral health outcomes<sup>1</sup>. Since 2013, the local, state and national emphasis on these early childhood interventions has only grown, and new opportunities for provider training, parental supports and reimbursement for care have emerged.

This referral directs Administration to build on and expand the Universal Developmental Screening Initiative (USDI), in partnership with FIRST 5 of Santa Clara County, to explore three key goals:

1. Include Adverse Childhood Experiences (ACEs) screenings for children into routine well-child visits.
2. Establish integrated supports for mental, behavioral and social-emotional wellness into obstetric/gynecologic, pediatric and/or family practice clinics for children and their parents or caregivers when needs are identified through ACEs or developmental screenings.

3. Extend models of screening, support services, and billing beyond VMC clinics to community clinic partners or private health care systems, in partnership with local health plans.

This revitalization of the USDI should begin with the convening of local stakeholders and a planning period to develop a pilot program that may be launched in County or partner clinics to achieve the goals outlined above. The pilot program should address and evaluate:

- Mechanisms of systems coordination and linkage to care,
- Maximizing billing and financial reimbursement for screening and supportive services,
- Required staffing models for service delivery, and
- Health plan policy issues including mental health parity requirements.

A pilot program plan and timeline should be presented to the Board of Supervisors by the Spring of 2021 for consideration and include clear options on program design, budget and funding sources.

As with the prior workgroups supporting the Universal Developmental Screening Initiative, it is recommended that FIRST 5 and a designee of the Health and Hospital System co-chair the initiative to develop plans collaboratively. FIRST 5 has committed to pursue a technical assistance agreement with the USCF HealthySteps Program to support pre-pilot planning with a collaborative funding approach among stakeholders without utilizing County general funds. Participants for this effort may include representatives from the County Health and Hospital System Medical Staff, VMC Administration, the Behavioral Health System Department, the Public Health Department's Maternal and Child Health Branch and Valley Health Plan. Additional engagement of local community clinics, Community Health Partnership, Anthem and the Santa Clara Family Health Plan would support expanded reach and sustainability of recommended options to be developed in response to this referral.

Notably, this referral is intended to focus on routine integrated screening for mental, behavioral, social-emotional health and trauma for all children through well-child visits and improving access for these universal screenings. Separate efforts underway in the County, in response to a referral by Supervisor Chavez<sup>2</sup>, to explore the development of a center for specialized diagnostic screenings for children and families with identified needs is an entirely complementary effort and together these efforts can expand the continuum of supports for children and families.

## **FISCAL IMPLICATIONS**

Approval of this referral would result in only minimal expense to the County in the form of staff time to participate in planning activities and development of options to report back to the Board of Supervisors. It is expected that County staff, in partnership with local health plans and providers, would develop options for a pilot program that includes billing mechanisms and funding sources to be presented to the Board prior to any commitment of County financial resources. Consistent with the goals above, any pilot program developed should be focused on sustainability of expanded childhood screening and early intervention

services rather than being dependent on the County general fund or term-limited grant resources.

## **BACKGROUND**

Since 2006 the County of Santa Clara has partnered with FIRST 5 of Santa Clara County to develop, implement and evaluate systems of screening and support to meet the developmental and behavioral health needs of young children through the KidConnections Network.

In January 2013 the Santa Clara County Board of Supervisors, in response to a referral from Supervisor Ken Yeager, approved a referral to launch the Universal Developmental Screening Initiative<sup>1</sup> to ensure that developmental and behavioral screening with a standardized tool for children birth through age five is routinely conducted during well-baby/well-child checks in pediatric clinics throughout Santa Clara County. This broad approach was intended to enable the earliest possible identification of developmental and behavioral concerns in young children and facilitate connections to comprehensive assessment, educational and early intervention services. A successful pilot program from 2014 – 2017 showed that American Academy of Pediatric recommended screenings<sup>3</sup> could be funded in a sustainable manner leveraging health plan and state incentives. These findings led to the placement of Licensed Vocational Nurses in each of the eight VMC pediatric clinics to conduct developmental and behavioral health screenings at all well-child clinic visits starting in 2018.

Continued support and expansion of early childhood screenings was identified as one of the seven key priorities arising out of the County of Santa Clara's Child Health Assessment<sup>4</sup>. Action plans developed in the Santa Clara County Children's Health Improvement Plan<sup>5</sup> and the California ACEs Aware Initiative<sup>6</sup> have placed continued importance on broad access to screenings and integrated supports for children and families.

FIRST 5 Santa Clara County is currently exploring a partnership with UCSF's HealthySteps Program<sup>7</sup> to obtain technical assistance to inform strategies that could be applied to County Health and Hospital system clinics or community clinics in Santa Clara County. UCSF's HealthySteps Program launched a pilot program in 2019 to provide an integrated program of screenings and mental health supports to children and their parents/caregivers in pediatric health clinics, as well as how to maximize MediCal billing for program sustainability.

## **REFERENCES**

- 1) Supervisor Ken Yeager. Board Referral: Approve referral to Administration to establish a Universal Developmental Screening Initiative. Approved 2013 by the Santa Clara County Board of Supervisors.
- 2) Supervisor Cindy Chavez. Board Referral: Approve referral to Administration to report to the Board with options for consideration relating to an in-depth study on the current landscape and possibilities of creating a diagnostic center for children in the County. Approved November 5, 2019 by the Santa Clara County Board of Supervisors.
- 3) American Academy of Pediatrics (2006). *Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*. Retrieved from <https://pediatrics.aappublications.org/content/pediatrics/118/1/405.full.pdf>

- 4) County of Santa Clara, Public Health Department (2017). *Status of Children's Health: Santa Clara County 2017*. Retrieved from <https://www.sccgov.org/sites/phd/hi/hd/reports/child-health/Documents/status-v2.pdf>
- 5) County of Santa Clara, Public Health Department (2014). *Children's Health Improvement Plan 2018*.
- 6) California ACEs Aware Initiative, <https://www.acesaware.org/>
- 7) HealthySteps National Program Office, <https://www.healthysteps.org/>



**Responses to SCFHP’s Questions Regarding the Proposal  
 “Transforming Child Health with Early Childhood Behavioral Health Integration in Primary Care”  
 June 18, 2021**

1. Can SCFHP have input into the 7-10 practices to target? Our top PCP providers by number of members 0-5 years old (June 2021):
  - Yes. We will develop a Project Leadership Committee that will include SCFHP and other key stakeholders to co-design and provide oversight of the project, including site selection. FIRST 5 will be the backbone entity/lead for this project.

PCP Prov TIN	Grand Total	
946000533	8728	Valley Medical Center
941340523	3603	Kaiser
942476242	1701	Indian Health Center
941743078	1123	Gardner
237255435	713	BACH
941156581	443	PAMF
820789148	349	Bay Area Pediatric Care
943372130	340	Ravenswood
814537987	328	Juan Carrillo
770031679	287	School Health Clinics
262674804	254	Indira Venuri

2. If the state is implementing this benefit in January 2022, SCFHP would need to train all participating providers, not just the top 7-10. Will we be duplicating efforts and/or will the training be consistent between UCSF and SCFHP? Should we wait for state guidance on billing to minimize confusion?
  - We will develop a capacity strengthening/training plan as part of this pilot project to avoid and mitigate duplication of efforts.
  - We do not recommend waiting until the state issues guidance on the dyadic benefit because while that will significantly support sustainability of this model of care, there is much work within and sustainability possibilities that can be leveraged using the existing Family Therapy Benefit. The recent claims analyses we conducted in the pilot program in San Francisco indicated that the preliminary billing that was done within existing claims allowances provided a sustainability pathway for up to 75% of our current staffing. For FQHCs in particular, the work that can be performed on non-same day visits (i.e., behavioral health visit done on a different day from the medical visit) using the Family Therapy Benefit that is eligible for the full Prospective Payment System (PPS) rate, makes sustaining dyadic behavioral health services possible.



**SECTION 7. Section 14132.755 is added to the Welfare and Institutions Code to read:**

**14132.755.** (a) Commencing no sooner than January 1, 2022, dyadic behavioral health visits shall be a covered benefit under the Medi-Cal program, subject to utilization controls.

(b) The dyadic services benefit is a family and care-giver focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and fosters access to preventive care for children, rates of immunization completion, coordination of care, child social-emotional health and safety, developmentally appropriate parenting and maternal mental health. Dyadic behavioral health visits are provided for the child and caregiver or parent at medical visits, providing screening for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability, and referrals for appropriate follow-up care.

3. Goal—sustainably integrate dyadic into high volume clinics (7-10):
  - A. Many of these high volume clinics are FQHCs, so they will not be able to ‘earn’ more revenue than the PPS rate, per current regulations.
    - While subject to the same day exclusion and more narrow provider qualification requirements (fully licensed staff listed on their scope), FQHCs can bill the Mild to Moderate as a separate visit. The Fee-for-Service (FFS) payment received by the MCO is an eligible visit during the reconciliation process.
    - What this means in practice is the MCO pays the FQHC an FFS payment for an eligible visit (for example \$90 for a family therapy session). If the PPS rate for the FQHC is \$290, the state and feds make an additional payment to the FQHC (in this example, an additional \$200).
    - Additionally, the dyadic behavioral health services that we support implementing consist of a hybrid model of same day and follow up visits. The follow-up visits conducted on a different day from another medical visit are eligible for the full PPS rate and thus create a promising pathway for sustaining the full scope of services.
  - B. (1) Do these clinics have to hire new/different staff to perform this work?
    - Some clinics will choose to re-allocate their existing staff, especially if they have existing behavioral health clinician staff. Other clinics will choose to hire staff that would be exclusively dedicated and specialized to provide dyadic services.
  - (2) How will the extra cost be funded before reimbursement is established?
    - As part of the site selection, implementation and sustainability planning process in the first half of Phase 2 of the proposal, FIRST 5 will work with partner sites to identify their individual resource needs and how to address them.
    - FIRST 5 has made an allocation from our own funds, in addition to the savings from the 15% reduction in indirect costs in this proposal from UCSF (which had originally proposed an indirect cost rate of 30%), to support any identified extra costs to be funded before reimbursement is established.

- Not all participating sites will need to be funded for extra costs to participate in this project, such as Valley Medical Center. In discussions about being a potential participant in this project, Valley Medical Center has agreed to explore utilizing their existing staff and/or leverage staff funded through FIRST 5 as part of being a Help Me Grow/KidConnections provider (which is sustained through Medi-Cal/EPSDT), so there will be project savings from not having to provide incentives and start-up/ramp-up costs for Valley Medical Center as a potential participant.
- (3) For FQHCs, new reimbursements are included in the PPS max reimbursement reconciliation
- See response to question 3A above regarding follow-up visits.
- C. What is the level of interest by these providers, as they will have to incur additional FTE costs and the visits are extended for the providers? The providers (Pediatricians/Family Practitioners) will need to extend oversight to another FTE and the related activities.
- Our preliminary discussions with Valley Medical Center and Gardner Health Services indicate that there is a high level of interest by providers to receive technical assistance from UCSF to develop a sustainable staffing model that is customized to each participating clinic.
  - The proposal includes engagement with partners to develop capacity strengthening/training, implementation and sustainability plans that will address additional costs, oversight, and other implementation activities.
- D. Please share evidence of HEDIS improvement from HealthySteps/dyadic clinics.
- See link for “How HealthySteps Connected Kids to Coverage”:
    - <https://www.healthysteps.org/article/healthysteps-and-connecting-kids-to-coverage-50>
    - <https://www.healthysteps.org/article/healthysteps-evidence-10>
  - Randomized Controlled Trial findings showed that HealthySteps children were:
    - 1.5 to 2.4 times more likely to receive age-appropriate well-child visits on time than children in the control group;
    - 1.4 to 1.6 times more likely to receive age-appropriate vaccinations on time, and 1.4 times more likely to be up-to-date on their vaccinations by 2 years old;
    - 8 times more likely to receive a developmental assessment at 30-33 months; and
    - 23% less likely to visit the emergency room for injury-related causes in a 1-year period.
  - Additional Evidence not related to HEDIS metrics—Healthy Steps parents/caregivers were:
    - 10 times more likely than those in the control group to discuss six or more age-appropriate topics with clinic professionals;
    - 27% less likely to use severe physical discipline such as a slap in the face or spanking with an object;
    - 4 times more likely to receive information on community resources;
    - More likely to be satisfied with their pediatric care; and

- Almost twice as likely to remain with the same practice until their child was at least 20 months old. The evaluations also found that HS families were more likely to:
  - ✓ Discuss important concerns, including nutrition, discipline, language development, child temperament, and maternal depression and anxiety;
  - ✓ Show picture books to and play with their infants daily;
  - ✓ Interact sensitively with their infants by reading their cues; and
  - ✓ Ensure that newborns slept on their backs to prevent Sudden Infant Death Syndrome(SIDS).
  
- E. What is the level of interest and commitment from the provider system/organizations? Are there incentives for participation since there are start-up/ramp-up costs?
  - Our preliminary discussions with Valley Medical Center and Gardner Health Services indicate that there is a high level of interest by providers to receive technical assistance from UCSF to develop a sustainable model of integrated behavioral health. Partner commitments will be formalized as part of the site selection and implementation planning process, as indicated in the proposal for the first half of Phase 2 (July 1, 2021 – December 31, 2021).
  
  - Valley Medical Center has expressed their initial interest and commitment for this project to support the **Board of Supervisors’ Referral** that was approved in November 2020. This referral directs County Administration to build on and expand the Universal Developmental Screening Initiative, in partnership with FIRST 5 Santa Clara County, to explore three key goals: (1) Include Adverse Childhood Experiences (ACEs) screenings for children into routine well-child visits; (2) Establish integrated supports for mental, behavioral and social-emotional wellness into obstetric/gynecologic, pediatric and/or family practice clinics for children and their parents or caregivers when needs are identified through ACEs or developmental screenings; and (3) Extend models of screening, support services, and billing beyond **Valley Medical Center** health clinics to community clinic partners or private health care systems, **in partnership with local health plans**.
  
  - As part of the site selection and implementation planning process, FIRST 5 will work with partner clinics to identify the customized incentives/resource needs and develop a plan to address these needs. The sustainability plans that will be developed for each site in Phase 2 (FY 21/22) will address ongoing resource needs.
  
  - FIRST 5 has made an allocation from our own funds, in addition to the savings from the 15% reduction in indirect costs in this proposal from UCSF (which had originally proposed an indirect cost rate of 30%), to support any identified incentives and start-up/ramp-up costs.
  
  - Not all participating sites will need incentives or start-up/ramp-up costs, such as Valley Medical Center. In discussions about being a potential participant in this project, Valley Medical Center has agreed to explore utilizing their existing staff and/or leverage staff funded through FIRST 5 as part of being a Help Me Grow/KidConnections provider

(which is sustained through Medi-Cal/EPSDT), so there will be project savings from not having to provide incentives and start-up/ramp-up costs for Valley Medical Center as a potential participant.

- F. The proposal mentions behavioral health (BH) clinicians receiving training. Not all primary care clinics have such a person. Will the clinic have to hire this provider type or divert existing personnel to this training and work scope?
- Dyadic behavioral health services require a child development specialist or a behavioral health clinician to be part of the site staff. If a site does not have a staff member in this role, they would need to allocate or hire into that position. HealthySteps Specialist professional competencies are currently being developed. Dr. Margolis on the UCSF Technical Assistance Team is one of the six national experts writing these competencies.
  - See link for HealthySteps Specialist typical professional background: <https://www.healthysteps.org/article/preview/5118ad75-b1d0-4755-a66e-c08234054188#2>
- G. “Reimbursement strategies that can inform service sustainability” will need to address FQHCs’ PPS max reimbursement model that is part of CMS/DHCS rules. Does the project contemplate this?
- We have contemplated this question in depth and have sought guidance from various stakeholders to better understand exactly how same day claims are reimbursed, of which we have received divergent perspectives. As part of this project, we aim to clarify the answer as to whether additional same day behavioral health Fee for Service payments can be recuperated in addition to the PPS rate paid for a medical visit. In San Francisco, our claims analyses suggest that additional FFS payments for same day behavioral health services are recuperated above and beyond the PPS rate paid for another same day visit.
  - We have modeled sustainability scenarios for each of the multiple interpretations of how Mild to Moderate reimbursement should be managed in the context of PPS and the same day exclusion. As stated above we are working at the highest level of HHS and DHCS to generate specific guidance.
- H. Is an equivalent HealthySteps Specialist required for the practice? What is the background of the position?
- A child development specialist or behavioral health clinician with expertise in serving young children and families is required to optimally deliver the behavioral intervention. Many professionals, even those who specialize in children and families, do not have early childhood expertise. As is our plan in San Francisco, the UCSF TA team will provide the necessary training to behavioral health clinicians to ensure they have the skills and knowledge to deliver early childhood and dyadic behavioral health services. From the HealthySteps website, here is information about the typical professional background of a practitioner in a dyadic behavioral health model:
    - HealthySteps Specialists are frequently social workers with mental health training, psychologists, early childhood educators, and/or nurses with experience in early childhood development (the minimum requirement is a



bachelor's degree, although a master's degree is preferred). The National Office highly recommends that a practice hire a candidate with a mental health background (ideally infant and early childhood mental health or infant and early childhood development). Mental health professionals are well-suited for the position due to their clinical training, skills related to reflective practice, and the ability to provide consultation and care coordination. You can consult with the National Office prior to recruitment for this position to help clarify what professional background would best meet the needs of your practice and families, while also potentially maximizing your site's ability to bill for HS services. Our team can also provide a sample job description.

4. Besides funding, what role does SCFHP play? Additionally, it is not clear whether First 5 is asking SCFHP to fund these services for the providers? Is this proposal focused on capacity building, technical assistance and evaluation only, and not funding direct services? If yes, to funding services, will SCFHP need to augment our provider contracts?
  - We would like SCFHP's role to also be a partner in the reimbursement and integration of covered benefits in pediatric primary care and family practice settings. The Family Therapy Benefit and recently propose Dyadic Benefit will require SCFHP to load new codes, reimburse for new services, measure new data points and support practice improvement and quality—all work the plan can and will do, but in this case with the support of the UCSF Dyadic Care TA Center.
  - FIRST 5 is not asking SCFHP to fund these services for the providers but rather, to fund a portion of the technical assistance (as outlined in the proposal and budget) provided through UCSF to implement this pilot project.
5. What roles will Anthem, Valley Health Plan, and Kaiser play in the project?
  - We are requesting that the Medi-Cal Managed Care Plans in Santa Clara County collaborate to lead the State's adoption and implementation of dyadic models of integrated behavioral health. While little besides startup funding is being requested of plans outside their existing contractual obligations, this project is about speeding and demonstrating the impact of dyadic models in pediatric primary care settings—first and foremost, of course, on health outcomes and patient experience, but also on critical regulatory and quality measures relating access to preventive care, access to behavioral health and strategies to address the social determinants of health.
6. How is this program going to improve capacity of the medical provider to identify, assess, and triage, and then treat social, emotional, and developmental issues of infants and toddlers.
  - A model like HealthySteps has eight core components that are delivered across a tiered approach to the entire 0-3 patient population. Tier 1 services target the identification, assessment, and triaging aspect of the general population. Tier 2 and Tier 3 target additional specialist assessment and consultation in addition to treatment that occurs internally in some cases and externally via a targeted referral in other cases. Having dyadic behavioral health professionals onsite means the expanding of the medical team so that provider capacity improves by way of new knowledge and skills as well as the involvement of other team members to more appropriately and skillfully manage issues that are beyond the scope or time constraints of the provider.

- A. **Staffing:** Dyadic services requires adding a behavioral health clinician to the medical team. Many sites have also chosen to rethink, reallocate, or add staff members that can support the medical team with additional case management or navigation to help with resource or referral linkage.
  - B. **Tools:** The UCSF Dyadic TA Center partners with the HealthySteps National Office to make available all of the training, patient materials, and workflows that have been created to support and optimize the implementation of dyadic services. This also includes sharing of best practices around data reporting, including clinical informatics within the electronic medical record.
  - C. **Organization (e.g., practice transformation):** At the organizational perspective, dyadic models, like HealthySteps, have been shown to transform the way in which clinics provide care by improving the promise of pediatric primary care. They improve team-based functioning, reduce provider burnout, and identify/address patient risks and problems early so that there are fewer downstream negative consequences of unaddressed mental health risks. (Click on the following link for a summary of the evidence of HealthySteps on improving provider satisfaction and organizational functioning: [https://ztt-healthysteps.s3.amazonaws.com/documents/277/attachments/HealthySteps\\_Mitigates\\_Provider\\_Burnout.pdf?1588786899](https://ztt-healthysteps.s3.amazonaws.com/documents/277/attachments/HealthySteps_Mitigates_Provider_Burnout.pdf?1588786899))
7. Will this program include the county BH providers, as many of the children will need to be referred to them?
- Yes. This program will partner with Help Me Grow/KidConnections Network of providers (which includes Behavioral Health Services Department, Valley Medical Center, and six community-based organizations) who have been sustainably delivering specialty behavioral health services focused on the 0-5 population since 2006.
  - As part of the Board of Supervisors established Universal Developmental Screening Initiative, Valley Medical Center, Gardner Health Services, as well as other community pediatric health clinics are an integral part of the referral network into the Help Me Grow/KidConnections system of care. **Pediatric health clinics are the number one referral source into Help Me Grow/KidConnections and represent 40% of all incoming referrals.**
  - FIRST 5 and Behavioral Health Services Department co-fund the Help Me Grow/KidConnections Network, which is sustained by leveraging Medi-Cal/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) funds. **For example, in FY 19/20 Behavioral Health Services Department was able to leverage FIRST 5's investment in Help Me Grow/KidConnections as a match to obtain \$11,420,675 in Medi-Cal/EPSDT reimbursement.**
8. Santa Clara County is not a Whole Child county. How does this program apply to CalAIM in Santa Clara County?
- Whole Child refers to the integration of the California Children's Services (CCS) programs into Medi-Cal Managed Care plans, services and supports largely focused on medically fragile children (though admittedly, there are some lower acuity qualifying conditions).



- While CCS eligible children get enhanced services and care coordination and other benefits under the CCS program, they remain eligible for the full scope of benefits offered by Medi-Cal Managed Care plans under their contract with DHCS. This project is based on these benefits, specifically, the Mild to Moderate Behavioral Health Benefit. Santa Clara County's CCS integration status will not impact this project.
  - Dyadic services in primary care is entirely consistent with the stated intent and purpose of CalAIM, as well as the Children and Youth Behavioral Health Initiative (<https://lao.ca.gov/Publications/Report/4439>) and the Surgeon General's work focused on mitigating the impact of toxic stress (<https://www.acesaware.org/>).
  - Specific to CalAIM, addressing the social determinants of health through integrated behavioral health is a specific focus of the proposal as are enhanced care coordination models named in Enhanced Care Management and Population Health Proposals. CalAIM envisions a patient-centered and dramatically enhanced medical home model where culturally concordant and fully integrated services and supports are available to beneficiaries. **Dyadic models of care, which this proposal is proposing to implement, are not only consistent with the stated intent and purpose of CalAIM, but also are highlighted in the governor's recently released Children and Youth Behavioral Health Initiative. This proposal will build and strengthen participating sites' capacity to implement a dyadic model of care, such as Healthy Steps, that will be in alignment with the CalAIM vision.**
9. Will the funding for this project support BH clinicians to participate in intensive infant/early childhood BH training and reflective supervision? Or, for the primary care clinics?
- Yes. As part of the proposed technical assistance services, we include reflective supervision for clinicians learning to practice within the dyadic services in primary care. We will also work with experts and collaborators at Zero to Three and other renowned early childhood mental health programs, such as Dr. Alicia Lieberman's Child Trauma Research Program, to make trainings and other educational resources available. If HealthySteps is the selected model, the HealthySteps National Office has a series of catalogued e-learnings and webinars meant to support training needs of dyadic behavioral health providers. Trainings target both the clinics and BH Clinicians.
10. Is program for non-Medi-Cal patients?
- Yes. A service delivery plan will be developed for each clinic that will outline how children with varying health insurance plans will be served. Dyadic behavioral health services are recommended to support all young children and their families regardless of health insurance type.
11. How will the program support the new TA team trained to then train the providers outside the pilot?
- As part of the implementation phase of the collaboration with UCSF, we will develop a sustainability plan that includes transitioning as much of the TA as possible to the local Santa Clara County community. UCSF does not envision being involved long term in this project but is available to support as needed.
  - New sites outside of the original pilot that elect to utilize the HealthySteps model would be required to do some training and technical assistance with the HealthySteps National Office. Technical assistance supports that can be more easily transitioned to the local community would

include standardized workflows, EHR integration, network of care coordination, and catalogued trainings. Ideally, champions from the initial pilot cohort would emerge who would be interested in serving as TA supports to new practices interested in pursuing this type of service. UCSF could be available for lighter touch TA for additional practices in the future if there were interest.

12. For the improved Coordination and Access to Care, how does the model potentially link the caregiver on the same day to those concerns identified at the WCC visit?
  - The caregiver is connected with the dyadic BH clinician who assesses, intervenes, and refers (if necessary) on that same day during their child’s appointment. Many times, we learn that the support from the dyadic BH clinician is sufficient to meet the need, even if just initially, and is often preferred to receiving another referral. We have patient level data to support this from the San Francisco pilot.
- A. Does this mean that the BH team will need to have additional appointments available, or assign a case manager/BH provider available?
  - The dyadic behavioral health services we refer to leverage the periodicity of the well child visit schedule, meaning that we optimize connections with families by providing the service on the same day they are in clinic as a critical engagement strategy. The model needs to have BH clinicians available to do warm hand offs and provide same day supports as they arise. There are plenty of models for how to do this that could also leverage a hybrid open schedule for warm hand offs while also having some scheduled visits.
- B. Does this account for FQHC billing same day visits?
  - Yes, even with the same day restrictions of the FQHC practices, there needs to be at minimum a hybrid model where clinicians can conduct same day visits and warm hand offs in addition to having separately scheduled follow up visits. Our revenue modeling suggests that the Family Therapy Benefit would support much of the sustainability needs doing a limited amount of follow up scheduled visits in addition to the less lucrative same day BH visits.
13. For sustainability: what does this look like to sustain this program within Santa Clara County?
  - A. Are the partners who have participated within the pilot expected to train other providers/clinics?
    - UCSF will facilitate a learning collaborative as part of the initial pilot cohort and will develop materials and processes that would facilitate providers training one another in the future.
  - B. What is the proposal to fund this pilot to other clinics/providers?
    - This is a good question but it is yet to be determined. We will learn how to scale this project as part of this demonstration project with the safety net clinics in Santa Clara County, which includes development of recommended sustainability and revenue generation strategies to sustain this program.
14. Is the BH access issue addressed with this program?
  - Yes. By way of having qualified early childhood mental health staff on the team to manage behavioral health issues in-house and via early screening and intervention, we alleviate some of the bottleneck that is created in the referral to external programs. We also ensure that referrals that are made externally, such as to Help Me Grow/KidConnections Network for specialty





mental health, are appropriate and that families are ready to engage in treatment. This preventative approach helps to reduce waitlists and save time and resources.

- A. Are there recommendations to increase BH access (appointments and providers) to the children and caregivers?
  - By introducing a workforce to provide screening, assessment and early intervention to mitigate dyadic BH issues within primary care, we address many of the downstream bottleneck that occurs with external agencies. We also prevent problems from becoming worse by intervening early and in shorter, more effective doses, which makes for fewer referral needs later on.
- 15. In providing funding for past initiatives, the Governing Board has not recognized or funded overhead in excess of 15%. It appears overhead for UCSF in this proposal is ~30%.
  - UCSF can accommodate a 15% cap on indirect costs and has done so in the past.

## FY 2020-21 FOCUS

### Drive Quality Improvement & Achieve Operational Excellence

**DRAFT**

	Plan Objectives	Success Measures	Preliminary Year-End Status (as of 6/17/21)
1	Pursue benchmark quality performance	<ul style="list-style-type: none"> <li>• Increase screenings to <math>\geq 11,000</math> developmental, <math>\geq 5,000</math> trauma, &amp; <math>\geq 9,500</math> blood lead (children 0-3)</li> <li>• Achieve HEDIS average performance score of 2.52 for Medi-Cal and 2.02 for Cal MediConnect (CMC)</li> <li>• Reduce Medi-Cal Plan All-Cause Readmissions (PCR) to 7.48%</li> <li>• Achieve 75% of points required for Medi-Cal NCQA Interim Accreditation</li> </ul>	<ul style="list-style-type: none"> <li>- Increased screenings to 8,766 developmental, 4,785 trauma, and 3,954 blood lead</li> <li>x HEDIS average performance score stayed flat at 2.24 for Medi-Cal and decreased to 1.71 for CMC</li> <li>x Medi-Cal Plan All-Cause Readmissions increased to 9.55%</li> <li>- Achieved 72% of points for Medi-Cal NCQA Interim Accreditation</li> </ul>
2	Enhance compliance program and delegation oversight	<ul style="list-style-type: none"> <li>• <math>\geq 95\%</math> of metrics on Compliance Dashboard in compliance</li> <li>• Implement delegate oversight dashboard by December 2020</li> </ul>	<ul style="list-style-type: none"> <li>x 91.9% of Compliance Dashboard metrics in compliance</li> <li>x Initial version of delegate oversight dashboard published Jan.'21; efforts continue toward automation</li> </ul>
3	Improve IT infrastructure	<ul style="list-style-type: none"> <li>• Add Pharmacy, Case Management, and G&amp;A data to Enterprise Data Warehouse; produce reports</li> <li>• Implement vendor solution for Fast Healthcare Interoperability Resource (FHIR) by March 2021</li> <li>• Develop authorization submission capability in provider portal by March 2021</li> </ul>	<ul style="list-style-type: none"> <li>✓ EDW projects completed in March 2021</li> <li>x FHIR anticipated to be implemented in July 2021, meeting start of CMS enforcement</li> <li>- Development of auth submission capability in provider portal completed in April 2021; provider training and phased production rollout currently in progress</li> </ul>
4	Foster membership growth and retention	<ul style="list-style-type: none"> <li>• Increase Medi-Cal market share to 80%</li> <li>• Achieve net increase of 600 CMC members</li> <li>• Expand provider network in accordance with DHCS standards at network level</li> </ul>	<ul style="list-style-type: none"> <li>x Medi-Cal market share effectively unchanged at 78.7%; DHCS paused auto-assignment adjustment which was based on favorable CY'19 quality metrics</li> <li>✓ Directly enrolled 2,045 new CMC members, for a net increase of 1,051; increased market share to 84.6%</li> <li>- DHCS standard for 2021 changed to assessing overall Plan network; expanding network to fill gaps in South County for HIV/AIDs, endocrinology &amp; physical</li> </ul>

Critical Priority



## FY 2021-22 FOCUS

### Drive Quality Improvement & Reduce Health Disparities

**DRAFT**

	Plan Objectives	Success Measures
1	<b>Lead improvement in the health of communities impacted by disparities</b>	<ul style="list-style-type: none"> <li>Pursue bold initiative(s) to address community health disparities in collaboration with community partners</li> <li>Collaborate with community &amp; system partners on programs/services/resources at the CRC to advance health/well-being of members &amp; residents</li> <li>Explore South County community resource center</li> <li>Implement YMCA membership benefit for Medi-Cal and CMC members</li> <li>Expand health education offerings and participation for members and community</li> <li>Raise Plan visibility in community and with elected officials</li> </ul>
2	<b>Pursue benchmark quality and health equity</b>	<ul style="list-style-type: none"> <li>Increase screenings to <math>\geq 11,000</math> developmental &amp; <math>\geq 9,500</math> blood lead (&lt; 6 yrs), and <math>\geq 7,500</math> trauma (&lt; 65 yrs)</li> <li>Achieve HEDIS average performance score of 2.30 for Medi-Cal and 2.02 for Cal MediConnect</li> <li>Pursue reduction in HEDIS outcome disparities by network and ethnicity on <math>\geq 2</math> metrics</li> <li>Develop roadmap for NCQA Distinction in Multicultural Health Care</li> <li>Successfully pass NCQA re-survey of CMC by March 2022</li> <li>Execute 100% of Medi-Cal NCQA Delegation Agreements by June 2022</li> <li>Implement CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) by January 2022</li> <li>Create a Population Health Management (PHM) strategy that aligns with CalAIM and NCQA</li> <li>Increase behavioral health prevention and treatment in schools</li> </ul>
3	<b>Enhance compliance program and delegation oversight</b>	<ul style="list-style-type: none"> <li><math>\geq 95\%</math> of metrics on Compliance Dashboard in compliance</li> <li>Update delegate agreements to strengthen compliance enforcement</li> </ul>
4	<b>Foster membership growth and retention</b>	<ul style="list-style-type: none"> <li>Increase Medi-Cal market share to 80%</li> <li>Achieve net increase of 835 Cal MediConnect members</li> <li>Establish provider/delegate satisfaction baseline, by line of business, by March 2022</li> <li>Evaluate provider network access at a delegate level by March 2022</li> <li>Implement new provider payment vendor solution by November 2021</li> <li>Execute preparatory steps for Dual Eligible Special Needs Plan (D-SNP) implementation January 2023</li> </ul>
5	<b>Achieve budgeted financial performance</b>	<ul style="list-style-type: none"> <li>Achieve FY 2021-22 net surplus of \$8.6 million (0.6% of revenue)</li> <li>Maintain administrative loss ratio <math>\leq 7\%</math> of revenue</li> </ul>
6	<b>Seek to be an Employer of Choice</b>	<ul style="list-style-type: none"> <li>Achieve average of overall ratings on employee satisfaction survey that exceeds norm of CA plans surveyed</li> <li>Provide unconscious bias training to all staff, and diversity &amp; sensitivity training to management</li> </ul>

**Critical Priority**