Regular Meeting of the

Santa Clara County Health Authority Governing Board

Thursday, September 22, 2022, 12:00 PM – 2:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference Only
(408) 638-0968
Meeting ID: 811 0228 8572
Passcode: GovBd2022!
https://us06web.zoom.us/j/81102288572

AGENDA

1.	**Roll Call** Welcome new Governing Board Members, Jennifer Cloyd and Sarah Jeevanjee, MD.	Ms. Lew	12:00	5 min
2.	**Public Comment** 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.	Ms. Lew	12:05	5 min
3.	**Approve Consent Calendar and Changes to the Agenda** Items removed from the Consent Calendar will be considered as regular agenda items. **Possible Action:** Approve Consent Calendar	Ms. Lew	12:10	5 min

a. Approve minutes of the June 23, 2022 **Governing Board** Meeting
b. Accept minutes of the July 28, 2022 **Executive/Finance Committee** Meeting
   - Ratify approval of Claims Policies
     - CL.01 v5 Interest on the Late Payment of Claims
     - CL.02 v4 Misdirected Claims
     - CL.03 v5 Notice of Denial of Payment
     - CL.04 v3 Skilled Nursing Facility
     - CL.05 v3 Long Term Care
     - CL.06 v5 Inpatient Admission
     - CL.07 v6 Emergency Room Services
     - CL.08 v4 General Physician Professional Services
     - CL.09 v4 Claims Timeframes Turn-Around-Time
     - CL.10 v4 Provider Dispute Resolution
     - CL.11 v3 Ambulatory Surgery Center (ASC)
     - CL.13 v5 Processing of Family Planning Claims
     - CL.12 v3 Coordination of Benefits and Medicare_Medi-Cal Crossover Claims
     - CL.14 v3 Processing of Radiology Claims

- CL.15 v3 Processing of Anesthesia Claims
- CL.16 v3 Processing of Drugs and Biologicals Claims
- CL.17 v3 Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims
- CL.18 v3 Processing of Home Health Claims
- CL.19 v3 Processing of Rehabilitation Therapies Claims
- CL.20 v5 Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims
- CL.21 v5 Claims Processing & Adjudication
- CL.22 v5 Processing of Abortion Claims
- CL.23 v3 Overpayment Recovery
- CL.24 v3 Timely Processing of Non-Clean Claims
- CL.25 v4 Direct Member Reimbursement
- CL.26 v3 Claim Development of Non-Clean Non-Contracted Medicare Claims
- CL.27 v3 Non-Medical Transportation
- CL.28 v2 Other Health Coverage Cost Avoidance and Post Payment Recovery
- CL.29 v2 Third Party Tort Liability Reporting Requirements

- Ratify approval of the May 2022 Financial Statements
- Ratify approval of funding for the YMCA Diabetes Prevention Program from the Board Designated Innovation Fund
- Ratify approval of funding for the South County Compassion Center Rental Assistance Program from the Special Project Fund for CBOs

c. Accept minutes of the August 25, 2022 **Executive/Finance Committee** Meeting
- Ratify approval of the Network Detection and Prevention Update
- Ratify approval of Governance Policy GO.01 v2 Organizational Policies
- Ratify approval of Claims Policies
  - CL.02 v4 Misdirected Claims
  - CL.04 v3 Skilled Nursing Facility
  - CL.07 v6 Emergency Room Services
  - CL.10 v4 Provider Dispute Resolution
  - CL.28 v2 Other Health Coverage Cost Avoidance and Post Payment Recovery
- Ratify approval of the County of Santa Clara Reentry Resource Center sponsorship
- Ratify approval of the June 2022 Financial Statements
- Ratify approval of an adjustment to the use and terms of funding for the FIRST 5 Integrated Behavioral Health Pilot Project from the Board Designated Innovation Fund

d. Accept minutes of the August 31, 2022 **Compliance Committee** Meeting
- Accept Compliance Dashboard
- Ratify approval of HIPAA Policies
  - HI.01 v2 Privacy Officer Assignment and Responsibilities
  - HI.02 v2 Privacy Training Requirements
  - HI.03 v2 Minimum Necessary Standards
  - HI.06 v3 Request for Access
  - HI.07 v3 Amendments to Protected Health Information
  - HI.08 v2 Accounting of Disclosures

- HI.10 v3 Uses by and Disclosures to Business Associates and Third Parties
- HI.11 v3 De-Identification of Health Information
- HI.12 v3 Uses and Disclosures of Limited Data Sets
- HI.13 v2 Requests for Restrictions on Uses and Disclosures
- HI.14 v2 Request for Confidential Communications
- HI.16 v2 Reporting and Responding to Privacy Complaints
- HI.18 v2 Safeguards
- HI.19 v3 Notice of Privacy Practices
- HI.20 v3 Personal Representatives
- HI.22 v2 Individual Caller Identification
- HI.24 v2 Communications with Minors
- HI.25 v2 Leaving Message with PHI
- HI.26 v2 Uses and Disclosures of Protected Health Information
- HI.46 v2 Photographing, Video Recording, Audio Recording and Other Imaging
- HI.51 v2 Breach Notification Requirements

e. Accept minutes of the August 9, 2022 **Quality Improvement Committee** Meeting
- Ratify approval of the Cal MediConnect Availability of Practitioners Evaluation
- Ratify approval of the Annual E-Mail Quality and Analysis Report
- Ratify approval of the Santa Clara Family Health Plan Member Experience, including Behavioral Health: 2021 Analysis
- Ratify approval of QI Policies
  - QI.17 Behavioral Health Care Coordination
  - QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors
  - QI.21 Information Exchange Between SCFHP & SCCBHSD
  - QI.25 Palliative Care
  - QI.34 Housing and Homelessness Incentive Program
- Ratify approval of Committee Reports
  - Credentialing Committee - June 1, 2022

f. Accept minutes of the August 10, 2022 **Provider Advisory Council** Meeting

g. Accept minutes of the September 6, 2022 **Consumer Advisory Committee** Meeting

h. Approve **Publicly Available Salary Schedule**

i. Approve **D-SNP Encounter Submission Services Vendor Contract**

j. Approve **D-SNP Customer Service Support Vendor Contract**

k. Approve **2023 Board & Committee Meeting Calendar**

l. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953

4. July 2022 Financial Statements — Mr. Jarecki — 12:15 — 10 min

Review July 2022 Financial Statements.

Possible Action: Approve the July 2022 Financial Statements

5. Fiscal Year 2021-2022 Team Incentive Compensation — Ms. Tomcala — 12:25 — 10 min

Review performance on team incentive metrics.

Possible Action: Approve FY ’21-’22 Team Incentive Payout

6. Fiscal Year 2022-2023 Team Incentive Compensation Consider proposed team incentive compensation program. **Possible Action:** Approve FY '22-'23 Team Incentive Compensation Program	Ms. Tomcala	12:35	10 min
7. Innovation Fund Expenditure Request Consider designating funding for a health care scholarship program in honor of SCFHP's 25th Anniversary. **Possible Action:** Approve expenditure from the Board Designated Innovation Fund for a health care scholarship program	Ms. Byom	12:45	10 min
8. CEO Update Discuss status of current topics and initiatives.	Ms. Tomcala	12:55	10 min
9. Compliance Report Review and discuss compliance activities and notifications.	Mr. Haskell	1:05	5 min
10. Government Relations Update Discuss local, state, and federal legislative and policy issues impacting the Plan and its members.	Mr. Haskell	1:10	10 min
Announcement Prior to Recessing into Closed Session Announcement that the Governing Board will recess into Closed Session to discuss Item No. 11 below.			
11. Adjourn to Closed Session		1:20	60 min

a. **Existing Litigation** (Welfare and Institutions Code Section 54956.9(d)(1)):
It is the intention of the Governing Board to meet in Closed Session to confer with Legal Counsel regarding litigation initiated by a vendor. Case name unspecified: disclosure of case name may jeopardize existing settlement negotiations.

b. **Pending Litigation** (Government Code Section 54956.9(d)(1)):
It is the intention of the Executive/Finance Committee to meet in Closed Session to confer with Legal Counsel regarding Kindred Hospital - San Francisco Bay Area v. Santa Clara Family Health Plan; Superior Court of the State of California for the County of Alameda Case No.: RG20076644

c. **Contract Rates** (Welfare and Institutions Code Section 14087.38(n)):
It is the intention of the Governing Board to meet in Closed Session to discuss Plan partner rates.

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

12. Report from Closed Session	Ms. Lew	2:20	5 min

13. Annual CEO Evaluation Process Consider potential annual salary adjustment and incentive compensation for the Chief Executive Officer. **Possible Action:** Approve annual compensation for the CEO	Ms. Lew	2:25	5 min
14. Adjournment		2:30	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Executive/Finance Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The 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 Ashley Kerner 48 hours prior to the meeting at (408) 874-1896.
- To obtain a copy of any supporting document that is available, contact Ashley Kerner at (408) 874-1896. 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.

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Thursday, June 23, 2022, 12:00 PM – 2:30 PM
Santa Clara Family Health Plan - Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Bob Brownstein, Chair
Dave Cameron
Kathleen King
Liz Kniss
Sarita Kohli
Michele Lew
Sue Murphy
Ria Paul
Debra Porchia-Usher
Sherri Sager
Eva Terrazas

Members Absent
Alma Burrell
Darrell Evora

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 Operations Officer
Ngoc Bui-Tong, VP, Strategies and Analytics
Chelsea Byom, VP, Marketing, Communications & Outreach
Teresa Chapman, VP, Human Resources
Tyler Haskell, Interim Compliance Officer
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri, Controller
Mike Gonzalez, Director, Community Engagement
Khanh Pham, Director, Financial Reporting & Budgeting
Ashley Kerner, Manager, Administrative Services
Lloyd Alaban, Copy Writer & Content Strategist
Magaly Fernandez, Temp Community Health Worker
Robyn Esparza, Administrative Assistant
Rita Zambrano, Executive Assistant

Others Present
Lucy Navarro, Community Leader in Gilroy
Patty Pena, Community Leader in Gilroy
Richard Noack, Hopkins & Carley
Dolores Alvarado, Community Health Partnership
Reymundo Espinoza, Gardner Family Health Network
Elena Guzman, Community Health Partnership
Sonya Tetnowski, Indian Health Center
Laura Clendaniel, Healthier Kids Foundation
Laura Champion, Healthier Kids Foundation
Christine Rutherford-Stuart, Office of County Supervisor
Susan Ellenberg
Tiffany Washington, Valley Health Plan

1. Roll Call and Board Member Recognition

Bob Brownstein, Chair, called the meeting to order at 12:00 pm. Roll call was taken and a quorum was established.

Christine Tomcala, Chief Executive Officer, acknowledged outgoing board members Bob Brownstein, Darrell Evora, and Debra Porchia-Usher, and thanked them for their years of service.

2. Public Comment

Ria Paul arrived at 12:03 pm.

Patty Pena and Lucy Navarro, Gilroy Community Leaders, asked how SCFHP can help recreate the benefits of a Community Resource Center (CRC) in Gilroy.

Mr. Brownstein acknowledged their comments, noting the Board may not respond to their request at the meeting, as it was not an agenda topic.

3. Adjourn to Closed Session

a. Conference with Labor Negotiators
The Governing Board met in Closed Session to confer with its management representatives regarding negotiations with SEIU Local 521.

b. Contract Rates
The Governing Board met in Closed Session to discuss plan partner rates.

Ms. Porchia-Usher arrived at 12:45 pm.

4. Report from Closed Session

Mr. Brownstein reported the Governing Board met in Closed Session to discuss labor negotiations and contract rates.

5. Tentative Agreement with SEIU Local 521

Mr. Brownstein reported that during Closed Session, the health plan's negotiating team apprised the Board of a request to approve the agreement with SEIU Local 521.

It was moved, seconded, and the agreement with SEIU Local 521 was **unanimously approved.**

Motion:	Ms. Terrazas
Second:	Ms. King
Ayes:	Mr. Brownstein, Mr. Cameron, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Absent:	Ms. Burrell, Mr. Evora

6. 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 March 24, 2022 **Governing Board** Meeting
b. Accept minutes of the April 25, 2022 **Special Executive/Finance Committee** Meeting
- Ratify approval to continue use of teleconferencing

c. Accept minutes of the April 28, 2022 **Executive/Finance Committee** Minutes
- Ratify approval of Finance Policies
  - FA.01 v3 Finance - General
  - FA.02 v3 Cash & Cash Receipts
  - FA.03 v3 Cash Disbursements

- FA.04 v3 Accounts Receivable & Revenue
- FA.05 v3 Payroll & Employee Expenses
- FA.06 v3 Fixed Assets & Depreciation Expense
- FA.08 v3 Treasury & Debt
- FA.09 v3 Financial Close & Reporting
- FA.10 v3 Medical Expenses & Incurred-But-Not-Paid (IBNP)
- FA.11 v2 Healthcare Economics
- FA.12 v2 Employee Recognition Gift Cards

- Approve Microsoft License Renewal
- Ratify approval of the February 2022 Financial Statements
- Ratify approval of Investment Policy FA.07v4
- Ratify approval of an extension to the Institute on Aging Contract for Assisted Living Services
- Ratify approval of funding for the Alum Rock Counseling Center Clinic Renovations Project from the Board Designated Innovation Fund

d. Accept minutes of the May 26, 2022 **Executive/Finance Committee** Meeting

- Ratify acceptance of the Network Detection & Prevention Update
- Ratify approval of Finance Policy
  - FA.14 Board Committee Stipends
- Ratify approval of the Dynamic Module for D-SNP revenue reconciliation
- Ratify approval of the Healthcare Fraud Shield software solution
- Ratify approval to continue use of teleconferencing
- Ratify approval of the March 2022 Financial Statements

e. Accept minutes of the May 26, 2022 **Compliance Committee** Meeting

- Ratify approval of Compliance Policies
  - **o** CP.01 Regulatory Reporting
  - **o** CP.02 Fraud Waste and Abuse
  - **o** CP.04 Data Mining to Detect, Correct and Prevent FWA
  - **o** CP.05 Record Retention
  - **o** CP.06 False Claims Act
  - **o** CP.07 Corrective Actions
  - **o** CP.08 Compliance Reporting Mechanisms
  - **o** CP.09 Exclusion Screening
  - **o** CP.10 Compliance Training
  - **o** CP.11 Effective Communications
  - **o** CP.12 Annual Compliance Program Effectiveness Audit
  - **o** CP.15 Standard of Conduct
  - **o** CP.16 Vendor and FDR Contracting
  - **o** CP.17 Risk Assessment and Audit Work Plan
  - **o** CP.18 Protection of HIV AIDS Information
  - **o** CP.26 Compliance Hotline
  - **o** CP.30 Subcontracting Terminations and Block Transfer Filings
  - **o** CP.31 Conducting Internal Investigations
  - **o** CP.32 Conflict of Interest
  - **o** CP.33 Well-Publicized Disciplinary Standards
  - **o** CP.35 Key Personnel Filing
  - **o** CP.37 DMHC Independent Medical Review (IMR)
  - **o** DE.01 Delegation Oversight
  - **o** DE.02 Pre-Delegation Audit
  - **o** DE.03 Delegation Agreement
  - **o** DE.05 Joint Operation Committee Meetings Between SCFHP and FDRs/Delegated Entities
  - **o** DE.07 Delegation Corrective Action

f. Accept minutes of the April 12, 2022 **Quality Improvement Committee** Meeting

- Ratify approval of the Medi-Cal (MC) & Cal MediConnect (CMC) Quality Improvement (QI) Work Plan 2022
- Ratify approval of the MC & CMC QI Program Evaluation 2021
- Ratify approval of the Pharmacy Benefit Information Analysis
- 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.15 Transitions of Care
  - QI.16 Managed Long Term Services and Support Care Coordination
  - QI.19 Care Coordination Staff Education and Training
  - QI.23 SABIRT Misuse of Alcohol and Substances
  - QI.28 Health Homes Program
  - QI.30 Health Risk Assessment
  - QI.31 Community Supports (CS)
  - QI.32 Enhanced Care Management (ECM)
- Ratify acceptance of Committee Reports
  - Consumer Advisory Board– March 3, 2022
  - Pharmacy and Therapeutics Committee **–** March 17, 2022
  - Credentialing Committee Report – February 23, 2022

g. Accept minutes of the June 14, 2022 **Quality Improvement Committee** Meeting
- Ratify approval of the Cal MediConnect Cultural & Linguistics Provider
- Ratify approval of the CMC Population Health Assessment 2022
- Ratify approval of the CMC Population Health Management Impact Analysis
- Ratify approval of the CMC and Medi-Cal PHM Strategy 2022
- Ratify approval of the Activities and Resources Grid
- Ratify approval of QI Policies
  - QI.08 Cultural and Linguistically Competent Services
  - QI.20 Information Sharing with San Andreas Regional Center (SARC)
  - QI.22 Early Start Program (Early Intervention Services)
  - QI.33 SCFHP ECM Denial & Disenrollment
- Ratify approval of the Grievance & Appeals Report Q1 2022
- Ratify acceptance of Committee Reports
  - Utilization Management Committee– April 20, 2022
  - Consumer Advisory Board– June 2, 2022
  - Credentialing Committee Report – April 6, 2022

h. Accept minutes of the May 11, 2022 **Provider Advisory Council** Meeting

i. Accept minutes of the June 3, 2022 **Consumer Advisory Committee** Meeting

j. Approve **Publicly Available Salary Schedule**

k. Approve March 2022 **Quarterly Investment Performance & Compliance Report**

l. Approve **Cisco Phone System 3-Year Subscription Maintenance**

m. Accept **FY'21-'22 Donations & Sponsorships Annual Report**

n. Accept **Board Designated Project Funding Report**

o. Accept **FY'21-'22 Employee Gift Card Report**

p. Accept **2022 Employee Satisfaction Survey Highlights**

q. **Elect Officers** to a two-year term:
Chairperson – Michele Lew
Secretary – Sarita Kohli

r. Appoint **Sarita Kohli to the Executive/Finance Committee**

s. Appoint **Sherri Sager to chair the Consumer Advisory Committee**

t. Appoint **Sherri Sager, Sue Murphy, Michele Lew, Sarita Kohli, and Eva Terrazas to a temporary, ad-hoc subcommittee to conduct the annual evaluation of the CEO**

u. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953

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

Motion: Ms. Murphy
Second: Ms. King
Ayes: Mr. Brownstein, Mr. Cameron, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Absent: Ms. Burrell, Mr. Evora

7. April 2022 Financial Statements

Mr. Cameron left the meeting at 1:00 pm.

Mr. Jarecki presented the unaudited financial statements for April 2022, which reflected a current month net surplus of $7.9 million ($7.7 million favorable to budget) and a year-to-date net surplus of $24.3 million ($15.7 million favorable to budget) through ten months of the fiscal year.

Enrollment increased by 1,646 members from the prior month to 298,818 members (10,382 members or 3.4% lower than budget, largely due to fewer newly-eligible members having Other Health Coverage (OHC) than budgeted. Membership continues to grow due to the extended duration of the COVID public health emergency during which member disenrollments have been suspended. YTD member months trailed budget by 80,355 member months or 2.7%.

Revenue reflected a net favorable current month variance of $529 thousand (0.4%) due to several factor. Unfavorable variances resulted from: (1) the inclusion of Medi-Cal pharmacy throughout FY22 in the budget (pharmacy was carved-out of managed care effective January 1, 2022, which significantly reduced revenue (with a corresponding reduction to medical expense), (2) lower enrollment, predominately fewer OHC members (with a corresponding reduction to medical expense), and (3) additional CMC medical loss ratio accruals payable to DHCS. Positive variances resulted from: (1) favorable calendar year 2022 Medi-Cal non-dual CCI rates versus budget, (2) CY20 Medicare quality withhold earned in excess of accrual, (3) Enhanced Care Management (ECM) incentive payment earned in excess of accrual, (4) increased Prop 56 revenue and unbudgeted COVID vaccine program revenue.

Medical Expense reflected a net favorable current month variance of $7.7 million (6.8%) largely due to the favorable offsets of key revenue items above (pharmacy carve-out and reduced OHC enrollment). Additionally, certain fee-for-service expense categories reflected favorable variances due to reduced enrollment and lower utilization than budgeted. Increased Prop 56 expenses exceeded budget, offsetting increased Prop 56 revenue). The Plan received an unbudgeted pharmacy guarantee payment. Capitation expense was unfavorable to budget due to higher CY22 capitation rates paid vs. budget partially offset by lower enrollment vs. budget.

Administrative Expense was $246 thousand (3.6%) unfavorable to budget for the month largely due to the net effect of (1) lower headcount than budgeted and (2) an unfavorable variance in non-personnel expense due to the timing of certain expenses vs. in the budget.

The **Balance Sheet** reflected a Current Ratio, a key measure of liquidity, of 1.31:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $279.1 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $237.8 million.

Capital Investments of $1.0 million have been made year-to-date, predominately computer software licenses, versus the annual capital budget of $3.25 million.

It was moved, seconded, and the April 2022 unaudited Financial Statements were **unanimously approved.**

Motion: Ms. King
Second: Ms. Kniss
Ayes: Mr. Brownstein, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Absent: Ms. Burrell, Mr. Cameron, Mr. Evora

8. Fiscal Year 2022-2023 Budget

Mr. Jarecki presented the proposed 2022-2023 operating and capital budgets. Due to the extended Public Health Emergency (PHE), enrollment is projected to peak at 320,000 members by mid-year and decline thereafter as member disenrollments resume. Revenue is projected to decrease to $1.4 billion due largely to declining enrollment. Medical expense is projected to decrease to $1.3 billion also due largely to declining enrollment. Administrative expense is projected to increase to $90 million due to increased headcount (reflecting new programs, compliance requirements and addition complexities) and increased non-personnel expenses. The proposed operating budget projects a net surplus of $11.8 million (representing 0.9% of revenue) with many significant uncertainties throughout the year. The proposed capital budget of $6.1 million largely reflects enhancements to the Plan's information technology infrastructure.

It was moved, seconded, and the Fiscal Year 2022-20'23 Operating and Capital Budgets were **unanimously approved.**

Motion: Ms. Kohli
Second: Ms. Porchia-Usher
Ayes: Mr. Brownstein, Ms. King, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Absent: Ms. Burrell, Mr. Cameron, Mr. Evora

9. Innovation Fund Expenditure Requests

Ngoc Bui-Tong, VP, Strategies and Analytics, presented the Committee with two Innovation Fund requests. The first, from Community Health Partnership for Community Health Centers' OCHIN Epic Implementation, is for an electronic medical record system customized for FQHC operations. The funding request for $503,329 reflects costs associated with the following: roster management, CalAIM ECM, laboratory and radiology Interface, and quality improvement.

It was moved, seconded, and the Community Health Partnership request for $503,329 to fund Community Health Centers' OCHIN Epic Implementation was **unanimously approved.**

Motion: Ms. Lew
Second: Ms. King
Ayes: Mr. Brownstein, Ms. King, Ms. Kniss, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Abstain: Ms. Kohli
Absent: Ms. Burrell, Mr. Cameron, Mr. Evora

The second, from the Healthier Kids Foundation for My HealthFirst Rescreening, requested funding in the amount of $250,000 to rescreen 5th graders who are now 6th graders to assess their status, as well as to screen new 6th grade students at Luther Burbank, Franklin-McKinley, and Alum Rock Union School Districts. This is the third SCFHP funding request for this project. The initial amount of $41,710 funded in February 2020, was used to develop a roadmap for planning, implementing, and evaluating a collective action to implement mental health screening and referrals, and improve mental health outcomes, for children and youth in Santa Clara County public schools. The second amount of $42,000 funded in December 2020, was used to pilot the screening in Franklin McKinley School District.

It was moved, seconded, and the Healthier Kids Foundation request for $250,000 to fund My HealthFirst expansion was **unanimously approved.**

Motion: Ms. Kniss
Second: Ms. Porchia-Usher
Ayes: Mr. Brownstein, Ms. Kniss, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Porchia-Usher, Ms. Sager, Ms. Terrazas
Abstain: Ms. King
Absent: Ms. Burrell, Mr. Cameron, Mr. Evora

Mr. Brownstein left the meeting at 1:45 pm.

10. Preliminary Fiscal Year 2021-2022 Year in Review

Ms. Tomcala reviewed preliminary year-end performance on the FY'21-'22 Plan Objectives. A status summary of the Plan Objectives was provided.

Ms. Porchia-Usher left the meeting at 1:55 pm.

11. Fiscal Year 2022-2023 Plan Objectives

Ms. Tomcala presented the Fiscal Year 2022-2023 Plan Objectives, which focus on quality improvement, and reducing health disparities. She identified specific objectives in seven areas: Lead improvement in the health of communities impacted by disparities, Pursue benchmark quality and health equity, Implement CalAIM deliverables and new benefits, Enhance compliance program and delegation oversight, Foster membership retention, Achieve budgeted financial performance, and Seek to be an Employer of Choice.

Ms. Kniss left the meeting at 2:00 pm.

It was moved, seconded, and the FY'23 Plan Objectives were **unanimously approved.**

Motion: Ms. Murphy
Second: Ms. Kohli
Ayes: Ms. King, Ms. Kohli, Ms. Lew, Ms. Murphy, Dr. Paul, Ms. Sager, Ms. Terrazas
Absent: Mr. Brownstein, Ms. Burrell, Mr. Cameron, Mr. Evora, Ms. Kniss, Ms. Porchia-Usher

12. CEO Update

Ms. Tomcala presented the updated COVID vaccination graphs including data by age group, ethnicity, and booster status. Ms. Tomcala shared there is currently a 17% gap between eligible SCFHP members age 5+ (73%) and overall Santa Clara County residents (90%), who have received at a minimum of one COVID vaccine dose. She noted the zero to 5-year-olds are now eligible for vaccinations. Ms. Tomcala said 41% of the SCFHP membership population has received a COVID booster.

Ms. Tomcala provided an update on the ongoing efforts at the Blanca Alvarado Community Resource Center (CRC). She noted that SCFHP has administered over 2,500 shots and continues to offer COVID-19 vaccine clinics with a $50 incentive for SCFHP Medi-Cal members, and is focused on grassroots efforts to reach the remaining unvaccinated and unboosted members. Ms. Tomcala stated SCFHP maintains our partnership in these efforts with the Bay Area Community Health (BACH), the County of Santa Clara Mobile Vaccine Unit, COVID-19 Black, and Roots Community Health Center.

Ms. Tomcala communicated that SCFHP is in the process of returning staff to the office. Approximately 20% of staff work in the office full time, 43% are fully remote, and the remaining staff will maintain a hybrid work schedule.

Ms. Tomcala shared that it is SCFHPs 25th anniversary. We currently serve over 300,000 members, or 15% of the residents in Santa Clara County.

Ms. Tomcala concluded her presentation by sharing the Board Dashboard.

13. Compliance Report

Tyler Haskell, Interim Compliance Officer, provided updates on current compliance activity, beginning with the annual Medicare Data Validation Audit, for which our 2021 data has just been 100% validated by an outside auditor and will be submitted to CMS soon. The Plan is undergoing a triennial DMHC financial audit and is preparing for an October full-scope DMHC audit. Mr. Haskell discussed the DHCS 2024 contract operational readiness project, in which the Plan will submit a series of deliverables to demonstrate 2024 readiness over the next several months. He informed the Board that the Plan has not yet received official results from the 2022 DHCS audit.

14. Government Relations Update

Tyler Haskell, Director of Government Relations, provided updates on federal and state governmental actions affecting health plan operations. He discussed the decreasing likelihood of Congress approving further federal COVID-19 funding, the remaining possibility of Medicaid legislation as part of a reconciliation bill, a new bipartisan bill to regulate insulin pricing, and developing mental health legislation among Senate Finance Committee members. Mr. Haskell also discussed the particulars of the recently-passed state budget and other relevant legislation, including a bill to make Kaiser a directly-contracted Medi-Cal managed care plan.

15. Adjournment

The meeting was adjourned at 2:35 pm.

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Sarita Kohli, Secretary

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, July 28, 2022, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Sue Murphy, Chair
Alma Burrell
Dave Cameron
Sarita Kohli
Michele Lew

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Executive Finance 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
Tyler Haskell, Interim Chief Compliance Officer
Barbara Granieri, Controller
Lori Anderson, Operations Director, Long Term Services and Supports
Khanh Pham, Director, Financial Reporting & Budgeting
Arlene Bell, Director, Claims
Gaya Amirthavasar, Manager, Social Determinants of Health
Lucille Baxter, Manager, Qualitiy and Health Education
Kris Cameron, Strategic Planning Project Manager
Lloyd Alaban, Copy Writer and Content Strategist
Nancy Aguirre, Administrative Assistant

Others Present
John Domingue, Rossi Domingue LLP
Tim Davis, South County Compassion Center
Erin O'Toole, YMCA of Silicon Valley
Mary Hoshiko Haughey, YMCA of Silicon Valley

1. Roll Call

Sue Murphy, Chair, called the meeting to order at 10:30 AM. Ms. Murphy welcomed Sarita Kohli to the Executive/ Finance Committee and acknowledged Michelle Lew as the new Chair of the Governing Board. Roll call was taken and a quorum was established.

2. Public Comments

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

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

Christine Tomcala, Chief Executive Officer, requested that item 3.b. be deferred to the August meeting.

a. Approve May 26, 2022 **Executive/Finance Committee** minutes
b. Approve **Policy GO.01 v3 – Organizational Policies**
c. Approve **Claims Policies:**

- CL.01 v5 Interest on the Late Payment of Claims
- CL.02 v4 Misdirected Claims
- CL.03 v5 Notice of Denial of Payment
- CL.04 v3 Skilled Nursing Facility
- CL.05 v3 Long Term Care
- CL.06 v5 Inpatient Admission
- CL.07 v6 Emergency Room Services
- CL.08 v4 General Physician Professional Services
- CL.09 v4 Claims Timeframes Turn-Around-Time
- CL.10 v4 Provider Dispute Resolution
- CL.11 v3 Ambulatory Surgery Center (ASC)
- CL.12 v3 Coordination of Benefits and Medicare_Medi-Cal Crossover Claims
- CL.13 v5 Processing of Family Planning Claims
- CL.14 v3 Processing of Radiology Claims
- CL.15 v3 Processing of Anesthesia Claims
- CL.16 v3 Processing of Drugs and Biologicals Claims
- CL.17 v3 Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims
- CL.18 v3 Processing of Home Health Claims
- CL.19 v3 Processing of Rehabilitation Therapies Claims
- CL.20 v5 Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims
- CL.21 v5 Claims Processing & Adjudication
- CL.22 v5 Processing of Abortion Claims
- CL.23 v3 Overpayment Recovery
- CL.24 v3 Timely Processing of Non-Clean Claims
- CL.25 v4 Direct Member Reimbursement
- CL.26 v3 Claim Development of Non-Clean Non-Contracted Medicare Claims
- CL.27 v3 Non-Medical Transportation
- CL.28 v2 Other Health Coverage Cost Avoidance and Post Payment Recovery
- CL.29 v2 Third Party Tort Liability Reporting Requirements

d. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953.

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

Motion: Mr. Cameron
Second: Ms. Lew
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew, Ms. Murphy

3. May 2022 Financial Statements

Neal Jarecki, Chief Financial Officer, presented the unaudited financial statements for May 2022, which reflected a current month net surplus of $1.7 million ($1.7 million favorable to budget) and a year-to-date net surplus of $26.0 million ($17.4 million favorable to budget) through eleven months of the fiscal year.

Enrollment increased by 2,444 members from the prior month to 301,262 members (4,945 members or 1.6%

lower than budget, largely due to fewer newly-eligible members having Other Health Coverage (OHC) than budgeted. Membership continues to grow due to the extended duration of the COVID public health emergency during which member disenrollments have been suspended. YTD member months of 3,211,417 trailed budget by 85,300 member months or 2.6%.

Revenue reflected a net unfavorable current month variance of $11.5 million (1.6%) due to several factors. Unfavorable variances resulted from: (1) the inclusion of Medi-Cal pharmacy throughout FY22 in the budget (pharmacy was carved-out of managed care effective January 1, 2022, which significantly reduced revenue (with a corresponding reduction to medical expense), (2) lower enrollment, predominately fewer OHC members (with a corresponding reduction to medical expense), (3) additional CMC medical loss ratio accruals payable to DHCS, and (4) retroactive DHCS recoupments for fiscal years 2011-2020. Positive variances resulted from: (1) favorable calendar year 2022 Medi-Cal non-dual & CCI rates versus budget, and (2) increased Medi-Cal supplemental revenue.

Medical Expense reflected a net favorable current month variance of $12.7 million (11.3%) largely due to the favorable offsets of key revenue items above (pharmacy carve-out and reduced OHC enrollment). Certain fee-for-service expense categories reflected unfavorable variances due to increased unit costs and higher supplemental services expenses than budgeted. Capitation expense was net favorable to budget due to higher CY22 capitation rates paid vs. budget partially offset by lower capitated enrollment vs. budget.

Administrative Expense was $530 thousand (7.6%) unfavorable to budget for the month largely due to the net effect of (1) lower headcount than budgeted and (2) a favorable variance in non-personnel expense due to the timing of certain expenses vs. in the budget.

The **Balance Sheet** reflected a Current Ratio, a key measure of liquidity, of 1.30:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $280.8 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $240.5 million.

Capital Investments of $1.1 million have been made year-to-date, predominately computer software licenses, versus the annual capital budget of $3.25 million, with certain Medicare-related projected deferred into the fiscal year 2022-2023.

It was moved, seconded, and the unaudited May 2022 Financial Statements were **unanimously approved.**

Motion: Ms. Kohli
Second: Mr. Cameron
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew, Ms. Murphy

5. Innovation Fund Expenditure Request

Ngoc Bui-Tong, VP, Strategies & Analytics, presented a funding request from the YMCA of Silicon Valley (YMCA) Diabetes Prevention Program (DPP). The funds requested will fund a position to build capacity and provide oversight and strategic direction to the Diabetes Prevention Program. Ms. Tomcala introduced Erin O'Toole and Mary Hoshiko Haughey of YMCA of Silicon Valley, who were available for questions.

It was moved, seconded, and the YMCA request for $240,000 to fund the Diabetes Prevention Program was **unanimously approved** as an expenditure from the Board Designated Innovation Fund.

Motion: Ms. Lew
Second: Ms. Kohli
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew, Ms. Murphy

6. Special Project Fund for CBOs Expenditure Request

Ms. Bui-Tong presented a funding request from the South County Compassion Center (SCCC) Rental Assistance Program. The funds requested would fund a part-time Rental Assistance Program Manager. Ms. Bui-Tong introduced Tim Davis of South County Compassion Center, who was available for questions.

It was moved, seconded, and the South County Compassion Center request for $35,000 to fund the Rental Assistance Program was **unanimously approved** as an expenditure from the Board Designated Special Project Fund, for CBOs.

Motion: Ms. Kohli
Second: Ms. Burrell
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew, Ms. Murphy

7. CY'21 HEDIS Measure Analysis

Laurie Nakahira, D.O., Chief Medical Officer, shared the calendar year 2021 Healthcare Effectiveness Data and Information Set (HEDIS) Measure Analysis, including the Medi-Cal Managed Care Accountability Set performance trend, Medi-CAL HEDIS measure percentiles by network and ethnicity, Department of Health Care Services (DHCS) BOLD Goals, and the CMS HEDIS/Stars Rate Overview. Dr. Nakahira highlighted that measures change from year to year as plans improve and new performance measures are identified. There was discussion about root causes and planned interventions.

8. Housing & Homelessness Incentive Program (HHIP) Overview

Lori Anderson, Director, Long Term Services and Supports introduced Gaya Amirthavasar, Manager, Social Determinants of Health, who presented a report on the Housing and Homelessness Incentive Program (HHIP). Ms. Amirthavasar shared the Department of Health Care Services (DHCS) goals, expectations, program timeline and HHIP incentive funds. Ms. Amirthavasar shared the HHIP deliverables and highlighted the approximately 48.8 million dollars available in funds to draw down. Ms. Amirthavasar explained that receipt of the entirety of the funds is not guaranteed and depends upon SCFHP accomplishing certain metrics.

Ms. Amirthavasar provided an update on activities to date, next steps, and possible strategies that may be deployed using the HHIP metrics set forth by DHCS.

Ms. Amirthavasar then shared the Plan's commitment to partner with HumanGood for the residents of an 81 unit planned housing development in the city of Morgan Hill targeted to the 62+ population that meet certain eligibility criteria. The partnership would be initiated with the opening of the housing, estimated for 2024, and last a minimum of five years at the estimated cost of $500,000. It is expected that this cost would be covered by the HHIP funding.

9. Government Relations Update

Tyler Haskell, Interim Compliance Officer, presented federal issues of note, including the recent renewal of the COVID-19 public health emergency with assurance from the Secretary of Health and Human Services that we will be provided 60-days notice prior to expiration.

Mr. Haskell shared information on a congressional reconciliation bill that includes a prescription drug reform proposal allowing the Federal Government to negotiate prices for a limited amount of drugs for Medicare. Mr. Haskell stated the bill will include three years of enhanced subsidies for individual Plans on the exchanges. Mr. Haskell shared insulin was carved out of the reconciliation bill to be addressed in a separate bill that may have trouble securing the required votes to pass.

Mr. Haskell introduced the topic of "coding intensity adjustment" designed to adjust for differences in diagnosis coding patterns between Medicare Advantage (MA) and traditional Medicare. Dual Eligibility Special Needs Plans (DSNP) are considered MA plans and SCFHP will be converting our Medicare line of business to a DSNP next

year. Mr. Haskell noted his intention to recommend to legislators to carve out DSNPs to ensure they are not adversely impacted.

Mr. Haskell discussed a Medicare Advantage bill intended to address issues relating to a Government Accountability Office report on MA indicating problems with prior authorization and MA members not having treatments approved on time. The bill includes a concerning provision known as "gold carding," which would allow physicians who have a 90% prior authorization approval rate over a six-month period on certain services to be exempt from prior authorization requirements.

Mr. Haskell presented state issues impacting the Plan as a result of the passing of the budget, including the eligibility expansion of undocumented members between ages 26 and 50 that will go into effect January 2024 and continuous eligibility for children up to age 5. Mr. Haskell highlighted that Proposition 56 Provider Payments have been extended indefinitely. Mr. Haskell shared there is a new Medi-Cal benefit in the budget for an annual cognitive health assessment for members over age 65 if they are ineligible for it under Medicare. Mr. Haskell stated the legislature reinstated into the budget the $700 million Equity and Practice Transformation Grants.

Mr. Haskell reported Assembly Bill 2724 on the Kaiser direct Medi-Cal contract has been signed into law. Mr. Haskell explained, the Plan is now working on transitioning Kaiser out of our network as of 2024.

10. CEO Update

Ms. Tomcala, provided a brief update on the percentage difference (17%) between the SCFHP and Santa Clara County population who have received a COVID-19 vaccine, noting the stability in the percentage over the past several months.

Ms. Murphy requested that this topic be retired for future meetings and brought back when any notable changes occur.

11. Adjourn to Closed Session

a. Existing Litigation

The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding litigation initiated by a vendor.

b. Contract Rates

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

13. Report from Closed Session

Ms. Murphy reported that the Executive/Finance committee met in Closed Session to discuss existing litigation and contract rates.

14. Adjournment

The meeting was adjourned at 12:40 PM.

DocuSigned by:
Sarita Kohli
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Sarita Kohli, Secretary

Santa Clara Family Health Plan™

Annual Review of Claims Policies
July 28, 2022

Policy No.	Policy Title	Changes
CL.01 v5	Interest on the Late Payment of Claims	Revised
CL.02 v4	Misdirected Claims	Revised
CL.03 v5	Notice of Denial of Payment	Revised
CL.04 v3	Skilled Nursing Facility	Revised
CL.05 v3	Long Term Care	Revised
CL.06 v5	Inpatient Admission	Revised
CL.07 v6	Emergency Room Services	Revised
CL.08 v4	General Physician Professional Services	Revised
CL.09 v4	Claims Timeframes Turn-Around-Time	Revised
CL.10 v4	Provider Dispute Resolution	Revised
CL.11 v3	Ambulatory Surgery Center (ASC)	Revised
CL.12 v3	Coordination of Benefits and Medicare_Medi-Cal Crossover Claims	Revised
CL.13 v5	Processing of Family Planning Claims	Revised
CL.14 v3	Processing of Radiology Claims	Revised
CL.15 v3	Processing of Anesthesia Claims	Revised
CL.16 v3	Processing of Drugs and Biologicals Claims	Revised
CL.17 v3	Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims	Revised
CL.18 v3	Processing of Home Health Claims	Revised
CL.19 v3	Processing of Rehabilitation Therapies Claims	Revised
CL.20 v5	Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims	Revised
CL.21 v5	Claims Processing & Adjudication	Revised
CL.22 v5	Processing of Abortion Claims	Revised
CL.23 v3	Overpayment Recovery	Revised
CL.24 v3	Timely Processing of Non-Clean Claims	Revised
CL.25 v4	Direct Member Reimbursement	Revised
CL.26 v3	Claim Development of Non-Clean Non-Contracted Medicare Claims	Revised
CL.27 v3	Non-Medical Transportation	Revised
CL.28 v2	Other Health Coverage Cost Avoidance and Post Payment Recovery	Revised
CL.29 v2	Third Party Tort Liability Reporting Requirements	Revised

POLICY

Policy Title:	**Interest on the Late Payment of Claims**	**Policy No.:**	CL.01 ~~v4~~v5
Replaces Policy Title (if applicable):	Interest on the Late Payment of Claims	**Replaces Policy No. (if applicable):**	CL.01 ~~v3~~v4
Issuing Department:	Claims Department	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To accurately calculate and apply interest and applicable penalties on late paid claims in accordance with State and Federal regulations.

II. Policy

Interest Payment Requirements

To pay interest and applicable penalties on late paid claims in accordance with the applicable laws and regulations for the State of California and Centers for Medicare and Medicaid Services~~,~~ (CMS).

Medi-Cal (MC) (Contracted & Non-Contracted Providers)

All claims shall be paid within forty-five (45) working days (sixty-two (62) calendar days)~~;~~, otherwise, interest shall begin accruing on the first day following the forty-fifth (45th) working day (sixty-second (62nd) calendar days). The payment of interest applies to both contracted and non-contracted providers for the Medi-Cal line of business. Failure to pay interest due automatically requires a $10.00 late fee to be paid in addition to any interest due.

Cal ~~Medi-Connect~~ MediConnect (CMC) (Non-Contracted Providers)

For ~~Cal Medi-Connect (~~ CMC~~)~~ primary claims, interest on late payment applies only to non-contracted providers clean claims. All claims from non-contracted providers shall be paid within thirty (30) calendar days; otherwise, interest shall begin accruing on the thirty-first (31st) calendar day after the date of receipt (first date stamp).

Interest is applied to the non-contracted CMC secondary claim if not paid within forty-five (45) working days (sixty two (62) calendar days). Failure to pay interest due automatically requires a $10.00 late fee to be paid in addition to any interest due.

POLICY

~~Cal Medi-Connect~~ CMC (Contracted Providers)

Interest does not apply to ~~Cal Medi-Connect (~~CMC~~)~~ primary claims, however interest is applied to the CMC secondary claim if not paid within forty-five (45) working days (sixty two (62) calendar days). Failure to pay interest due automatically requires a $10.00 late fee to be paid in addition to any interest due.

Interest Rate

Interest, and any applicable fees, shall be paid in accordance with the detailed calculations within CL01.01 Interest on Late Payment of Claims Procedure.

III. Responsibilities

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

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.

IV. References

Title 22, California Code of Regulations, Section 53622
Title 28, California Code of Regulations, Section 1300.71
California Health and Safety Code Section 1371
California Evidence Code section 641
U.S. Treasury Department - Interest rate on semi-annual basis
Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Section 80.2.2
42 C.F.R. § 422.500; § 422.520(a) (1)
Medicare Managed Care Manual Chapter 11 – Medicare Advantage Application, Providers and Contract Requirements, Section 100.2.

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~2~~05/~~9/2021~~12/2022 Date	Neal Jarecki Chief Financial Officer ~~2~~05/~~10/2021~~12/2022 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 – 08/26/16	N/A	N/A	N/A
2	Revised – 12/20/18	N/A	N/A	N/A
3	Revised – 09/05/19	N/A	N/A	N/A
4	Revised	Executive/Finance	Approve	02/25/2021
5	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Misdirected Claims**	**Policy No.:**	CL.02 ~~v3~~v4
Replaces Policy Title (if applicable):	Misdirected Claims	**Replaces Policy No. (if applicable):**	CL.02 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

To ensure that at least ninety-five percent (95%) of Misdirected Claims received by Santa Clara Family Health Plan (SCFHP) are sent to the payor who bears the financial responsibility for the claim within ten (10) working days of receipt.

II. Policy

Ninety-five percent (95%) of Misdirected Claims are to be forwarded to the payor who has the financial responsibility for the claim within ten (10) working days of the date of receipt. The Misdirected Claims Policy does not apply to:

- Cal ~~Medi-Connect~~MediConnect (CMC) line of business as SCFHP has full financial responsibility for all CMC claims.
- Split risk claims (combination of payable and denial claim lines items).

III. Responsibilities

A. The Information Technology Department is responsible to:

~~A.~~1. Post the outbound misdirected claims file 5010 837i / 837p to a secure FTP site for pick-up~~.~~ on a daily basis.

~~B.~~2. Validates and confirms that all outbound misdirected claims files are successfully transmitted on working days (Monday through Friday).

B. The Claims Department is responsible for overseeing the misdirected claims process. As part of its oversight role, the Claims Department:

~~C.~~3. May provide feedback to other departments and/or divisions within SCFHP to ensure that the misdirected claims process is operating effectively and efficiently.

~~D.~~4. Monitors that SCFHP is compliant at all times with the ten (10) working day turn-around time requirement.

~~E.~~5. Reviews and audits outbound misdirected claims files to ensure correct payer disbursement.

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(b) (2)
Claims Processing Time Limits and Measurements - Assembly Bill -AB1455

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~02/09/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~02/10/2021~~05/13/2022 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 - 02/24/2020	N/A	N/A	N/A
3	Revised	Executive/Finance	Approve / 02/25/2021	~~02~~Ratify / 03/25/2021
4	Revised	Executive/Finance	TBD / 08/25/2022	

POLICY

POLICY

Policy Title:	**Notice of Denial of Payment**	**Policy No.:**	CL.03 ~~v4~~v5
Replaces Policy Title (if applicable):	Notice of Denial of Payment	**Replaces Policy No. (if applicable):**	CL.03 ~~v3~~v4
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☐ Medi-Cal	☒ CMC	

I. Purpose

To ensure that when a claim is denied involving a Santa Clara Family Health Plan (SCFHP) Cal ~~Medi-Connect~~MediConnect (CMC) member and results in a member liability, that a Notice of Denial of Payment, which includes the CMC member's right to request an appeal of the denial, is provided to the provider of the services, the SCFHP CMC member, and/or the member's representative.

II. Policy

SCFHP shall issue a Notice of Denial of Payment to the provider of the service, the SCFHP CMC member, and/or the member's representative when SCFHP denies, in whole or in part, a request for a medical service/item, or a request for payment of a medical service/item the member has already received and the member may be responsible for payment.

SCFHP shall determine whether to reimburse or deny a CMC claim within the following timeframes:

- Non-Contracted Providers - within 30 calendar days for clean claims
- Contracted Providers/Non-Contracted Provider, unclean claims - within 60 calendar days

CMS-Integrated Denial Notice (IDN)), or an MA health plan Regional Office-approved modification of the IDN, must be sent to the member. The written denial must clearly state the service denied and the denial reason. Denial letters for Part C organization determinations must include adequate rationales and contain correct/complete information specific to denials, or must be written in a manner easily understandable by members.

If SCFHP denies a request from a non-contracted provider, SCFHP will notify the non-contract provider of the specific reason for the denial and will provide a description of the appeals process.

POLICY

Upon determination that a CMC claim is to be denied, The Notice of Denial of Payment shall be sent to the provider of the service, the SCFHP CMC member, and/or the member's representative within five (5) working days.[1]

III. Responsibilities

The Claims Department is responsible for sending a Notice of Denial of Payment of medical coverage to the CMC member and/or the members' representative, and the provider of the service.

The Medical Services Department is responsible for send a Notice of Denial of Coverage letter for of medical coverage to the CMC member and/or the members' representative, and the provider of the service.

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

42 C.F.R. §§ 422.568(d), 423.568(g)
42 C.F.R. §§ 423.572(c)(2) and 423.590(g)
42 C.F.R. § 422.520 Prompt payment by MA organization

Parts C&D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance (February 2019), Section 40.2.2
Medicare Managed Care Manual Chapter 3, Payments to Medicare Advantage Organizations
Notice of Denial of Medical Coverage Form CMS-10003-NDMC (http://www.cms.hhs.gov/bni/07_MADenailNotices.asp)
IOM Pub. 100-16
http://www.cms.gov/Medicare/Appeals-andGrievances/MMCAG/Downloads/Appendix-7-Waiver-of-Liability-Notice.pdf
CMC Medicare Enrollment & Appeal Group Memo – See Attachment
Time Limits and Measurements – Assembly Bill 1455

[1] This timeline is not a requirement. Denied CMC claims will follow this timeline for the issuance of the Notice of Denial of Payment and the notices are processed in line with the checks for approved claims.

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~02/09/2021~~05/12/2022 Date	Neal Jarecki Chief Financial Officer ~~02/10/2021~~05/12/2022 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
~~V1~~v1	Original – 08/26/2016	N/A	N/A	N/A
~~V2~~v2	Revised – 03/22/2018	N/A	N/A	N/A
~~V3~~v3	Revised – 02/28/2020	N/A	N/A	N/A
~~V4~~v4	Revised	Executive/Finance	Approve	02/25/2021
v5	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Skilled Nursing Facility**	**Policy No.:**	CL.04 ~~v2~~v3
Replaces Policy Title (if applicable):	Skilled Nursing Facility	**Replaces Policy No. (if applicable):**	~~CL044~~CL.04 v2
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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~~CMC: For CMC claims regarding SNF from non-contracted providers, SCFHP shall pay all 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.

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

F. Share of Cost

1. Certain MC members may have a Share of Cost (SOC) that they are required to pay the SNF prior to being reimbursed by the Plan. SCFHP will deduct any applicable SOC from the SNF reimbursement. CMC members do not have a SOC for SNF services.

III. Responsibilities

A. 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~~MC and CMC members.

B. The Claims Department is responsible for ensuring applicable rates, SOC, 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.

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~~MC 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

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~04/15/2021~~05/12/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/12/2022 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	Executive/Finance	Approve / 04/22/2021	~~4/22~~Ratify / 06/24/2021
3	Revised	Executive/Finance	TBD / 08/25/2022	

POLICY

Policy Title:	**Long Term Care**	**Policy No.:**	CL.05 ~~v2~~v3
Replaces Policy Title (if applicable):	Long Term Care	**Replaces Policy No. (if applicable):**	Cl.05 ~~v1~~v2
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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~~CMC: 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.

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

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

b.

F. Share of Cost

1. Certain MC and CMC members may have a Share of Cost (SOC) that they are required to pay the SNF prior to being reimbursed by the Plan. SCFHP will deduct any applicable SOC from the SNF reimbursement.

III. Responsibilities

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

POLICY

B. 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~~MC and CMC members.

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.~~E. 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
DHCS.ca.gov
CCR, Title 22, Section 51511 (a) (3)

~~V.~~ Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~04/15/2021~~05/12/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/12/2022 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	n/a	n/a	n/a
V2	Revised	Executive/Finance	Approve	04/22/2021
V3	Revised	Executive/Finance	Recommend	07/28/2022

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POLICY

Policy Title:	**Inpatient Admission**	**Policy No.:**	CL.06 ~~v4~~v5
Replaces Policy Title (if applicable):	Inpatient Admission	**Replaces Policy No. (if applicable):**	CL.06 ~~v3~~v4
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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

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POLICY

a. ~~Medi-Cal~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

b. ~~Cal Medi-Connect~~CMC: 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.

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

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POLICY

1. Contracted Providers

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

2. Non-Contracted Providers

   a. ~~Medi-Cal~~MC: 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.

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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~~MC 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/

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POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/12/2022 Date	Neal Jarecki Chief Financial Officer 05/12/2022 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	Approve	5/27/21
~~4~~5	Revised	Executive/Finance	Recommend ~~05/27/2021~~	~~N/A~~07/28/2022

POLICY

Policy Title:	**Emergency Room Services**	**Policy No.:**	CL.07 ~~v5~~v6
Replaces Policy Title (if applicable):	~~Processing of~~ Emergency Room ~~Professional Fees by Delegated Sub-Contractors~~ ~~Reimbursement to Emergency Room Physicians~~ ~~Reimbursement of Emergency Department Claims (Non-Admission)~~ Services	**Replaces Policy No. (if applicable):**	~~CL0090_03~~ ~~CL026~~ ~~CL039~~CL.07 v5
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To accurately process claims regarding emergency room (ER) services in accordance with State and Federal regulatory requirements.

To describe the circumstances under which sub-contractors are responsible for professional and technical component services.

II. Policy

A. Timeframes

1. Contracted Providers

a. Medi-Cal: For Medi-Cal (MC) claims regarding ~~emergency room~~ER 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 (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding ~~emergency room~~ER 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~~MC: For ~~Medi-Cal~~MC claims regarding ~~emergency room~~ER services 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~~CMC: For ~~Cal Medi-Connect (~~CMC~~)~~ claims regarding ~~emergency room~~ER services from non-contracted providers, SCFHP shall pay all clean cleans within thirty (30) calendar days of the date of receipt.

3. Sub-contracted Providers

   a. ~~SCFHP to require~~Based on their Division of Financial Responsibility (DOFR), SCFHP requires the delegated sub-contracted providers be responsible for processing in-area ~~emergency room~~ER professional services with the exception of claims by Physician Medical Group of San Jose (PMGSJ) for ER physician groups or physicians billing emergency E&M codes for members participating in their network for the ~~Medi-Cal~~MC line of business.

B. Availability and Accessibility

   b. 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.

   c. SCFHP or its delegated groups is 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 reasonable person or a prudent layperson's definition of "emergency medical ~~condition,"~~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 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.

F. Reimbursement Rates

~~1.~~ Contracted Providers

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

1.

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

2. Non-Contracted Providers

a. ~~Medi-Cal~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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. The Claims Department is responsible for ensuring applicable rates and interest payments are calculated accurately, applied correctly, and processed timely.

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

~~B.~~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.

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

POLICY

IV. References

Covered Services: Services set forth in Article 4, Chapter 3 (beginning with Section 51301), Sub-division 1, Division 3, Title 22, CCR, which are included as Covered Services under the State ~~Medi-Cal~~MC.
Title 22, California Code of Regulations, Section 51301

Title 22, California Code of Regulations, Section 53622
Title 28, California Code of Regulations, Section 1300.71
Title 28, California Code of Regulations, Section 1300.67.2© and 1300.67(g)(1)
CA Health and Safety Code section 1371.4(a)(b)
Medicare Managed Care Manual, Chapter 4 section 20.3
APL 17-017, Knox-Keene Act Standard For Determining Whether An "Emergency" Existed For Purposes Of Provider Reimbursement

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~12~~5/~~28/2020~~13/2022 Date	Neal Jarecki Chief Financial Officer ~~01~~5/~~21/2021~~13/2022 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 – 2/28/2018			
3	Revised - 2019			
4	Revised – 2/19/2020			
5	Revised	Executive-/Finance	Approve / 01/28/2021	~~1/28~~Ratify / 03/25/2021
6	Revised	Executive/Finance	TBD / 08/25/2022	

POLICY

Policy Title:	**General Physician/Professional Services**	**Policy No.:**	CL.08 ~~v3~~ v4
Replaces Policy Title (if applicable):	General Physician/Professional Services	**Replaces Policy No. (if applicable):**	CL.08 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

b. ~~Cal Medi-Connect~~CMC: 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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.

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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 08/236/2016	N/A	N/A	N/A
2	Revised 02/19/2020	N/A	N/A	N/A
3	Revised	Executive/Finance	Approve	04/22/2021
4	Revised	Executive/Finance	Recommend	7/28/2022

POLICY

Policy Title:	**Claims Timeframes Turn-Around-Time**	**Policy No.:**	CL.09 ~~v3~~v4
Replaces Policy Title (if applicable):	Claims Timeframes Turn-Around-Time	**Replaces Policy No. (if applicable):**	CL.09 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To ensure that Santa Clara Family Health Plan (SCFHP) processes all claims in accordance with State and Federal regulatory timeframe requirements, as well as in line with its contractual obligations.

II. Policy

A. This policy regarding timely processing of claims is to document SCFHP processes to ensure all claims received are processed timely and according to the appropriate State and Federal turnaround time requirements.

B. The receipt date serves as record of a valid submission. It is used to determine if the claim was filed timely and is the receipt date for the purposes of determining claims processing timeliness.

C. All claims shall be processed on a first-in-first-out basis to maximize the timely and accurate completion of claims, in accordance with statutory, regulatory, and contractual standards.

D. SCFHP shall accept provider claims in both paper and electronic format and shall process claims received within Federal and State timeframe requirements. These requirements are specifically noted, by type of claim, within Procedure CL.09.01.

E. For the Medi-Cal (MC) line of business, capitated subcontractors that are delegated for claims payment are required to adhere to the same statutory, regulatory, and contractual timeframe requirements as the Plan. SCFHP's monitoring and annual audit of its capitated subcontractors will ensure that these requirements are being followed.

POLICY

III. Responsibilities

A. The Claims Department is responsible to ensure that the inventory of claims is managed with an ongoing emphasis on compliance with timelines for payment of all type of claims in accordance with Federal and State requirements, as well as contractual obligations. The Claims Management is responsible for overseeing the overall process and evaluating the claims on hand on a daily basis.

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

C. 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.

IV. References

Claims Processing Time Limits and Measurements - Assembly Bill -AB1455
California Health and Safety Code Section 1371
Title 28, California Code of Regulations, Section 1300.71
Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Section 80.2.2
CFR 422. 422.100 - General requirements
Social Security Act, Section 1816 – Clean claims
42 C.F.R. § 422.500
§ 422.520(a)(1) & (3) Prompt payment by MA organization

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POLICY

V. Approval/Revision/History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~02/09/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~02/10/2021~~05/13/2022 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 – 02/27/2020	N/A	N/A	N/A
3	Revised	Executive/Finance	Approve	02/25/2021
4	Revised	Executive/Finance	Recommend	07/28/2022

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POLICY

Policy Title:	**Provider Dispute Resolution**	**Policy No.:**	CL.10 ~~v3~~v4
Replaces Policy Title (if applicable):	Provider Dispute Resolution	**Replaces Policy No. (if applicable):**	CL.10 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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~~–~~ (MC) – 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~~MC – forty-five (45) working days or sixty-two (62) calendar days after receipt date.

C. Cal ~~Medi-Connect~~MediConnect (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.
2. Non-Contracted Providers – These are handled as an appeal by the Grievance & Appeals department.

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

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(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.

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

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POLICY

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)

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POLICY

V. Approval/Revision/History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/13/2022 Date	Neal Jarecki Chief Financial Officer 05/13/2022 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~~Approve / 05/27/2021	~~N/A~~Ratify 06/24/2021
4	Revised	Executive/Finance	TBD 08/25/2022	

POLICY

~~n~~

Policy Title:	**Ambulatory Surgery Center (ASC)**	**Policy No.:**	CL.11 ~~v2~~v3
Replaces Policy Title (if applicable):	Ambulatory Surgery Center (ASC)	**Replaces Policy No. (if applicable):**	~~c~~lCL.11 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding ASC 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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

   b. ~~Cal Medi-Connect~~CMC: For CMC claims regarding ASC 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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

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

~~C.~~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.

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

E.

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 ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

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POLICY

Policy Title:	**Coordination of Benefits and Medicare_Medi-Cal Crossover Claims**	**Policy No.:**	CL.12 ~~v2~~v3
Replaces Policy Title (if applicable):	Coordination of Benefits and Medicare_Medi-Cal Crossover Claims	**Replaces Policy No. (if applicable):**	CL.12 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ 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 (MC) claims related to Coordination of Benefits (COB) and Medicare ~~Medi-Cal~~MC Crossover claims, Santa Clara Family Health Plan (SCFHP) will 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. 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

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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.

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

~~D.~~E. Claims and Finance Recovery staff are responsible for identifying potential COB situations.

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

IV. References

~~Medi-Cal~~MC – Other Health Coverage (OHC) and Medicare/~~Medi-Cal~~MC Claims – www.~~medi-cal~~MC.ca.gov

Medicare Managed Care Manual - Chapter 4 - Benefits and Beneficiary Protections
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pd

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

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V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/13/2022 Date	Neal Jarecki Chief Financial Officer 05/13/2022 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	Approve	05/27/2021
~~2~~3	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

POLICY

Policy Title:	Processing of Family Planning Claims	Policy No.:	CL.13 ~~v4~~v5
Replaces Policy Title (if applicable):	Processing of Family Planning Claims	Replaces Policy No. (if applicable):	~~CL005 01~~CL.13 v4
Issuing Department:	Claims	Procedure Review Frequency:	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

It is the policy of Santa Clara Family Health Plan (SCFHP) that all members have the right to self-refer to a qualified family planning provider for family planning services or ~~STD~~ Sexually Transmitted Diseases (STD) related services. SCFHP members may self-refer to in-network or out-of-network qualified family planning providers for family planning services.

Members, when appropriate, are to be provided with sufficient information to allow them to make informed choices regarding the types of family planning services available, to have access to these services in a timely and confidential manner, and if part of a family planning visit, receive diagnosis and initial treatment of ~~Sexually Transmitted Diseases (STDs)~~ STDs and/or HIV counseling and testing.

II. Policy

A. Timeframes

1. Contracted Providers

   a. Medi-Cal: For Medi-Cal (MC) claims regarding family planning 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~~~~ (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding family planning 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~~MC: For ~~Medi-Cal~~MC claims regarding family planning 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 family planning 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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

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

A.

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

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

Title 28, California Code of Regulations, Section 1300.71
Senate Bill 94 – Family Planning Services
42 CFR Ch. IV (10-1-08 Edition § 441.18
2088.5 Freedom of Choice for Family Planning Services.--Sections 1902(a)(23)(B) and 1905(a)(4)(C) of the Act and 42 CFR 431.51(b)
APL 10-014 Correction to All Plan Letter 10-003 Regarding Augmented Reimbursement for Family Planning Services

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~10~~5/~~6/2021~~13/2022 Date	Neal Jarecki Chief Financial Officer ~~10~~5/~~21/2021~~13/2022 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		
2	Revised – 2/28/2018	N/A		
3	Revised – 1/6/2020	N/A		
4	Revised	Executive-/Finance	Approve	1/28/2021
5	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Radiology Claims**	**Policy No.:**	CL.14 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Radiology Claims	**Replaces Policy No. (if applicable):**	CL.14 v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding radiology 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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar 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 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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.

IV. References

Title 28, California Code of Regulations, Section 1300.71

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~~MC 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 ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Anesthesia Claims**	**Policy No.:**	CL.15 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Anesthesia Claims	**Replaces Policy No. (if applicable):**	CL.15 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims related to anesthesia 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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

   b. ~~Cal Medi-Connect~~CMC: For CMC claims related to anesthesia 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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 Clams 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, Section 1300.71

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Drugs and Biologicals Claims**	**Policy No.:**	CL.16 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Drugs and Biologicals Claims	**Replaces Policy No. (if applicable):**	CL.16 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims related to drugs and biologicals 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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

   b. ~~Cal Medi-Connect~~CMC: For CMC claims related to drugs and biologicals 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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.

IV. References

Title 28, California Code of Regulations, Section 1300.71

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 ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	NA
2	Revised	Executive/Finance	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims**	**Policy No.:**	CL.17 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Durable Medical Equipment, Orthotics, and Prosthetics Claims	**Replaces Policy No. (if applicable):**	CL.17 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC claims regarding DME 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~~CMC: 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 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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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~~MC 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.

IV. References

Title 28, California Code of Regulations, Section 1300.71

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 ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	NA
2	Revised	Executive/Finance	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Home Health Claims**	**Policy No.:**	CL.18 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Home Health Claims	**Replaces Policy No. (if applicable):**	CL.18 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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~~(MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

   b. ~~Cal Medi-Connect~~CMC: 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.

POLICY

~~3.~~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.

~~4.~~C. Date of Payment

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

~~5.~~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.

~~B.~~E. Reimbursement Rates

1. Contracted Providers

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

2. Non-Contracted Providers

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

IV. References

Title 28, California Code of Regulations, Section 1300.71

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 ~~04/15/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/13/2022 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	NA
2	Revised	Executive/Finance	Approve	04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Processing of Rehabilitation Therapies Claims**	**Policy No.:**	CL.19 ~~v2~~v3
Replaces Policy Title (if applicable):	Processing of Rehabilitation Therapies Claims	**Replaces Policy No. (if applicable):**	CL.19 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

   b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

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POLICY

b. ~~Cal Medi-Connect~~CMC: For CMC claims regarding rehabilitation therapy services from non-contracted providers, SCFHP shall pay all clean cleans 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.

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~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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

Santa Clara Family Health Plan™

POLICY

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~~MC 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.

IV. References

Title 28, California Code of Regulations, Section 1300.71

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 05/13/2022 Date	Neal Jarecki Chief Financial Officer 05/13/2022 Date

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POLICY

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	Approve	05/27/2021
~~2~~3	Revised	Executive/Finance	Recommend ~~/ 5-27-2021~~	~~N/A~~07/28/2022

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims**	**Policy No.:**	CL.20 ~~v4~~v5
Replaces Policy Title (if applicable):	Processing of Inpatient Psychiatric Facility and Outpatient Behavioral Mental Health Claims	**Replaces Policy No. (if applicable):**	CL.20 ~~v3~~v4
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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.

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POLICY

2. Non-Contracted Providers

   a. ~~Medi-Cal~~MC: For ~~Medi-Cal~~MC 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) (sixty-two (62) calendar days) working days of the date of receipt.

   b. ~~Cal-Medi-Connect~~CMC: 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

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POLICY

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

   b. CMC: Non-contracted providers will be ~~paid for covered services~~ reimbursed at rates in accordance with the Medicare Severity – Diagnosis Related Group (MS-DRG) schedule for inpatient and at not less than 100% of the ~~applicable Medicare FFS rates.~~ Medicare Outpatient Prospective Payment System (OPPS) for outpatient services.

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~~MC 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.

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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
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

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

Santa Clara Family Health Plan™

POLICY

05/13/2022 Date	05/13/2022 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	Approve	05/27/2021
45	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

POLICY

Policy Title:	**Claims Processing & Adjudication**	**Policy No.:**	CL.21 ~~v4~~v5
Replaces Policy Title (if applicable):	Claims Processing & Adjudication	**Replaces Policy No. (if applicable):**	CL.21 ~~v3~~v4
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To ensure accurate and timely processing of claims according to benefit structure, provider contract, and State and Federal regulations.

II. Policy

All claims shall be processed so that timeliness and accuracy is maximized and regulatory and contractual standards are met.

III. Responsibilities

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

The Claims Management team 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, any and all information that is required to be kept confidential, shall be kept confidential.

The Claims Department will retain copies of all claims in accordance with SCFHP's Records Retention Policy.

IV. References

Title 22, California Code of Regulations, Section 51301

Title 22, California Code of Regulations, Section 53622

Title 28, California Code of Regulations, Section 1300.71(d) (1)

Medicare Claims Processing Manual Chapter 1 – General Billing Requirements

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~02/09/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~02/10/2021~~05/13/2022 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 – 12/21/2018	N/A	N/A	N/A
3	Revised – 09/06/2019	N/A	N/A	N/A
4	Revised	Executive/Finance	Approve	~~N02~~02/25/2021
5	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Processing of Abortion Claims**	**Policy No.:**	CL.22 ~~v4~~v5
Replaces Policy Title (if applicable):	Processing of Abortion Claims	**Replaces Policy No. (if applicable):**	~~CL025~~ CL.22 v4
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

It is the policy of Santa Clara Family Health Plan (SCFHP) covers abortions as a physician service regardless of the gestational age of the fetus. If SCFHP does not have contracted providers who perform abortions, SCFHP arranges and pays for abortions from a non-contracted provider. SCFHP also holds its sub-contractors accountable for ensuring that Medi-Cal policy on abortion is honored.

SCFHP's members may go to any provider of their choice for abortion services, at any time for any reason, regardless of network affiliation. However, no physician or other health care provider who objects to performing abortion services is required to do so, and no person refusing to perform an abortion is to be subject to retaliation in any form for such a choice.

Policy

A. Timeframes

1. Contracted Providers

a. Medi-Cal: For Medi-Cal (MC) claims regarding abortion 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- (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding abortion 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~~MC: For ~~Medi-Cal~~MC claims regarding abortion 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~~CMC: For CMC claims regarding abortion services from non-contracted providers, SCFHP shall pay all clean cleans 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.

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~~MC: Non-Contracted providers are paid for covered services at not less than 100% of the ~~Medi-Cal~~MC FFS rates
b. CMC: Non-contracted providers will be reimbursed at rates in accordance with the applicable Medicare fee schedule.

II. Responsibilities

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

B. 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.

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

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

III. References

Title 22, California Code of Regulations, Section 1300.71

Health and Safety [H&S] Code, Section 123420

The Reproductive Privacy Act (H&S Code, Section 123460, et seq.

Title 22, California Code of Regulations, Section 51327

www.Medi-Cal.ca.gov – Abortion Services

Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing, 100.1 - Billing for Abortion Services- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03aug_inpatient_hospital_09-3-3.pdf

~~IV.~~ **Approval/Revision History**

IV.

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~1~~05/~~6/2021~~13/2022 Date	Neal Jarecki Chief Financial Officer ~~1~~05/~~22/2021~~13/2022 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 – 2/28/2018			
3	Revised – 1/6/2020			
4	Revised	Executive-/Finance	Approve	~~1~~01/28/2021

POLICY

5	Revised	Executive/Finance	Recommend	07/28/2022

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POLICY

Policy Title:	**Overpayment Recovery**	**Policy No.:**	CL.23 ~~v2~~v3
Replaces Policy Title (if applicable):	Overpayment Recovery	**Replaces Policy No. (if applicable):**	CL.23 ~~v1~~v2
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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~~MediConnect (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 (MC)**
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.

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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.

   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~~ Department of Health Care Services (DHCS) as appropriate.

C. Managed Care Plan (MCP) Retention of Provider Overpayments

The MCP shall retain all recoveries less than $25 million for all overpayments and recoveries of overpayments from the MCP to a network provider, including overpayments due to fraud, waste, or abuse, identified by the MCP. In the event an MCP recovers an overpayment to a provider of $25 million or more, DHCS and the MCP will share the recovery amount equally. Sixty (60) days after the date that the overpayment was identified, the MCP must report the overpayment to DHCS through their contract manager. DHCS will recoup the overpayment from the MCP capitated payment. The statement issued to the MCP will reflect the overpayment. The MCP shall submit the overpayment amount that was recovered, the provider(s) information, and steps taken to correct future occurrences to the MCP's assigned Managed Care Operations Division Contract Manager.

~~C.~~D. SCFHP claims in conjunction with compliance promptly reports all overpayments identified or recovered that are deemed to be potential fraud, waste or abuse.

~~D.~~E. 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.

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POLICY

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).~~
- §455.2 and Welfare and Institutions (W&I) Code §14043.1
- 42 CFR §438.2
- 42 CFR §438.608(d)(2)(3)
- APL 17-003 Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Provider
- CP.02 Fraud Waste and Abuse

~~V.~~ Approval/Revision History

V.

First Level Approval	Second Level Approval

Santa Clara Family Health Plan™

POLICY

Arlene Bell Director, Claims 05/13/2022 Date	Neal Jarecki Chief Financial Officer 05/13/2022 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	Approve	05/27/2021
~~2~~3	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

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POLICY

Policy Title:	**Timely Processing of Non-Clean Claims**	**Policy No.:**	CL.24 ~~v1~~v3
Replaces Policy Title (if applicable):	Timely Processing of Non-Clean Claims	**Replaces Policy No. (if applicable):**	CL.24 v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☐ Medi-Cal	☒ 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~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MediConnect: 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.

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C. Date of Payment
The date of payment shall be the date of the check.

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

Santa Clara Family Health Plan™

POLICY

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

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 05/16/2022 Date	Neal Jarecki Chief Financial Officer 05/16/2022 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	Approve	05/27/2021
~~2~~3	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

Santa Clara Family Health Plan™

POLICY

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POLICY

Policy Title:	**Direct Member Reimbursement**	**Policy No.:**	CL.25 ~~v3~~v4
Replaces Policy Title (if applicable):	Direct Member Reimbursement	**Replaces Policy No. (if applicable):**	CL.25 ~~v2~~v3
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) LOB and within 180 days from date of service for Cal MediConnect (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.

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POLICY

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~~MC and CMC members.

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

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 Medi-Cal Member Handbook – Evidence of Coverage (EOC)
SCFHP Cal MediConnect Plan Member Handbook

IV. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/16/2022 Date	Neal Jarecki Chief Financial Officer 05/16/2022 Date

Santa Clara Family Health Plan™

POLICY

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	Approve	05/27/2021
~~3~~4	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Claim Development of Non-Clean Non-Contracted Medicare Claims**	**Policy No.:**	CL.26 ~~v2~~v3
Replaces Policy Title (if applicable):	Claim Development of Non-Clean Non-Contracted Medicare Claims	**Replaces Policy No. (if applicable):**	CL.26 ~~v1~~v2
Issuing Department:	Claims	**Procedure Review Frequency:**	Annual
Lines of Business (check all that apply):	☐ Medi-Cal	☒ 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~~MediConnect (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

Santa Clara Family Health Plan™

POLICY

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 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.

Santa Clara Family Health Plan™

POLICY

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/16/2022 Date	Neal Jarecki Chief Financial Officer 05/16/2022 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	Approve	05/27/2021
~~2~~3	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~07/28/2022

POLICY

Policy Title:	**Non-Medical Transportation Services**	**Policy No.:**	CL.27 ~~v2~~v3
Replaces Policy Title (if applicable):	Non-Medical Transportation Services	**Replaces Policy No. (if applicable):**	CL.27 ~~v1~~v2
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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 Managed Care Plans (MCPs) in order to be reimbursed for services provided to American Indians.

B. Timeframes

1. Contracted Providers

    a. ~~Medi-Cal~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

    b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding Non-Medical Transportation 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~~MC: For ~~Medi-Cal~~MC 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 (sixty-two (62) calendar days) of the date of receipt.

   b. ~~Cal Medi-Connect: For Cal Medi-Connect (CMC)~~ CMC: ForCMC claims regarding Non-Medical Transportation services from non-contracted providers, SCFHP shall pay all clean cleans 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.

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 05/~~13/2021~~16/2022 Date	Neal Jarecki Chief Financial Officer 05/~~20/2021~~16/2022 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	Approve	05/27/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

POLICY

Policy Title:	**Other Health Coverage Cost Avoidance and Post Payment Recovery**	**Policy No.:**	CL.28 ~~v1~~v2
Replaces Policy Title (if applicable):	~~N/A~~Other Health Coverage Cost Avoidance and Post Payment Recovery	**Replaces Policy No. (if applicable):**	~~N/A~~CL.28 v1
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ 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 (MC) member has other health coverage (OHC).

II. Policy

A. State law requires ~~Medi-Cal~~MC to be the payer of last resort for services in which there is a responsible third party. ~~Medi-Cal~~MC members with OHC must utilize their OHC for covered services prior to utilizing their ~~Medi-Cal~~MC benefits. Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the ~~Medi-Cal~~MC program.

B. SCFHP and its delegates utilize OHC information from the Department of Health Care ~~Services'~~Services (DHCS) ~~Medi-Cal~~MC 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.

D. Managed Care Plan (MCP) Retention of Provider Overpayments

The MCP shall retain all recoveries less than $25 million for all overpayments and recoveries of overpayments from the MCP to a network provider, including overpayments due to fraud, waste, or abuse, identified by the MCP. In the event an MCP recovers an overpayment to a provider of $25 million or more, DHCS and the MCP will share the recovery amount equally. Sixty (60) days after the date that the overpayment was identified, the MCP must report the overpayment to DHCS through their contract manager. DHCS will recoup the overpayment from the MCP capitated payment. The statement issued to the MCP will reflect the overpayment. The MCP shall submit the overpayment amount that

was recovered, the provider(s) information, and steps taken to correct future occurrences to the MCP's assigned Managed Care Operations Division Contract Manager.

III. Responsibilities

A. Information Technology (IT) is responsible for loading eligibility and OHC information into the claims system and for creating and submitting post payment recovery report.

B. Claims is responsible for denying claims without explanation of benefits (EOB) from OHC carrier for ~~Medi-Cal~~MC members with OHC.

C. ~~Finance~~Claims is responsible for receiving and processing of unsolicited post payment recovery of paid claims for ~~Medi-Cal~~MC members with OHC~~,~~ and for ~~reporting,~~reviewing and approving the monthly post payment recovery report.

~~C.~~D. Finance is responsible for reviewing and approving the monthly post payment recovery report of paid claims for MC members with OHC and repayment to DHCS of any recovery received on or after the 13th month of original claim payment.

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

IV. References

APL 17-003 Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Provider
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 ~~04/15/2021~~08/16/2022 Date	Neal Jarecki Chief Financial Officer ~~04~~08/16/~~2021~~2022 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	Approve	4/22/2021
2	Revised	Executive/Finance	Recommend	08/25/2022

POLICY

Policy Title:	**Third Party Tort Liability Reporting Requirements**	**Policy No.:**	CL.29 ~~v1~~v2
Replaces Policy Title (if applicable):	Third Party Tort Liability Reporting Requirements	**Replaces Policy No. (if applicable):**	CL.29 v1
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

To provide clarification and guidance to Santa Clara Family Health Plan (SCFHP) departments on the process for submitting service and utilization information and copies of paid invoices/claims for covered services related to third party liability (TPL) torts to the Department of Health Care Services (DHCS).

II. Policy

A. SCFHP must submit service and utilization information and, when requested, copies of paid invoices/claims for covered services to DHCS within 30 days of DHCS' request. Service and utilization information and copies of paid invoices/claims for covered services must include any services provided by the managed care plan (MCP), including, but not limited to, physical, mental, and dental health services. Records must include services provided on a fee-for-service, capitated, or other payment arrangement, regardless of whether payment was made or denied.

B. If SCFHP's Claims department suspects a potential tort liability action and has insurance and/or attorney information, they must notify the Compliance department of such.
   a. The Compliance Declarant must notify DHCS using the online forms on the Personal Injury Program site within ten (10) calendar days of discovering that a member has initiated the action.

III. Responsibilities

A. SCFHP Claims department is responsible to coordinate and complete the service and utilization report.

B. SCFHP Claims department is responsible to report suspected potential tort liability action and insurance and/or attorney information to the Compliance Declarant of such.

C. The Compliance Declarant must notify DHCS of reported potential tort liability actions, insurance and/or attorney information.

D. Provider Network Operations is responsible for communicating requirements to Delegates.

IV. References

APL 21-007 – Third Party Tort Liability Reporting Requirements
Welfare and Institutions Code section 14124.70
The online forms are available at: ~~https://www.dhcs.ca.gov/PIForms.~~
https://www.dhcs.ca.gov/services/Pages/TPLRD_PI_OnlineForms.aspx

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~8~~05/~~19/2021~~16/2022 Date	Neal Jarecki Chief Financial Officer ~~8~~05/~~19/2021~~16/2022 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	Approve	8/26/2021
2	Revised	Executive/Finance	Recommend	07/28/2022

Santa Clara Family Health Plan™

Unaudited Financial Statements

For The Eleven Months Ended May 31, 2022

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$107.8 M		$1.44 B	
Medical Expense (MLR)	$100.0 M	92.8%	$1.35 B	93.5%
Administrative Expense (% Rev)	$6.5 M	6.0%	$68.9 M	4.8%
Other Income/(Expense)	$406K		$1.7 M	
Net Surplus (Net Loss)	**$1.7 M**		**$26.0 M**	
Cash and Investments			$531 M	
Receivables			$547 M	
Total Current Assets			$1.09 B	
Current Liabilities			$834 M	
Current Ratio			1.30	
Tangible Net Equity			$281 M	
% of DMHC Requirement			**823.5%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $1.7M is $1.7M or 6,968.1% favorable to budget of $24K surplus. YTD: Surplus of $26.0M is $17.4M or 202.5% favorable to budget of $8.6M surplus.
Enrollment	Month: Membership was 301,262 (4,945 or 1.6% lower than budget of 306,207). YTD: Member Months YTD was 3,211,417 (85,300 or 2.6% lower than budget of 3,296,717).
Revenue	Month: $107.8M ($11.5M or 9.7% unfavorable to budget of $119.4M). YTD: $1.44B ($158.4M or 12.3% favorable to budget of $1.29B).
Medical Expenses	Month: $100.0M ($12.7M or 11.3% favorable to budget of $112.7M). YTD: $1.35B ($143.9M or 11.9% unfavorable to budget of $1.21B).
Administrative Expenses	Month: $6.5M ($530K or 7.6% favorable to budget of $7.0M). YTD: $68.9M ($5.4M or 7.2% favorable to budget of $74.3M).
Tangible Net Equity	TNE was $280.8M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $1.1M vs. $3.3M annual budget, primarily software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 301,262 members is 4,945 or 1.6% lower than budget. Since the beginning of the fiscal year, total enrollment has increased by 18,592 members or 6.6%.
- Medi-Cal & CMC enrollment have been increasing since March 2020 largely due to COVID. Beginning in March 2020, annual eligibility redeterminations were suspended and, as a result, enrollment continues to increase.
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 7.0%, Medi-Cal Dual enrollment has increased 4.4%, and CMC enrollment has grown 2.5%.

	For the Month May 2022				For Eleven Months Ending May 31, 2022					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY22 vs. FY21
Medi-Cal	290,928	295,387	(4,459)	(1.5%)	3,098,049	3,180,667	(82,618)	(2.6%)	2,864,681	8.1%
Cal Medi-Connect	10,334	10,820	(486)	(4.5%)	113,368	116,050	(2,682)	(2.3%)	106,285	6.7%
Total	**301,262**	**306,207**	**(4,945)**	**(1.6%)**	**3,211,417**	**3,296,717**	**(85,300)**	**(2.6%)**	**2,970,966**	**8.1%**

Santa Clara Family Health Plan Enrollment By Network
May 2022

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	38,389	13%	10,334	100%	48,723	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	145,029	50%	-	0%	145,029	48%
North East Medical Services	3,384	1%	-	0%	3,384	1%
Palo Alto Medical Foundation	7,428	3%	-	0%	7,428	2%
Physicians Medical Group	44,938	15%	-	0%	44,938	15%
Premier Care	16,272	6%	-	0%	16,272	5%
Kaiser	35,488	12%	-	0%	35,488	12%
Total	**290,928**	**100%**	**10,334**	**100%**	**301,262**	**100%**
Enrollment at June 30, 2021	272,590		10,080		282,670	
Net Δ from Beginning of FY22	6.7%		2.5%		6.6%	

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

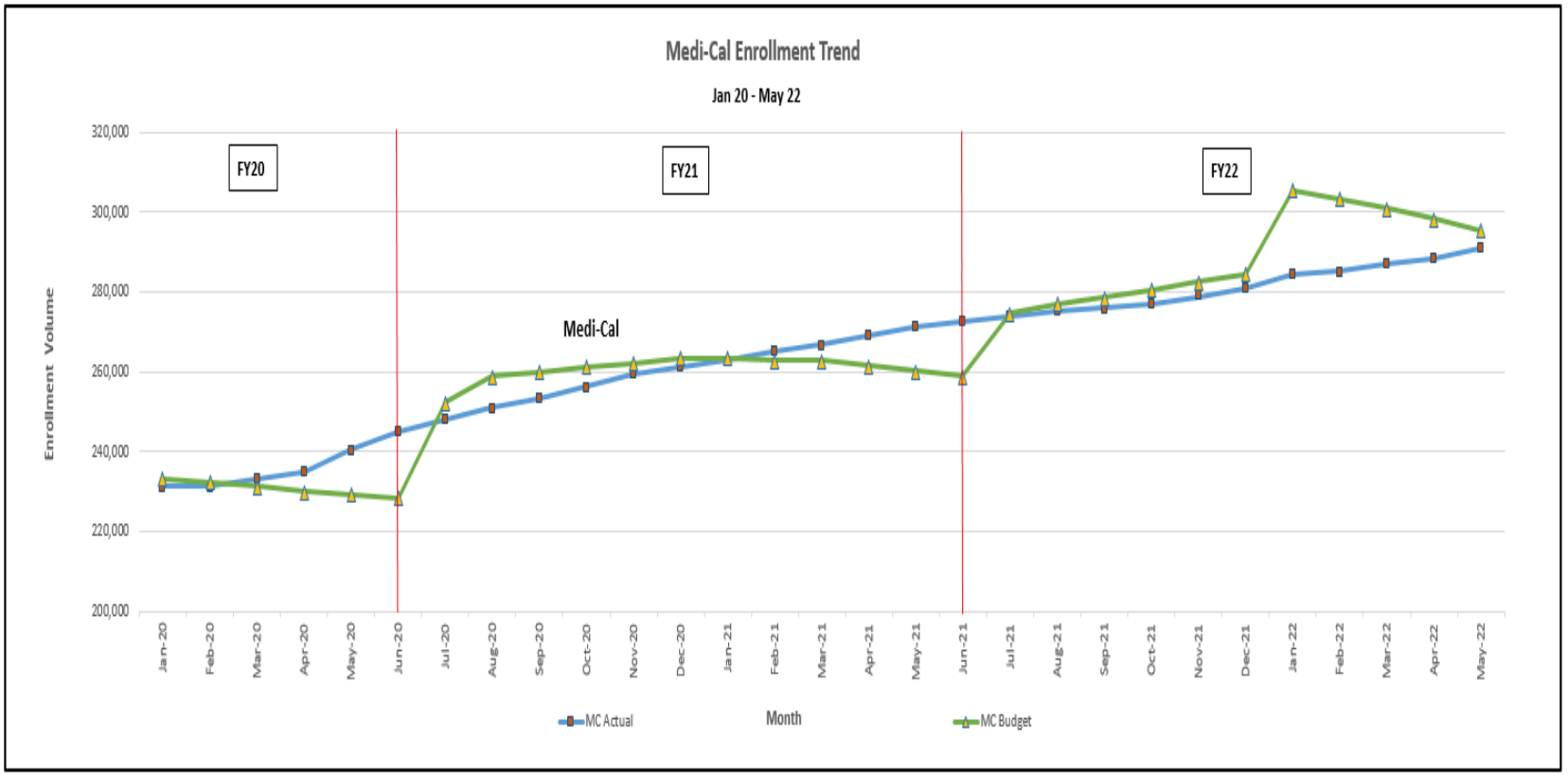
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD MAY - 2022

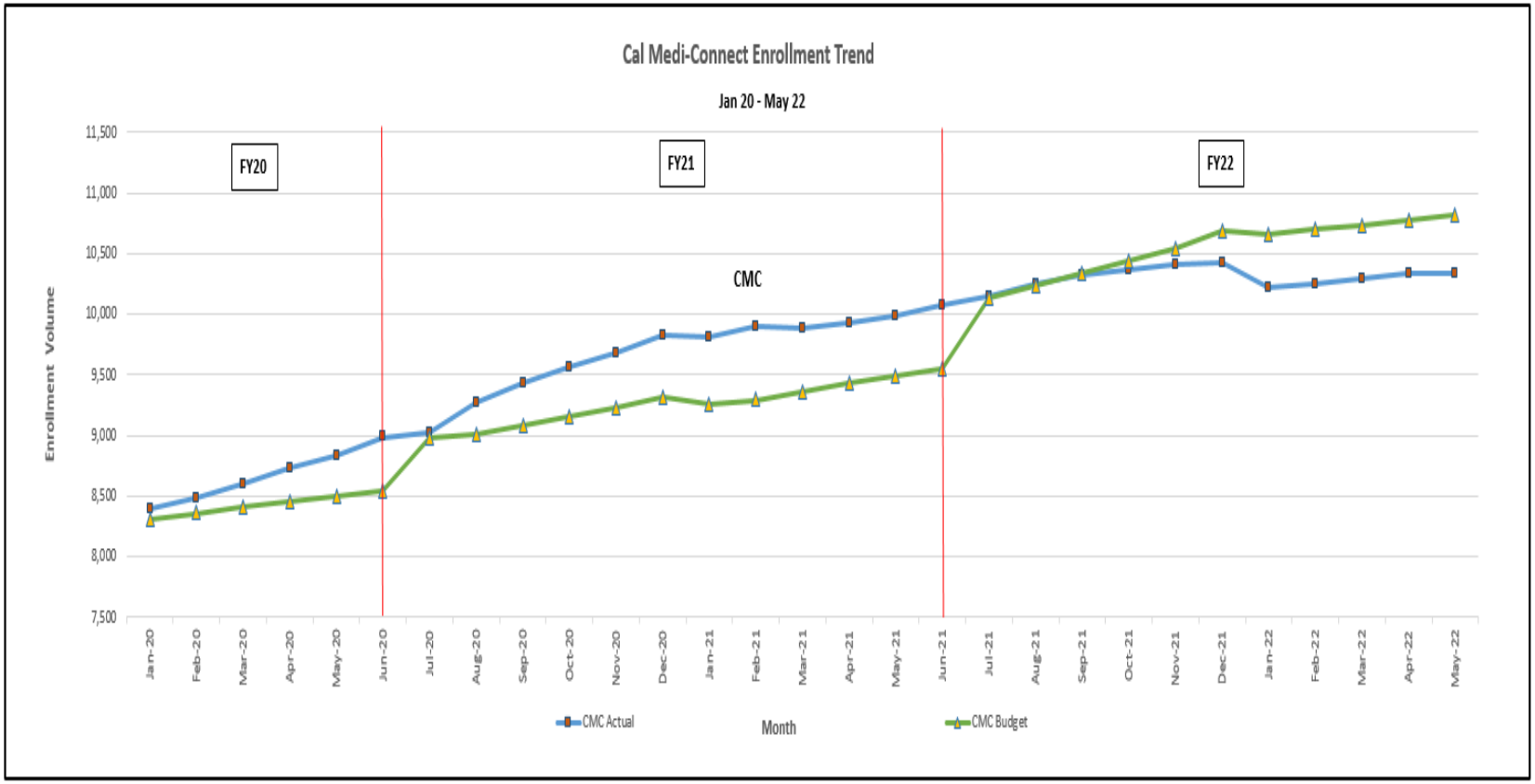
		2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	FYTD var	%
NON DUAL	Adult (over 19)	32,577	32,997	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	4,036	12.2%
	Child (under 19)	100,245	100,477	101,010	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	3,288	3.3%
	SPD	22,291	22,301	22,363	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	535	2.4%
	Adult Expansion	89,361	89,957	90,711	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	9,292	10.3%
	Long Term Care	367	365	414	408	401	391	385	392	391	403	395	393	397	32	8.8%
	Total Non-Duals	**244,841**	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**17,183**	**7.0%**
DUAL	Adult (over 21)	365	366	367	376	375	396	398	408	410	403	407	412	431	65	17.8%
	SPD	24,146	24,115	23,980	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	237	1.0%
	Long Term Care	1,031	1,060	1,127	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	66	6.2%
	SPD OE	863	952	1,063	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	787	82.7%
	Total Duals	**26,405**	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**1,155**	**4.4%**
	Total Medi-Cal	**271,246**	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**18,338**	**6.7%**
CMC	CMC Non-Long Term Care	9,809	9,895	9,939	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	233	2.4%
	CMC - Long Term Care	180	185	209	208	203	208	204	210	202	213	215	206	206	21	11.4%
	Total CMC	**9,989**	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**254**	**2.5%**
	Total Enrollment	**281,235**	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**18,592**	**6.6%**

Medi-Cal Enrollment Trend



- Actual enrollment, represented by the blue line, showed steeper initial COVID enrollment growth in FY21 followed by a lower growth in FY22 with continued public health emergency.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to sustained public health emergency. Current budget effective July 2021, the Budget included a higher projection of new mandatory Medi-Cal population having Other Health Coverage (OHC) starting Jan 2022.

Cal Medi-Connect Enrollment Trend

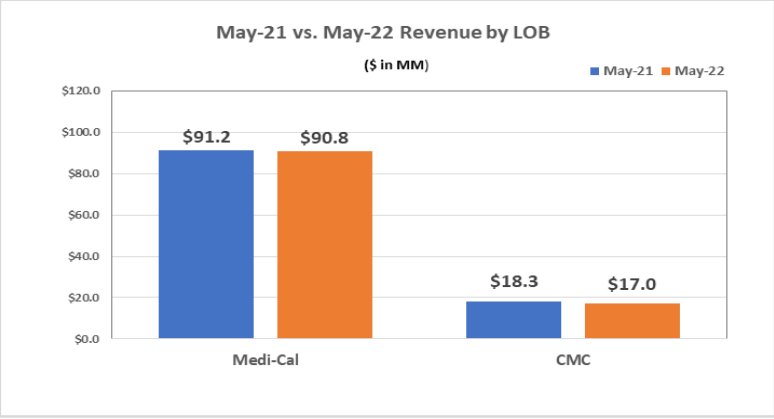


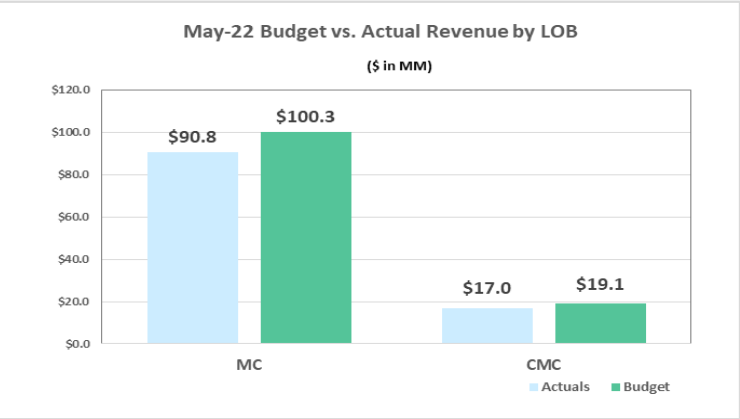
- Actual enrollment, represented by the blue line, showed steeper initial COVID enrollment growth in FY21 followed by a lower growth in FY22 with continued public health emergency.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to sustained public health emergency. Current budget effective July 2021 continues to increase.

Current Month Revenue

Current month revenue of $107.8M was $11.5M or 9.7% unfavorable to budget of $119.4M. The current month variance was primarily due to the following:

- Medi-Cal revenue was $9.2M unfavorable to budget due primarily to (1) the pharmacy benefit carve-out ($13.4M unfav) and (2) lower Other Health Coverage (OHC) mandatory enrollment ($2.2M unfav), partly offset by (3) higher CY22 rates versus budget ($6.4M fav). The Budget anticipated the Medi-Cal pharmacy benefit would continue until the end of fiscal year but pharmacy carve-out began on Jan 1. Unfavorable pharmacy revenue is offset by favorable pharmacy expense.
- Other Medi-Cal revenue was $300K net unfavorable to budget due to (1) $1.3M unfavorable variance of a DHCS retroactive recoupment for Date of Death Audit, (2) $463K favorable variance for School of Behavioral Health Incentive Program (SBHIP), (3) supplemental revenue favorable to budget by $545K due to increased retro BHT encounter data, offset by budgeted Hep-C and lower maternity deliveries.
- CMC revenue was $2.0M unfavorable to budget due to (1) additional CY20 medical loss ratio (MLR) accrual payables to DHCS & CMS ($1.2M unfav) and (2) lower enrollment versus budget ($800K unfav.).

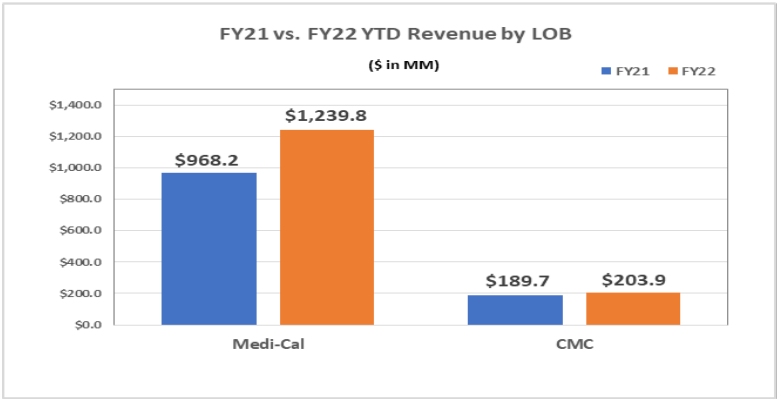


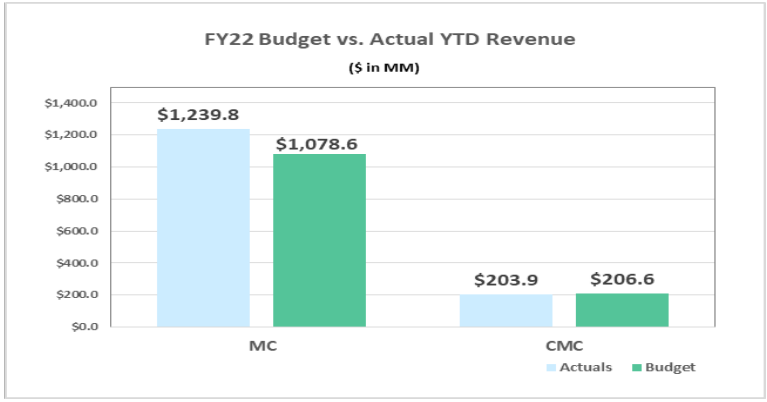


YTD Revenue

YTD revenue of $1.44B was $158.4M or 12.3% favorable to budget of $1.29B. The YTD variance was primarily due to the following:

- Due to a change in accounting prescribed by DHCS, hospital directed payments are now reported on the P&L resulting in a favorable current month revenue variance of $212.3M with an offsetting unfavorable medical expense.
- Medi-Cal revenue is $57.1M unfavorable largely due to the timing of the pharmacy benefit carve-out effective January 1st (the budget assumed the Rx benefit would continue through FY23). Lower pharmacy-related revenue is largely offset by lower pharmacy-related medical expense. Lower enrollment than anticipated from OHC contributes to the net unfavorable variance. Partially offsetting favorable variances pertained to higher CY22 rates versus budget and unbudgeted revenue associated with the COVID vaccine program (with associated expense).
- Supplemental revenue is $5.9M favorable to budget due to increased utilization in BHT, Health Homes, Hep-C, and higher maternity deliveries.
- CMC revenue was $2.7M unfavorable to budget due to accrued CY20 Medical Loss Ratio reserves payable to DHCS & CMS and lower enrollment, offset by CY20 Part-D Reconciliation payment, Part-C Quality Withholding Earnback received, and higher CY21 & CY22 CCI rates versus budget.

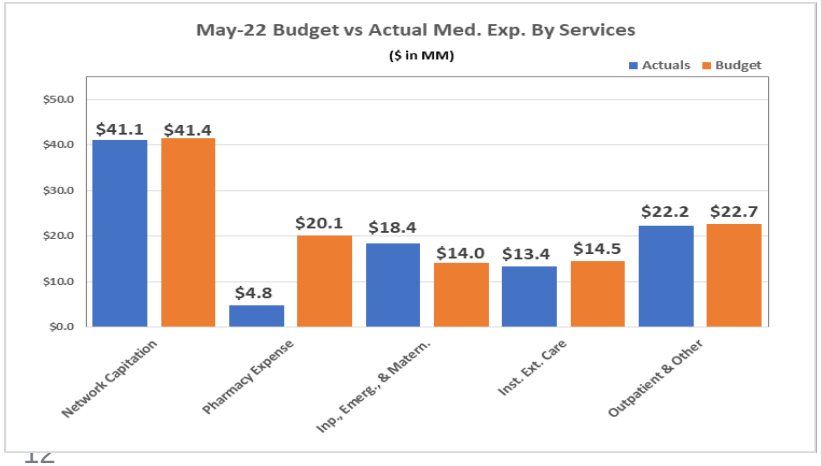


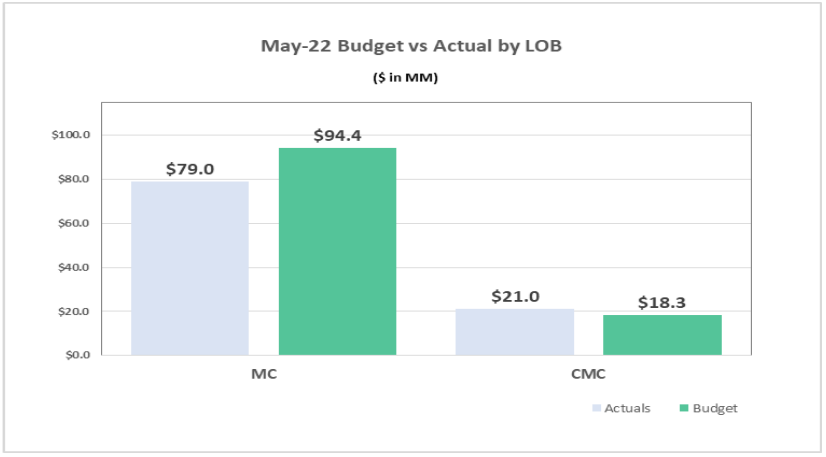


Current Month Medical Expense

Current month medical expense of $100.0M was $12.7M or 11.3% favorable to budget of $112.7M. The current month variance was due largely to:

- Pharmacy expense was $15.3M favorable to budget primarily due to timing of the Medi-Cal carve-out (offsetting the unfavorable revenue variance of $13.4M). The budget assumed the pharmacy benefit would continue through the end of fiscal year.
- Fee-For-Service expense was $2.1M or 4.3% unfavorable to budget due to (1) increased unit cost versus budget for Inpatient, Outpatient and Physician Specialty services and (2) increased supplemental services such as Behavioral Health Therapy (offset with favorable revenue variance), offset by (3) lower utilization in PCP, LTC, Emergency Room and Other MLTSS services.
- Reinsurance & Other expenses were $819K or 22.2% unfavorable to budget due to timing of Board Designated Fund payments ($474K unfavorable), $463K unfavorable SBHIP incentive program (offset with favorable revenue), prior year Prop-56 and hospital directed payment adjustments ($49K unfav) (offset with favorable revenue), coupled with favorable net claim recoveries ($167K fav).
- Capitation expense was $296K or 0.7% favorable to budget due to lower capitated enrollment than expected, offset by higher CY22 capitated rates.

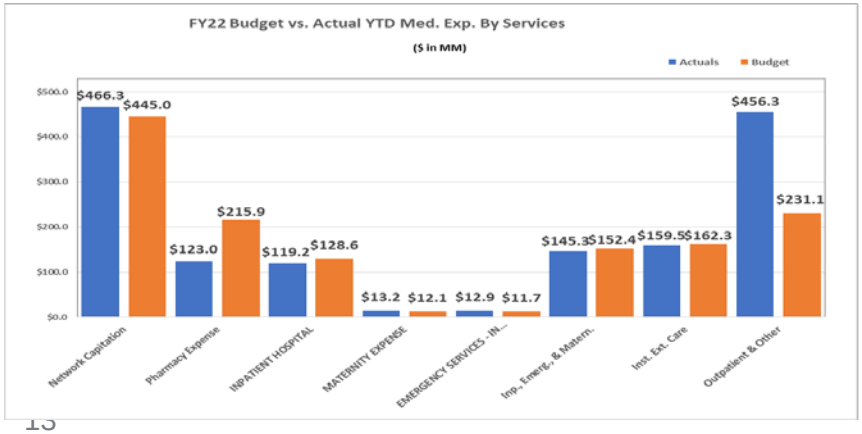


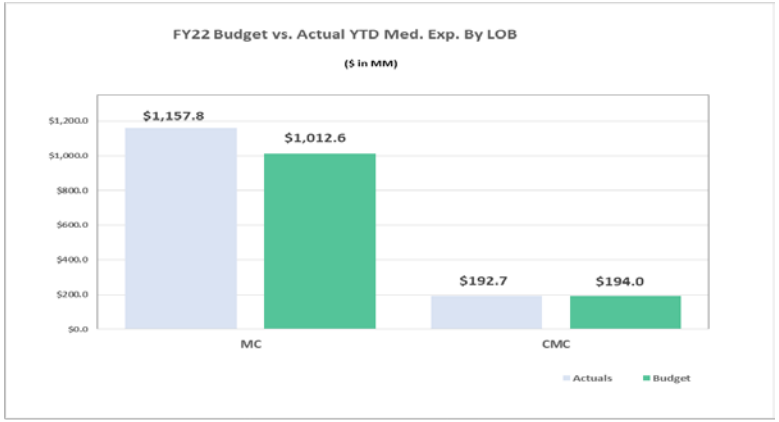


YTD Medical Expense

YTD medical expense of $1.35B was $143.9M or 11.9% unfavorable to budget of $1.21B. The YTD variance was due largely to:

- Due to a change in accounting prescribed by DHCS, hospital directed payments are now reported on the P&L resulting in an unfavorable medical expense of $212.3M with an offsetting favorable current month revenue variance.
- Pharmacy expenses were $92.9M or 43.0% favorable to budget because budget was projected to have pharmacy benefit continue until June 30 but it ended Jan 1 and lower enrollment from OHC than anticipated, thus lower overall pharmacy costs. Actual costs of diabetic drugs were also affected by lower enrollment. MC favorable pharmacy expenses were offset by unfavorable revenue.
- Capitation expense was $21.3M or 4.8% unfavorable to budget due to $23M accrued for VHP as one-time capitation payment for SPD utilization costs not reflected in original CY21 paid capitation rates. VHP is expected to pass the entire amount to VMC, offset by lower capitated MC enrollment.
- Fee-For-Service expense was $2.1M unfavorable to budget due to (1) increased unit cost versus budget in Outpatient, ER, Physician Specialty, PCP and Other Non MLTSS services and (2) increased supplemental services such as Behavioral Health Therapy, Health Homes, Maternity (offset with favorable revenue variance), offset by (3) lower utilization in Inpatient, LTC and Other MLTSS services.

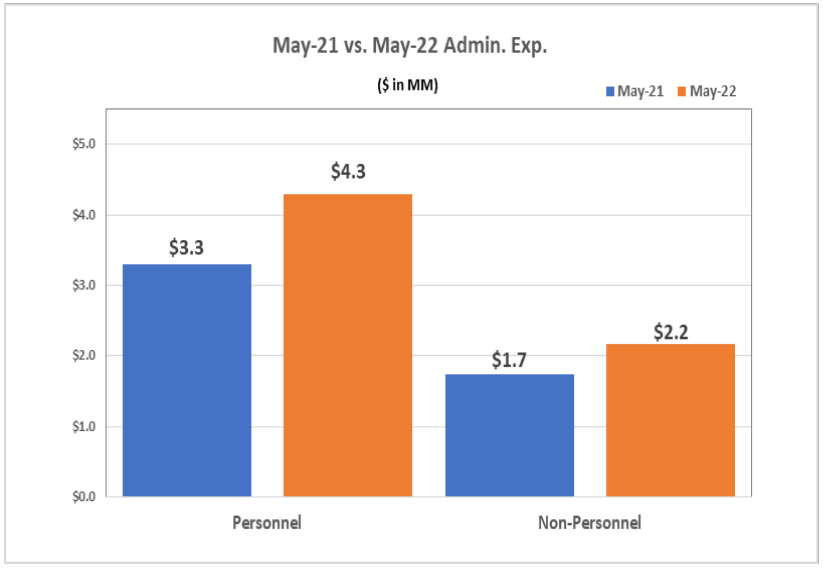


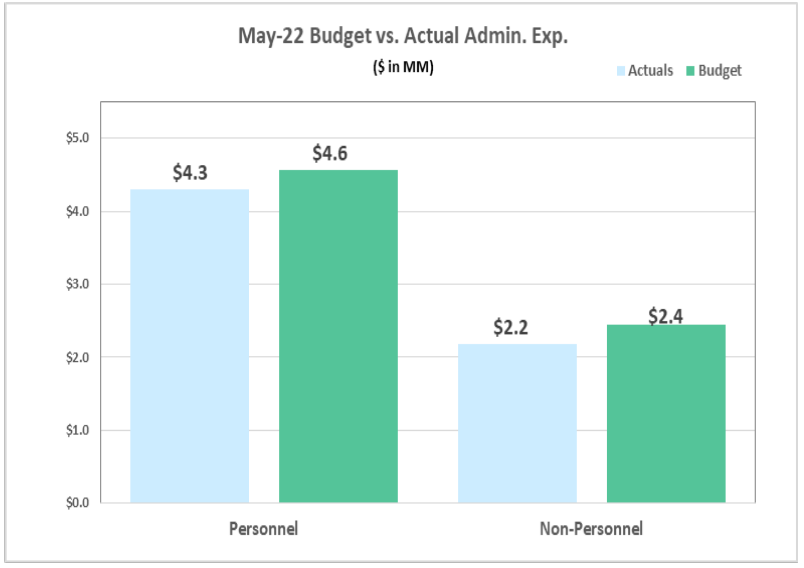


Current Month Administrative Expense

Current month expense of $6.5M was $530K or 7.6% favorable to budget of $7.0M. The current month variances were primarily due to the following:

- Personnel expenses were $266K or 5.8% favorable to budget due to lower headcount than budget which included payroll tax, benefit savings and CalPERS reconciliations.
- Non-Personnel expenses were $264K or 10.8% favorable to budget due to the timing of spending in certain expense categories (consulting, contract service, translation, and other fees). Other Expense also included unbudgeted COVID member incentive gift cards. COVID vaccination incentive program is provided by DHCS.

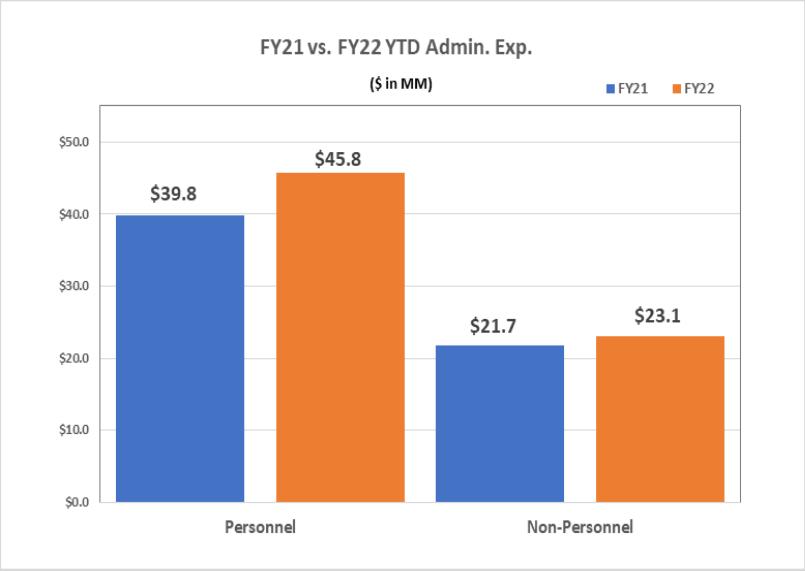


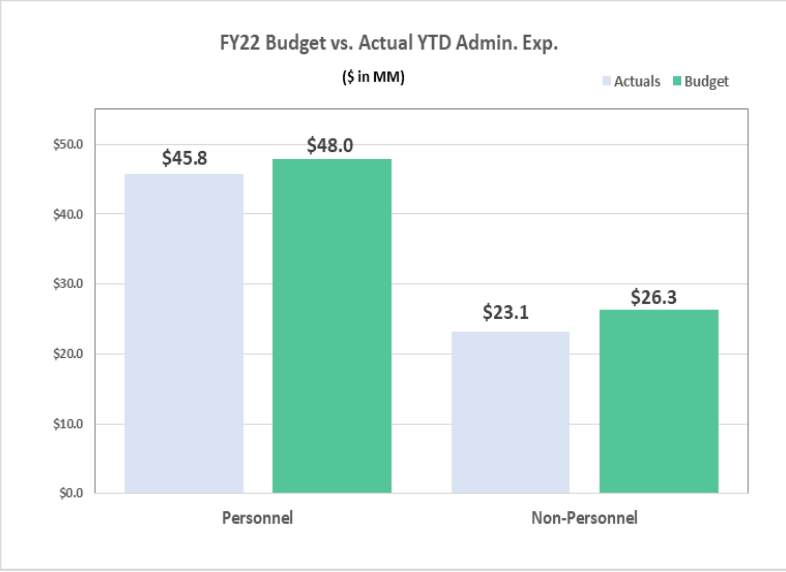


YTD Administrative Expense

YTD administrative expense of $68.9M was $5.4M or 7.2% favorable to budget of $74.3M. The YTD variance was primarily due to the following:

- Personnel expenses were $2.2M or 4.5% favorable to budget due to lower headcount than budget which included lower payroll tax, benefits and CalPERS reconciliations.
- Non-Personnel expenses were $3.2M or 12.2% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising, information systems, and other fees). Other Expense included unbudgeted COVID member vaccination incentives under DHCS program.





Balance Sheet

- Current assets totaled $1.09B compared to current liabilities of $833.7M, yielding a current ratio (Current Assets/Current Liabilities) of 1.30:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by $122.9M compared to the cash balance as of year-end June 30, 2021 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
Short-Term Investments				
County of Santa Clara Comingled Pool	$183,653,817	0.79%	$122,232	$1,194,578
Wells Fargo Investments	($20)	0.00%	$0	$34,513
City National Bank Investments	$270,873,918	0.95%	$249,884	$116,863
	$454,527,715		$372,116	$1,345,955
Cash & Equivalents				
Bank of the West Money Market	$0	0.00%	$0	$3,308
City National Bank Accounts	$71,271,248	0.01%	$437	$3,792
Wells Fargo Bank Accounts	$4,833,395	0.59%	$2,125	$5,932
	$76,104,643		$2,562	$13,031
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.01%	$3	$596
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$530,957,859**		**$374,681**	**$1,359,582**

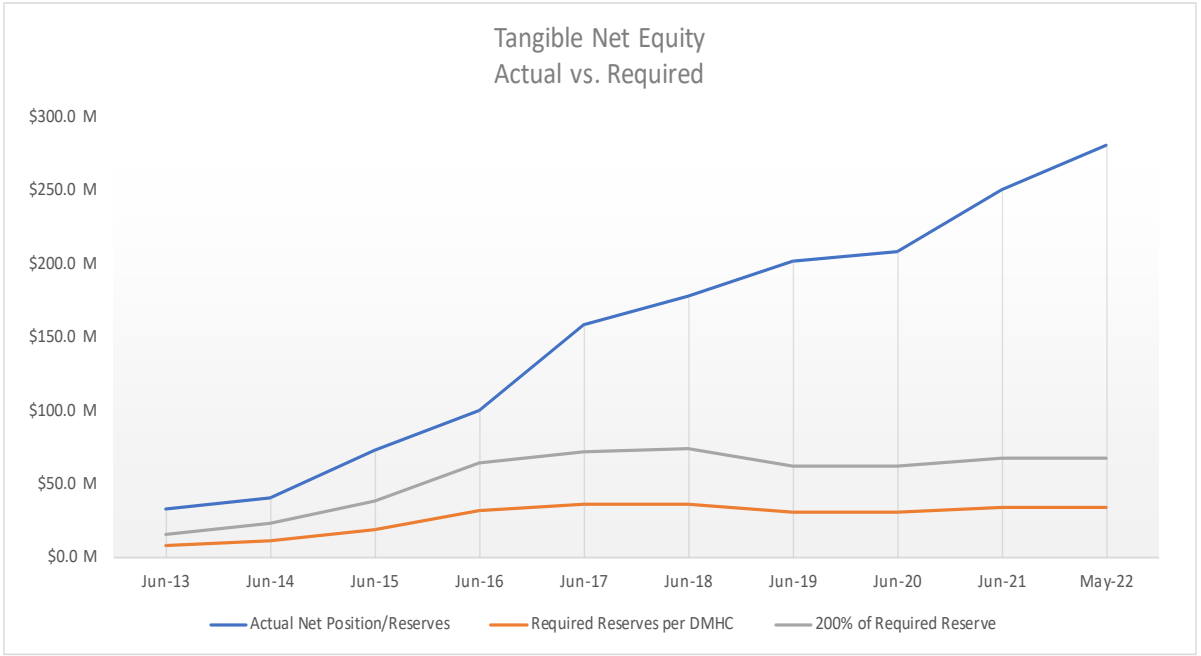
- Cash balances include balances payable to the State of CA for certain items.
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- The investment transition from Wells Fargo to City National Bank was largely completed in January.
- Overall cash and investment yield is lower than budget (0.76% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $280.8M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of May 31, 2022

	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	May-22
Actual Net Position/Reserves	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$280.8 M
Required Reserves per DMHC	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$34.1 M
200% of Required Reserve	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$68.2 M
Actual as % Required	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	823.5%



Reserves Analysis

SCFHP RESERVES ANALYSIS MAY 2022

Financial Reserve Target #1: Tangible Net Equity	Board Funds Committed	Approved Projects	Funds Expended	Balance	
Unrestricted Net Assets				**$240,509,845**	*
Board Designated Funds (Note 1):					
Special Project Funding for CBOs	$4,000,000	$739,995	$494,995	$3,505,005	
Innovation & COVID-19 Fund	$16,000,000	$7,704,043	$3,917,591	$12,082,410	
Subtotal	$20,000,000	$8,444,038	$4,412,585	$15,587,415	
Net Book Value of Fixed Assets				$24,414,144	
Restricted Under Knox-Keene Agreement				$325,000	
Total Tangible Net Equity (TNE)				$280,836,403	
Current Required TNE				$34,101,383	
TNE %				823.5%	
SCFHP Target TNE Range:					
350% of Required TNE (Low)				$119,354,842	
500% of Required TNE (High)				$170,506,917	
Total TNE Above/(Below) SCFHP Low Target				**$161,481,561**	
Total TNE Above/(Below) High Target				**$110,329,486**	
Financial Reserve Target #2: Liquidity					
Cash & Investments				$530,957,859	
Less Pass-Through Liabilities:					
Hospital Directed Payments				(357,440)	
MCO Tax Payable to State of CA				(24,890,650)	
Prop 56 / Whole Person Care				(1,684,180)	
Other Pass-Through Liabilities (Note 2)				(108,562,473)	
Total Pass-Through Liabilities				**(135,494,742)**	
Net Cash Available to SCFHP				395,463,116	
SCFHP Target Liquidity (Note 3)					
45 Days of Total Operating Expense				(179,617,236)	
60 Days of Total Operating Expense				(239,489,648)	
Liquidity Above/(Below) SCFHP Low Target				**215,845,880**	
Liquidity Above/(Below) High Target				**155,973,468**	

- **Unrestricted Net Assets represents approximately 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 & COVID-19 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

- YTD Capital investments of $1.1M, largely due to software licensing, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$19,064	$55,800
Hardware	$303,042	$1,060,000
Software	$638,172	$1,896,874
Building Improvements	$166,104	$62,000
Furniture & Equipment	$12,055	$179,101
TOTAL	**$1,138,438**	**$3,253,775**

Certain items, largely hardware and software projects, have been deferred.

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Eleven Months Ending May 31, 2022

	May-2022 Actuals	% of Rev	May-2022 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD May-2022 Actuals	% of Rev	YTD May-2022 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 90,790,595	84.2%	$ 100,293,518	84.0%	$ (9,502,923)	(9.5%)	$ 1,239,753,621	85.9%	$ 1,078,594,432	83.9%	$ 161,159,189	14.9%
CMC MEDI-CAL	3,316,480	3.1%	3,607,170	3.0%	(290,690)	(8.1%)	39,539,218	2.7%	40,560,791	3.2%	(1,021,573)	(2.5%)
CMC MEDICARE	13,730,369	12.7%	15,480,931	13.0%	(1,750,563)	(11.3%)	164,315,130	11.4%	166,040,859	12.9%	(1,725,729)	(1.0%)
TOTAL CMC	17,046,848	15.8%	19,088,101	16.0%	(2,041,253)	(10.7%)	203,854,348	14.1%	206,601,650	16.1%	(2,747,302)	(1.3%)
TOTAL REVENUE	**$ 107,837,443**	**100.0%**	**$ 119,381,619**	**100.0%**	**$ (11,544,176)**	**(9.7%)**	**$ 1,443,607,970**	**100.0%**	**$ 1,285,196,082**	**100.0%**	**$ 158,411,887**	**12.3%**
MEDICAL EXPENSES												
MEDI-CAL	$ 79,002,852	73.3%	$ 94,421,739	79.1%	$ 15,418,888	16.3%	$ 1,157,778,614	80.2%	$ 1,012,577,656	78.8%	$(145,200,958)	(14.3%)
CMC MEDI-CAL	3,268,088	3.0%	3,185,102	2.7%	(82,986)	(2.6%)	39,938,529	2.8%	33,829,258	2.6%	(6,109,272)	(18.1%)
CMC MEDICARE	17,773,304	16.5%	15,133,775	12.7%	(2,639,529)	(17.4%)	152,713,877	10.6%	160,173,745	12.5%	7,459,868	4.7%
TOTAL CMC	21,041,392	19.5%	18,318,877	15.3%	(2,722,515)	(14.9%)	192,652,406	13.3%	194,003,003	15.1%	1,350,596	0.7%
TOTAL MEDICAL EXPENSES	**$ 100,044,244**	**92.8%**	**$ 112,740,616**	**94.4%**	**$ 12,696,373**	**11.3%**	**$ 1,350,431,020**	**93.5%**	**$ 1,206,580,658**	**93.9%**	**$(143,850,361)**	**(11.9%)**
GROSS MARGIN	**$ 7,793,200**	**7.2%**	**$ 6,641,003**	**5.6%**	**$ 1,152,197**	**17.3%**	**$ 93,176,950**	**6.5%**	**$ 78,615,424**	**6.1%**	**$ 14,561,526**	**18.5%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 4,299,484	4.0%	$ 4,565,205	3.8%	$ 265,721	5.8%	$ 45,794,508	3.2%	$ 47,965,958	3.7%	$ 2,171,451	4.5%
RENTS AND UTILITIES	39,888	0.0%	42,067	0.0%	2,179	5.2%	421,121	0.0%	462,734	0.0%	41,613	9.0%
PRINTING AND ADVERTISING	28,533	0.0%	107,542	0.1%	79,009	73.5%	531,820	0.0%	1,184,958	0.1%	653,139	55.1%
INFORMATION SYSTEMS	325,773	0.3%	397,753	0.3%	71,980	18.1%	3,474,437	0.2%	4,245,930	0.3%	771,492	18.2%
PROF FEES/CONSULTING/TEMP STAFFING	1,055,420	1.0%	1,138,398	1.0%	82,978	7.3%	10,361,387	0.7%	12,358,063	1.0%	1,996,675	16.2%
DEPRECIATION/INSURANCE/EQUIPMENT	420,206	0.4%	452,953	0.4%	32,747	7.2%	4,440,965	0.3%	4,776,354	0.4%	335,388	7.0%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	59,218	0.1%	62,242	0.1%	3,024	4.9%	593,162	0.0%	685,265	0.1%	92,103	13.4%
MEETINGS/TRAVEL/DUES	114,850	0.1%	138,742	0.1%	23,892	17.2%	1,085,612	0.1%	1,500,855	0.1%	415,243	27.7%
OTHER	131,330	0.1%	99,307	0.1%	(32,023)	(32.2%)	2,207,360	0.2%	1,100,223	0.1%	(1,107,138)	(100.6%)
TOTAL ADMINISTRATIVE EXPENSES	**$ 6,474,702**	**6.0%**	**$ 7,004,208**	**5.9%**	**$ 529,506**	**7.6%**	**$ 68,910,372**	**4.8%**	**$ 74,280,339**	**5.8%**	**$ 5,369,967**	**7.2%**
OPERATING SURPLUS/(LOSS)	**$ 1,318,498**	**1.2%**	**$ (363,205)**	**(0.3%)**	**$ 1,681,703**	**(463.0%)**	**$ 24,266,578**	**1.7%**	**$ 4,335,085**	**0.3%**	**$ 19,931,493**	**459.8%**
INTEREST & INVESTMENT INCOME	$ 374,681	0.3%	$ 350,000	0.3%	$ 24,681	7.1%	$ 1,359,582	0.1%	$ 3,850,000	0.3%	$ (2,490,418)	(64.7%)
OTHER INCOME	31,209	0.0%	37,602	0.0%	(6,393)	(17.0%)	359,643	0.0%	404,695	0.0%	(45,052)	(11.1%)
NON-OPERATING INCOME	**$ 405,889**	**0.4%**	**$ 387,602**	**0.3%**	**$ 18,288**	**4.7%**	**$ 1,719,225**	**0.1%**	**$ 4,254,695**	**0.3%**	**$ (2,535,470)**	**(59.6%)**
NET SURPLUS (LOSS)	**$ 1,724,387**	**1.6%**	**$ 24,397**	**0.0%**	**$ 1,699,990**	**6,968.1%**	**$ 25,985,802**	**1.8%**	**$ 8,589,780**	**0.7%**	**$ 17,396,022**	**202.5%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of May 31, 2022

	May-2022	Apr-2022	Mar-2022	May-2021
Assets				
Current Assets				
Cash and Investments	$ 530,957,859	$ 498,171,830	$ 523,241,624	$ 623,375,356
Receivables	546,977,941	547,688,913	537,062,747	508,680,106
Prepaid Expenses and Other Current Assets	7,304,447	7,979,786	8,189,334	8,742,359
Total Current Assets	**$ 1,085,240,247**	**$ 1,053,840,528**	**$ 1,068,493,705**	**$ 1,140,797,820**
Long Term Assets				
Property and Equipment	$ 52,661,309	$ 52,541,558	$ 52,446,207	$ 51,226,087
Accumulated Depreciation	(28,247,165)	(27,900,369)	(27,559,133)	(24,128,608)
Total Long Term Assets	24,414,144	24,641,189	24,887,074	27,097,478
Total Assets	**$ 1,109,654,390**	**$ 1,078,481,717**	**$ 1,093,380,779**	**$ 1,167,895,299**
Deferred Outflow of Resources	**$ 5,379,606**	**$ 5,602,483**	**$ 5,825,360**	**$ 8,402,260**
Total Assets & Deferred Outflows	**$ 1,115,033,997**	**$ 1,084,084,200**	**$ 1,099,206,139**	**$ 1,176,297,559**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 11,108,109	$ 17,022,946	$ 27,246,778	$ 4,443,990
Deferred Rent	44,567	45,349	45,647	48,630
Employee Benefits	4,270,614	4,105,609	4,084,708	3,268,814
Retirement Obligation per GASB 75	2,459,537	2,419,412	2,379,287	2,965,368
Whole Person Care	1,684,180	1,687,180	1,690,180	1,948,180
Prop 56 Pass-Throughs	63,768,752	61,850,674	58,582,324	53,723,239
HQAF Payable to Hospitals	4,751	(1,533)	(1,415)	103,797
Hospital Directed Payment Payable	352,688	434,325	434,325	179,861,728
Pass-Throughs Payable	20,485,300	16,381,877	12,462,691	43,761,368
Due to Santa Clara County Valley Health Plan and Kaiser	77,175,627	70,625,067	63,609,776	29,138,890
MCO Tax Payable - State Board of Equalization	24,890,650	14,776,148	35,033,577	18,230,781
Due to DHCS	88,077,172	85,754,920	83,651,655	54,904,066
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,990,933
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
DHCS Incentive Programs	7,718,646	0	0	0
Medical Cost Reserves	103,332,724	101,045,936	109,955,316	114,710,988
Total Current Liabilities	**$ 833,658,276**	**$ 804,432,867**	**$ 827,459,806**	**$ 935,394,797**
Non-Current Liabilities				
Net Pension Liability GASB 68	(0)	(0)	(0)	1,445,958
Total Non-Current Liabilities	**$ (0)**	**$ (0)**	**$ (0)**	**$ 1,445,958**
Total Liabilities	**$ 833,658,275**	**$ 804,432,866**	**$ 827,459,806**	**$ 936,840,755**
Deferred Inflow of Resources	**$ 539,318**	**$ 539,318**	**$ 539,318**	**$ 1,661,827**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,505,005	$ 3,720,000	$ 3,636,290	$ 3,337,274
Board Designated Fund: Innovation & COVID-19 Fund	12,082,410	12,591,157	12,843,867	13,830,001
Invested in Capital Assets (NBV)	24,414,144	24,641,189	24,887,074	27,097,478
Restricted under Knox-Keene agreement	325,000	325,000	325,000	325,000
Unrestricted Net Equity	214,524,042	213,573,254	213,158,369	164,051,034
Current YTD Income (Loss)	25,985,802	24,261,415	16,356,415	29,154,190
Total Net Assets / Reserves	**$ 280,836,403**	**$ 279,112,016**	**$ 271,207,016**	**$ 237,794,977**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,115,033,997**	**$ 1,084,084,200**	**$ 1,099,206,139**	**$ 1,176,297,559**

Cash Flow Statement

Santa Clara Family Health Plan

	May-2022	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$ 120,985,170	$ 1,431,332,106
Medical Expenses Paid	(91,206,895)	(1,301,295,671)
Adminstrative Expenses Paid	2,721,616	(7,731,428)
Net Cash from Operating Activities	**$ 32,499,891**	**$ 122,305,007**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	$ (119,751)	$ (1,138,438)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	405,889	1,719,225
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ 32,786,029**	**$ 122,885,793**
Cash & Investments (Beginning)	498,171,830	408,072,066
Cash & Investments (Ending)	**$ 530,957,859**	**$ 530,957,859**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Surplus/(Loss)	$ 1,318,498	$ 24,266,578
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	346,796	3,780,958
Changes in Operating Assets/Liabilities		
Premiums Receivable	710,972	(34,758,416)
Prepaids & Other Assets	675,339	1,412,058
Deferred Outflow of Resources	222,877	2,033,751
Accounts Payable & Accrued Liabilities	232,660	46,233,532
State Payable	12,436,755	22,482,552
IGT, HQAF & Other Provider Payables	6,550,561	53,389,949
Medical Cost Reserves & PDR	10,005,434	3,464,045
Total Adjustments	**$ 31,181,393**	**$ 98,038,429**
Net Cash from Operating Activities	**$ 32,499,891**	**$ 122,305,007**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Eleven Months Ending May 31, 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$1,239,753,621	$39,539,218	$164,315,130	$203,854,348	**$1,443,607,970**
MEDICAL EXPENSE	$1,157,778,614	$39,938,529	$152,713,877	$192,652,406	**$1,350,431,020**
(MLR)	93.4%	101.0%	92.9%	94.5%	93.5%
GROSS MARGIN	$81,975,008	($399,311)	$11,601,253	$11,201,942	**$93,176,950**
ADMINISTRATIVE EXPENSE	$59,179,421	$1,887,398	$7,843,554	$9,730,951	**$68,910,372**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$22,795,587	($2,286,709)	$3,757,699	$1,470,991	**$24,266,578**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$1,476,450	$47,088	$195,687	$242,775	**$1,719,225**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$24,272,037	($2,239,620)	$3,953,386	$1,713,765	**$25,985,802**
PMPM (ALLOCATED BASIS)					
REVENUE	$400.17	$348.77	$1,449.40	$1,798.16	**$449.52**
MEDICAL EXPENSES	$373.71	$352.29	$1,347.06	$1,699.35	**$420.51**
GROSS MARGIN	$26.46	($3.52)	$102.33	$98.81	**$29.01**
ADMINISTRATIVE EXPENSES	$19.10	$16.65	$69.19	$85.84	**$21.46**
OPERATING INCOME/(LOSS)	$7.36	($20.17)	$33.15	$12.98	**$7.56**
OTHER INCOME/(EXPENSE)	$0.48	$0.42	$1.73	$2.14	**$0.54**
NET INCOME/(LOSS)	$7.83	($19.76)	$34.87	$15.12	**$8.09**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	3,098,049	113,368	113,368	113,368	3,211,417
REVENUE BY LOB	85.9%	2.7%	11.4%	14.1%	100.0%

Santa Clara Family Health Plan™

Appendices

Statement of Operations by Line of Business – Current Month

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For the Month May 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$90,790,595	$3,316,480	$13,730,369	$17,046,848	**$107,837,443**
MEDICAL EXPENSE	$79,002,852	$3,268,088	$17,773,304	$21,041,392	**$100,044,244**
(MLR)	87.0%	98.5%	129.4%	123.4%	92.8%
GROSS MARGIN	$11,787,743	$48,391	($4,042,935)	($3,994,544)	**$7,793,200**
ADMINISTRATIVE EXPENSE	$5,451,187	$199,126	$824,389	$1,023,515	**$6,474,702**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$6,336,557	($150,734)	($4,867,325)	($5,018,059)	**$1,318,498**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$341,727	$12,483	$51,680	$64,163	**$405,889**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$6,678,283	($138,251)	($4,815,645)	($4,953,896)	**$1,724,387**
PMPM (ALLOCATED BASIS)					
REVENUE	$312.07	$320.93	$1,328.66	$1,649.59	**$357.95**
MEDICAL EXPENSES	$271.55	$316.25	$1,719.89	$2,036.13	**$332.08**
GROSS MARGIN	$40.52	$4.68	-$391.23	($386.54)	**$25.87**
ADMINISTRATIVE EXPENSES	$18.74	$19.27	$79.77	$99.04	**$21.49**
OPERATING INCOME/(LOSS)	$21.78	($14.59)	($471.00)	($485.59)	**$4.38**
OTHER INCOME/(EXPENSE)	$1.17	$1.21	$5.00	$6.21	**$1.35**
NET INCOME/(LOSS)	$22.96	($13.38)	($466.00)	($479.38)	**$5.72**
ALLOCATION BASIS:					
MEMBER MONTHS	290,928	10,334	10,334	10,334	301,262
REVENUE BY LOB	84.2%	3.1%	12.7%	15.8%	100.0%

Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD JUNE - 2022

		2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	FYTD var	%
NON DUAL	Adult (over 19)	32,997	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	4,864	14.7%
	Child (under 19)	100,477	101,010	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	3,144	3.1%
	SPD	22,301	22,363	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	1,899	8.5%
	Adult Expansion	89,957	90,711	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	12,241	13.6%
	Long Term Care	365	414	408	401	391	385	392	391	403	395	393	397	398	33	9.0%
	Total Non-Duals	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**22,181**	**9.0%**
DUAL	Adult (over 21)	366	367	376	375	396	398	408	410	403	407	412	431	423	57	15.6%
	SPD	24,115	23,980	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	269	1.1%
	Long Term Care	1,060	1,127	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	88	8.3%
	SPD OE	952	1,063	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	865	90.9%
	Total Duals	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**1,279**	**4.8%**
	Total Medi-Cal	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**23,460**	**8.6%**
CMC	CMC Non-Long Term Care	9,895	9,939	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	232	2.3%
	CMC - Long Term Care	185	209	208	203	208	204	210	202	213	215	206	206	205	20	10.8%
	Total CMC	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**252**	**2.5%**
	Total Enrollment	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**23,712**	**8.4%**

Santa Clara County Health Authority
Board Designated Innovation Fund Request Summary

Organization Name:	YMCA of Silicon Valley (YMCA)
Project Name:	Diabetes Prevention Program (DPP)
Contact Name and Title:	Erin O'Toole, Vice President of Financial Development Erin.OToole@ymcasv.org 408.351.6437
Requested Amount:	$240,000
Time Period for Project Expenditures:	08/01/2022 – 7/31/2025
Proposal Submitted to:	Executive Finance Committee, 07/28/2022
Date Proposal Submitted to SCFHP for Review:	07/07/2022

Summary of Proposal:

This proposal seeks to partially fund a Community Health Director, who will continue to build internal capacity and referral partnership toward sustainability of all YMCA evidence-based community health programs. In addition to DPP, other programs in the community health suite are Blood Pressure Self-Monitoring, Enhanced Fitness, Matter of Balance and Livestrong Cancer Survivor.

Summary of Projected Outcome/Impact:

Through the work of the Community Health Director, the YMCA seeks to increase the number of participants directly impacted through Diabetes Prevention Program from 150 to at least 350 individuals annually, as well as increase community-wide awareness of Diabetes and preventative actions. Reaching at least 350 participants will enable the YMCA to hire and train at least five bi-lingual DPP lifestyle coaches in FY23 and build to 20 in FY25.

Summary of Additional Funding and Funding Requests:

YMCA has applied for and received a grant of $75,000 from The Health Trust. This grant will pay for a portion of the Community Health Director position for the first year with the remaining funded through this request. In years two and three, this funding request will fund 100% of the position.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Silicon Valley
Diabetes Prevention Program

Proposal for Santa Clara Family Health Plan Community-Based Organization Fund

The YMCA of Silicon Valley seeks to educate and support our community in the prevention of Type 2 Diabetes by expanding our outreach, increasing internal capacity, and strengthening our Diabetes Prevention Program (DPP) referral partnerships.

After the onset of COVID-19, our budget, staffing, and reach were reduced to approximately one-third of what they were prior to the pandemic. We are in a rebuilding phase for all our YMCA programs including our DPP program. As we slowly emerge from the pandemic, we are thrilled to see members returning to the Y and engaging in programs that continue to support their journeys to improve their health and well-being.

The Diabetes Prevention Program is a critical community program for our county. An estimated 46% of Santa Clara County's adults have prediabetes or undiagnosed diabetes according to Santa Clara County, based on modeled results of CA Health Interview Survey and National Health and Nutrition Examination Survey. Age is certainly a risk factor, with 62% of adults ages 55-69 and 65% ages 70 or older estimated to have prediabetes or undiagnosed diabetes, though we know this is a preventable condition. With early intervention promoting physical activity and weight management, along with sustained behavior change, Type 2 Diabetes can be prevented.

The **YMCA's Diabetes Prevention Program (DPP)** is based on the Diabetes Prevention Program research study led by the National Institutes of Health (NIH). The NIH's DPP study was a major, multicenter clinical trial that showed a lifestyle program informed by DPP can reduce the number of new cases of type 2 diabetes by 71% in adults over age 60 and by 58% among adults overall. The Y's DPP is part of the National Diabetes Prevention Program, an alliance (led by the Centers for Disease Control and Prevention) of public and private organizations that coordinates wide-scale implementation of lifestyle change programs proven to prevent type 2 diabetes.

The Y, in partnership with the Santa Clara County Public Health Department's Diabetes Prevention Initiative and other organizations, has taken a leadership role to promote and implement the DPP in Santa Clara County. YMCA of Silicon Valley first launched the DPP in October 2016; our first cohort served 15 participants and was hosted at the Central YMCA in San Jose. Since then, the YMCA of Silicon Valley DPP has served a total of 431 participants. Currently, the YMCA of Silicon Valley DPP is one of the few *local* community programs available both virtually and in-person (TBD).

With the generous support of The Health Trust for the last two years, the Y was able to transition the DPP to a virtual format after the onset of the pandemic, ensuring those with diabetes risk factors were able to continue to access essential prevention programming. The best practices and lessons learned from the Virtual DPP project will be carried forward beyond the pandemic, as online programming will remain an option for DPP participants. The second year of The Health Trust funding allowed us to focus on increasing our number of Medicare recipients and address food security by connecting our lowest income DPP participants with food resources. The work of our Health Trust grant will continue into FY23 with a no-cost extension request – primarily focusing on food security and in-person cohorts for Medicare recipients. The no-cost extension request includes funding for 33% of the Community Health Director position.

In FY22, our Y served 83 participants in the DPP program. Outcomes included:

- Strong attendance:
  - 86% attended 4+ classes
  - 73% attended 9+ classes
- Increased physical activity:
  - Averaged 278 physical activity minutes
- Successful weight loss:
  - Average 3.4% weight loss
  - 32% had 5% or more weight loss
  - 21% had 7% or more weight loss

Our Request

The Y respectfully requests **$240,000 from the Santa Clara Family Health Plan Community-Based Organization Fund for three years support ($80,000 per year)** to continue to build internal capacity and deepen our referral partnerships to build toward program sustainability. Specifically, these funds would support a portion (64%) of the direct staff costs for the **Community Health Director**, who will be responsible for all YMCA evidence-based community health programs. The future sustainability of the DPP program requires a dedicated Community Health Director to lead a strategy for capacity growth and increased reach, and this will be the highest priority for the next three years. Additional programs in the suite of health programs include Blood-Pressure Self-Monitoring, Enhanced Fitness, Matter of Balance and our cancer survivor program, Livestrong at the YMCA.

Currently, we are only able to serve up to 150 participants with existing staff and resources. Optimally, we aim to serve 350. In the first year, funding will support hiring a new Community Health Director, who will focus on securing Medi-Cal approval and reengaging all pre-COVID DPP referral partners from health and community agencies, as well as grow our team of bi-lingual DPP lifestyle coaches for direct service. During the second year of funding, we will focus on expanding referral partners in health and medical sectors, continuing to increase participation and engagement with a growing team of coaches, and closely evaluate program outcomes. Our third year we will continue to steward our strong referral partnerships and be fully equipped to lead, sustain, and evaluate at least 35 cohorts each successive year.

The Community Health Director position is currently vacant; the incumbent departed at the end of February. In the interim, we initiated conversations with key stakeholders to evaluate the need for the program and explore financial sustainability while continuing base levels of program operations under the direct leadership of our Chief Operating Officer. We determined that this is a strong program, with meaningful community impact, and we are committed to expanding the program in the coming years.

Goals

Successful national YMCA program models include a full-time professional leader. With the addition of a dedicated Community Health Director, we aim to serve at least 350 participants, which will ensure sustainability. Participant recruitment and program growth rely on partner referrals; we need three referrals for every one registered participant. To grow to scale, we will:

- Achieve Medi-Cal Supplier status with the State of California to comply with insurer requirements. Application submitted 4.22.2022 and under review as of 6.8.22.
- Increase referrals to sustain a minimum of 350 participants per year by FY25.
- Renew local clinic partnerships (suspended because of COVID-19) for referrals.
- Engage with at least five new health partners for referrals in the first year.
- Engage with two new health insurance partners for referrals annually.
- Engage with a minimum of five community-based partners for referrals (and hosting classes) annually.
- Increase staff capacity to lead both virtual and in-person cohorts – increasing from 9 cohorts in FY22 to 35 cohorts by FY25
- Build capacity for teaching in-person programs by hiring and training a minimum of five bi-lingual DPP lifestyle coaches in FY23 and building to 20 active DPP lifestyle coaches by FY25.
- Increase partnerships for community-based in-person classes to include a minimum of 20 in-person classes per year by FY25

Sustainability

In addition to fundraising, the key factors that will help sustain this project through the grant term and beyond are built into our strategic organizational priorities and in our Program Action Plan, including:

Community Partnerships. Building on and expanding the role of existing public health, clinic, and insurer partners, and developing new partnerships to reach a broad community of stakeholders who are invested in the well-being of the participants we serve, will help sustain, as well as expand, the DPP.

Referral Systems. Developing a robust referral system that casts a wide net and expanding existing referral partnerships are critical to the success and sustainability of the DPP. Referral partnerships allow us to expand our reach beyond our traditional promotional efforts resulting in higher numbers of program participants. During the pandemic, all current clinic referral partners turned their attention to protecting the community against COVID-19. While COVID-19 remains the primary focus, due to the strength of the program and our partnerships, we believe we will again be able to engage clinics and health care providers over the next three years.

Broadening Scope and Reach. Integrating successful strategies for referrals and program partner models in other communities or clinics, as well as incorporating successful strategies in the DPP moving forward and into other chronic disease prevention and control programs will broaden the scope and reach of the DPP. Medi-Cal certification will broaden our reach to DPP eligible Medi-Cal recipients. We will continue to expand reach through Medicare outreach and clinic referrals.

High Expectations for Program Quality and Fidelity. Systematizing program quality improvement, including collecting and using data to improve quality and measure effectiveness and providing extensive training and coaching for staff, will carry on to benefit this program in the future.

Addressing Health Equity. We will continue to concentrate on reducing barriers to participation to address health equity to achieve participant outcomes. Over the years, we have focused on reducing barriers to successful participation. Examples include hiring culturally competent lifestyle coaches who deliver the program in a participant's home language, training lifestyle coaches on the social determinants of health, translating the curriculum to Vietnamese (currently waiting for CDC to approve), hosting the program in communities, providing access to healthy fruits and vegetables through partnerships, and providing YMCA memberships for access to community and physical activity. After the onset of the pandemic, we pivoted to launch Virtual DPP which reduced barriers to participation due to pandemic related restrictions and will continue to reduce barriers (provide scales and access to chrome books) into the future as an option to participate without having to be physically located with the class.

Mission Focus and Organizational Priority. Chronic disease prevention, broadening partnerships in the community, and providing access to programs essential for well-being are an integral part of the YMCA of Silicon Valley's mission and organizational priorities. Two goals in our Strategic Plan drive and support this work: 1) Engage 3,000 new adults, annually, in healthy living and disease prevention programs. 2) Develop five new partnerships with health care organizations and employers, serving 5,000 new individuals in healthy living and disease prevention programs.

Passion. The passion and enthusiasm for the work, from our CEO, senior leaders, board members, and dedicated staff, as well as our partners, help ensure program success and ongoing commitment.

YMCA of Silicon Valley
Funding Request to Santa Clara Family Health Plan (SCFHP)
For Diabetes Prevention Program

Follow-up questions from SCFHP

- **Please provide the names of any additional funders sought, the amounts requested, and the outcomes of those requests.**

  We will seek a no cost extension for our current grant from The Health Trust in the amount of ~$75,000. This extension request will be submitted August 1, 2022.

- **Please describe plans to seek any additional funding.**

  We aim to build to sustainability in the next three years. A grant from SCFHP will ensure full program delivery in current year. In subsequent years, additional funding up to $75,000 annually will be pursued from targeted individual major gifts, as well as supplemented by funds raised though YMCA Annual Campaign.

  Additionally, we will pursue contracts with insurers to fund the Y DPP course for covered lives. (More detail in response to question #7 below)

- **Initial request indicates 86% attendance at 4 sessions and 73% attendance at 9 sessions. What is the attendance rate for 22 modules? What is the attendance rate for the full 26 modules?**

  The program includes an introductory module and 25 classes. The first 16 are core classes. Of the last six cohorts that completed 25 classes plus introductory module:
  - 42% attended through class 25
  - 49% attended through class 22
  - 60% attended through class 16

  One current in-flight cohort has completed 23 classes
  - 67% attended class 22

  Spanish-Speaking Cohort data
  - 58% attended through class 25
  - 67% attended through class 16

- **How many DPP coordinators are currently in place?**

  Our funding request will support a Community Health Director, whose responsibilities will include coordination, outreach, and growth strategy. Currently, our COO acts in this role in addition to managing administrative and supervisory activities. We currently have four (4) lifestyle coaches leading cohorts; the lead coach manages referrals and placement of participants into cohorts.

  We will also add, (included in Health Trust grant) a part-time food security coordinator to connect DPP participants to fresh food and meal resources.

- **If you are granted Medi-Cal approval, how will you be able to shift resources to outreach and allow for Medi-Cal referrals from SCFHP to ensure that SCFHP members are prioritized in this program?**

  We understand that the SCFHP Medi-Cal line's network partner is VHP, which accounts for a significant segment of our current enrollees. SCFHP Medi-Cal VHP Network is already a high priority referral source for us, accounting for 50% of our current participants were referred from. We have a number of ways to deepen this outreach including the VHP outreach, health providers, YMCA After School fliers, SCFHP YMCA

Fitness members, SCFHP member newsletters and website, and potentially Community Health Partners, and Health Kids Foundation. As referrals and participation increases, we will hire additional lifestyle coaches to ensure adequate capacity to deliver the program to this constituency. Our application for Medi-Cal approval has been submitted and is still currently under review as of July 15, 2022.

- **Please provide information on the "five new health partnerships for referrals" you are seeking in the first year.**

  We seek to increase the number of clinics and health providers who provide direct referrals to the Y's DPP program and have targeted the following sources for outreach to develop these partnerships: clinics from the county health clinic system, PAMF health providers, Community Health Partners, Healthy Kids Foundation (family systems), and school districts/after school programs.

- **Please provide information on the "two new health insurance providers" from whom you plan to seek referrals?**

  We currently work with the California State Alliance of YMCA's to engage with insurers who have a state-wide presence (e.g. Kaiser, Blue Shield and Blue Cross, United Health) to negotiate contracts for YMCA Diabetes Prevention Programs and other YMCA Healthy Living programs. We will pursue referral sources from this group of insurers and YMCA state-wide effort. This work also illustrates our dual-purpose strategy to develop sustainable referral *and* funding sources.

- **What languages will be offered? SCFHP threshold languages include Spanish and Vietnamese.**

  We will offer our cohorts, at minimum, in Spanish and Vietnamese languages. We currently offer Spanish-speaking cohorts. We have a Vietnamese speaking coach who translates in class from the English curriculum. Now that we are switching over to the T2 DPP curriculum we will be able to offer cohorts that are fully Vietnamese speaking. We are planning on hiring lifestyle coaches that speak Mandarin and Cantonese. We currently have capacity for Russian and Hindi.

Further Clarification Provided Via Email Follows

- **Regarding The Health Trust funding has that already been granted to employ the Community Health Director and has that person been hired?**
  The Health Trust grant provides partial funding for the position, which enabled us to move forward with hiring. We have hired a Community Health Director, who starts August 1st. The SCFHP grant would support 2/3 of this role in the first year, and 100% in the second and third year of the grant.

Title	FY23 SCFHP	FY23 THT	Total	FY24 SCFHP	FY24 Y Funding *	Total	FY25 SCFHP	FY25 Y Funding*	Total
Community Health Director	80,000	40,900	**120,900**	80,000	44,527	**124,527**	80,000	48,262	**128,262**

* Y funding includes individual donors, annual campaign, increased direct/claims billing
By the end of FY25, we will be fully sustainable on Y Funding

- **If not, when are you looking to hire the Community Health Director?**
  We have hired a Community Health Director, who starts August 1st.
- **What are the start and end dates of this project?**
  August 1, 2022 – July 31, 2025
- **We also wanted to clarify that our Medi-Cal network at SCFHP is wider than just VHP. Thank** you for the clarification; we were not aware of this and look forward to learning about the wider SCFHP network for Medi-Cal so we can refine our outreach plans.

Santa Clara County Health Authority

Board Designated Special Project Fund for CBOs Request Summary

Organization Name:	South County Compassion Center (SCCC)
Project Name:	Rental Assistance Program
Contact Name and Title:	Tim Davis, Executive Director tim@thecompassioncenter.org 408.763.7120
Requested Amount:	$35,000
Time Period for Project Expenditures:	07/01/2022 – 06/30/2023
Proposal Submitted to:	Executive Finance Committee, 07/28/2022 meeting
Date Proposal Submitted to SCFHP for Review:	06/16/2022

Summary of Proposal:

SCCC is requesting $35,000 to fund a part-time Rental Assistance Case Manager to manage the Rental Assistance Program. SCC's Rental Assistance Program works to keep residents of South Santa Clara County facing imminent eviction in their homes by disbursing rental assistance awards. A secondary objective is to offer additional resources and referrals to each applicant needing to increase their capacity to maintain their housing through their own means beyond the assistance period. SCCC will also assess eligibility for the County-wide Emergency Assistance Network (EAN).

Summary of Projected Outcome/Impact:

SCCC's Rental Assistance Program target is 130, or more, confirmed assistance awards by June 30, 2023. In addition, they will provide eligibility assessment for EAN to at least 60 renters.

Summary of Additional Funding and Funding Requests:

SCCC has sought additional funding from Union Pacific and Kaiser. Kaiser has awarded SCCC $25,000 towards staffing of the Rental Assistance Program. Additionally, SCCC will be applying to the County-wide Homelessness Prevention System (HPS)'s rental assistance program when the RFP is issued in the fall. This will provide funding not only for the rental assistance awards but also for administrative staffing to perform the assessment and coordination. SCCC is also awaiting an MOU from Sacred Heart to be an eligibility assessment partner.

SOUTH COUNTY COMPASSION CENTER

June 16, 2022

Jocelyn Ma
Santa Clara Family Health Plan
6201 San Ignacio Ave
San Jose, CA 95119-1325

Dear Jocelyn,

Thank you so much for the amazing support Santa Clara Family Health Plan has provided our organization.

I am writing to request funding from your Community Health Investment Grant (CHIG) Program to support our Rental Assistance Program that prevents homelessness for Santa Clara County Residents.

THE NEED

For every unhoused individual who gains access to housing in Santa Clara County, three others lose their housing and become homeless. The State-run "Housing is Key" rental assistance program—the largest in the nation—stopped taking new applications on March 31. The eviction moratorium, which protected vulnerable renters adversely affected by the pandemic, has also ended. As a result, more extremely low-income renters are at greater risk of falling into homelessness than before. We have offered relief to over 150 households through two rental assistance programs which have subsequently ended. We now have access to three additional sources of assistance funding through which we would like to begin assisting renters. However, these programs only provide direct assistance funding to these vulnerable renters. CHIG funding from SCFHP would support staff costs, and direct program costs associated with facilitating these applications, and to provide the wrap-around support needed to help these families increase their financial capacity to maintain their rental payments after their assistance ends. Examples of this support include access to benefits, legal assistance, financial management training, and job training, including enrollment into Community College certificate training programs that help our clients get trained and placed into a high paying career. The assistance sources evaluate each application and provide assistance directly to eligible applicants.

GOALS AND OBJECTIVES

The goal of our rental assistance program is to prevent homelessness for Santa Clara County residents facing imminent eviction from their homes. The primary objective of this program is to provide rental assistance to 130 eligible Santa Clara County families between July 1, 2022 and June 30, 2023. As a secondary objective, we aim to offer additional resources and referrals to each applicant needing to increase their capacity to maintain their housing through their own means beyond the assistance period. Lastly, as an assessment partner, we will provide eligibility assessments to at least 60 additional renters whom, if qualified, we will refer to the County-wide Emergency Assistance Network (EAN) which will also provide rental assistance through other funding sources.

These goals and objectives align with SCFHP's mission by directly improving "the well-being" of your members "by addressing their social needs" and by "partnering with providers … in our shared commitment to the health of our community." Studies show evictions cause anxiety, depression and PTSD. Evictions also frequently result in job loss, school displacement, difficulty securing future housing, and poor physical health outcomes. . The average lifespan of unhoused individuals is 20 years shorter than the average person, largely due to undiagnosed and untreated medical conditions.Preventing homelessness through this program can literally save lives, in addition to preventing job loss and academic disruptions., . According to several studies referenced in a 2019 article from the Center on Budget and Policy Priorities, rental assistance programs "reduce crowding, housing instability and homelessness," as well as "reduces poverty," while also improves "outcomes for children," and "improves adult well-being and can reduce health costs."

Lastly, funding for this program would align with SCFHP's vision to promote "Health for all – a fair and just community where everyone has access to opportunities to be healthy," by meeting the needs of our most vulnerable families at risk of homelessness who also are disproportionately represented by people of color.

Measuring Success

We will measure our impact of this program, and our ability to meet the above objectives through the following means. Through our rental assistance program partners, we will be notified of assistance awards to each applicant. If we have totalled 130, or more, confirmed assistance awards by June 30, 2023, we will consider this objective to have been met. For each qualified applicant, we will track how many were

offered resources and referrals to increase their capacity to maintain their housing via an assessment tracking list. If everyone on the list was assessed and offered services, we will consider this objective to have been met. Lastly, we will track the number of eligibility referrals to the EAN. If we have assessed and approved more than 60 by June 30, 2023, we will consider this objective to have been met.

Implementation Overview

As we have done for that past year, we will promote the program through area service provider partner agencies, referral agency websites, and social media channels. Our administrative staff will schedule appointments with prospective participants to meet with our rental assistance case manager, who will qualify them for eligibility, according to our rental assistance partners' guidelines. For those who qualify, we will assist them with their applications, and sometimes advocate on their behalf with landlords. Also, we will provide additional resources, and guidance to help them sustain their housing status beyond the term of assistance relief. These resources include financial management training, job training programs, community college certification programs, assistance with accessing benefits, relocation assistance, and more. Months after our applicants receive assistance, we will follow up with each of them to gauge their ability to continue retaining their housing, and, if needed, offer additional resources and/or guidance.

In addition, we will also provide deposit assistance to those seeking to end their homelessness but who are unable to finance the move-in fees.

We will provide support and materials in both English and Spanish. We have adopted a client-centered approach in which we cater to the individual's needs, clearly explain the steps they need to take, and offer support and encouragement to help them navigate the application process.

We will track our progress in meeting our objectives throughout the funding period. Our Rental Assistance Case Manager is Josie Mejia, who has received training through all of our current partnership programs. She has processed more than 150 applications since the start of the program. The Executive Director, Tim Davis, and the Outreach Safe Parking Case Manager have also received training in all of these programs as well, and can assist as needed.

Timeline

We will begin this program on July 1, 2022 and continue to provide assistance through

the aforementioned sources until June 30, 2023. As stated, we will follow up with each successful applicant six months after support has been granted to assess their ability to continue making their rent payments and provide additional guidance, and resources, as needed. By June 30, 2022, we will evaluate our efforts in meeting the objectives as described above, and will generate a report summarizing our findings.

Budget

We are requesting $35,000 from the CHIG Program to pay for staff time required for our Rental Assistance Program that prevents homelessness for Santa Clara County Residents. This amount, combined with funding from another source, will fund the payroll, taxes, benefits and workman's comp insurance toward our Rental Assistance Case Manager—for 20 hours per week, or 0.5 Full Time Employee (FTE)—and 0.125 FTE toward our Administrative Assistant—0.125 FTE—and 0.10 FTE toward our Executive Director for supervision of the program. All funding toward rental assistance payments, and other programmatic expenses will be funded by other sources. If only partial funding is provided, we will cover the shortfall from our unrestricted funding pool. A full program budget is attached.

Similar Programs and Providers

There are other rental assistance programs in Santa Clara County. However, since the County Program and State Program have closed down, and the eviction moratorium has ended, the need is far greater than the current program partners can provide. In fact, Destination: Home, in partnership with the County's Office of Supportive Housing, are planning to expand their Emergency Assistance Network (EAN)—also known as the Homeless Prevention System (HPS)—to include nearly double the current partners they have. This expansion is planned for January 1, 2023. South County Compassion Center will be applying for partnership funding. We expect to receive funding as we were partners in a similar program last year. The issue is that, between now, and the time of the ramp-up of new EAN-HPS partnerships, there will be thousands of evictions in the interim. In order to minimize the impending escalation of homelessness, our program is needed to fill the gap. Also, we will use a portion of these funds to assess the eligibility of those entering the current EAN-HPS program, thereby increasing the number of applications the current providers can process. In order to get assistance to as many as we can, we will rely on three different programs currently in place, and provide the staff time to efficiently assess and process these applications, in order to stave off their impending evictions, as we have, through these and other programs, in the past.

Partnerships/Collaborations

This program is built entirely on partnerships and collaborations. Our rental and utility assistance partners include Housing Industry Fund (HIF)—with whom we've been a partner for a number of years—and Seasons of Sharing—with whom we began a partnership this year. As previously mentioned, we will begin to assess the eligibility of prospective applicants for the EAN-HPS county-wide program beginning July 1, 2022, and then refer those individuals to the existing partners. We will also apply for a full-partnership in the fall and expect to begin assisting applicants in January 2023. We also partner with other South County service providers, government agencies, and houses of faith to get the word out through a variety of media channels. This combined effort will enable us to assist as many as we can with a focus of support for South Santa Clara County families in need.

For full-funding, or partial funding of this request, we would be happy to publicize your support to our many stakeholders via social media, our website and e-newsletter.

If you have any questions, or would like additional information, please contact me at tim@thecompassioncenter.org or by phone at (669) 270-7913.

Thank you very much for considering our request, and for all you do for our community.

Gratefully,

Tim Davis
Executive Director

SOUTH COUNTY COMPASSION CENTER

FY 2022-23 Rental Assistance
Program Budget

REVENUE	
Corporate	$7,425
HIF	$50,000
Seasons of Sharing	$50,000
Kaiser	$25,000
Santa Clara Family Health Plan	$37,000
TOTAL REVENUE	**$169,425**
EXPENSES	
Communications	$1,890
Insurance	$1,020
Office Costs	$1,200
Professional Services	$975
COVID Prevention	$500
Facilities Costs	$1,150
RENT	$1,695
Utilities.	$740
PAYROLL	
Wages / Salaries	$44,040
Empoyer Taxes. (10%)	$4,404
Workers' Comp (6.7%)	$3,083
Benefits	$7,729
Training	$1,000
Client RA Payments	$85,000
Client Utility Payments	$15,000
TOTAL EXPENSES	**$169,425**
Net Operating Income	**$0**

South County Compassion Center Board Designated Special Project Fund for CBOs Request Follow-up

1. Has organization sought other funders? Outcome? Intentions? How will you sustain this project post grant window?
    a. We have sought support for the payroll for our Rental Assistance program from other funders—from Union Pacific and Kaiser Permanente. Kaiser just awarded us $25,000 toward payroll for our Rental Assistance program.
    b. Additionally, we will be applying to become a partner organization in the County-wide Homelessness Prevention System (HPS) rental assistance program RFP issued in the fall. If awarded, this program would provide funding for not only the rental assistance payments, but also for our expenses for training and staff payroll. As we had been a partner in another version of this program in the latter half of 2021, we anticipate being awarded funding. We are also awaiting an MOU from Sacred Heart, the lead nonprofit program partner, to be an eligibility assessment partner through which we would refer eligible applicants to the program.
2. How does this align with submissions for HHAP-3 funding? Or the current Community Plan to End Homelessness?
        i. This program completely aligns with the current County Community Plan to End Homelessness (CPEH). Specifically, this project supports the CPEH's Strategy 2—to "Expand Homelessness Prevention", and sub-strategy 2-a, which provides "targeted financial resources to prevent homelessness and eviction for severely rent-burdened residents living in existing affordable units."
    b. If this project does not align – why not?
        i. HHAP-3 funding does not fund rental assistance. We are currently funded by HHAP for our Outreach Basic Needs services, and have been HHAP recipients since 2019.
    c. Will this project's existence outside of the above stated process impact its effectiveness?
        i. Not at all. In fact, we expect that this grant will help us meet the current overwhelming need while the new Homelessness Prevention System (HPS) is ramping up to launch an expansion to in early 2023.
3. How many SCFHP members would be served/impacted?
    a. This is unknown. However, since this program serves the County's most financially vulnerable who are most severely at-risk of losing their housing—those who earn 30%, or less, of the Area Median Income (AMI)—we estimate that a significant portion, and likely a majority, are also SCFHP members, based on the fact that both programs serve a similar financial demographic.
4. Which ethnicity, identity preference, language served/impacted? (REAL/CLAS/Orientation data)
    a. People of Color, and those who speak a language other than English, are disproportionally over represented by those who make the least and who are in the greatest need of rental assistance. Though we do not have any demographic data for those we've served through this program in the past,

data collected from Federal Rental Assistance programs, as reported by the Center on Budget and Policy Priorities, breakdown as follows: 20% are seniors, 25% have a disability, 58% are children with families. Also, according to the same article, the need for assistance dwarfs the funding available to support this need.

5. Which SDOH is being addressed? Please see the below SDOH and provide information on how this project will address one or more of the SDOHs.
    a. Economic Stability such as employment, income, expenses, debt, medical bills, etc.:
        i. Since this program provides emergency rental and utility assistance, and since the majority are paying well more than recommended maximum of 30% of their income in rent, this program would be a critical first step toward economic stability by keeping them in their homes so they can continue to build their financial capacity to retain their housing. In addition to the assistance, which eliminates the immediate threat of homelessness, our case managers will offer other interventions through case planning and referrals to financial management training, job training, access to benefits, legal assistance and other important services designed to enhance economic stability.
    b. Education Access and Quality such as literacy, language, vocational training, higher education:
    c. Health Care Access and Quality such as health coverage, provider linguistic and cultural competency, quality of care:
    d. Neighborhood and Built Environment such as housing, transportation, safety, food insecurity:
        i. By providing people with the means to remain in their homes, this program increases the number of housed individuals. Once they are able to resolve their housing crisis, they can begin to address their other basic needs such as food security, access to health care, safety and transportation.
    e. Social and Community Context such as social integration, social supports, community engagement, discrimination:
        i. This program helps people remain in the homes who would otherwise be evicted. Since many of these recipients make up marginalized communities, including many living in traditionally ethnic minority communities that are quickly becoming gentrified, this program can provide an influx of capital needed to counter this trend and help people remain ensconced in their multi-generational communities they, and their ancestors, helped to build.
6. How will you incorporate ECM and Community Supports for SCFHP members?
    a. Since our case management team provides many of the same services as Enhanced Care Management (ECM) and community supports, we will provide SCFHP members with needs assessments, and offer the appropriate referrals and resources designed to meet those needs such as housing deposit assistance, as a partner in the Housing Industry Fund's deposit assistance program, along with housing acquisition navigation and housing retention interventions. We already provide these services to our unhoused, newly housed and housing insecure clients who rely on us to eliminate their barriers to accessing and retaining their housing through financial assistance, housing search and applications,

financial management training, job training, and access to benefits.

7. Please see the below Strategic goals and provide information on how this project will address one or more goals.
    a. Community Health Leadership - Be a recognized local leader and collaborator in improving the health of communities impacted by disparities:
        i. Those who are at risk of losing their home face one of the most stressful experiences of their lives. This excess stress often contributes to other serious and fatal health conditions including heart attacks, strokes, depression and even suicide. This stress has a ripple effect throughout the family that cause harm to each member and spill over into other areas of their lives—work, school, marital stability. Since those who are most greatly affected by disparities in their community are overly represented in the populations served by this program, they will also realize the greatest health benefits as a result of the minimization of the financial triggers that cause this stress.
    b. Quality, Access, and Equity - Deliver exceptional quality outcomes and health equity for all Plan members:
        i. Our case management staff who implement the program are trained to be open, welcoming and skilled at delivering quality care for those facing a traumatic experience. This program is designed to offer access to assistance for those who have the least. Additionally, all of our case managers speak, read and write fluently in both Spanish and English and we've helped serve many for whom English is not their primary language. In the last year, we've helped 150 families remain in their homes. We do not turn anyone away from service who would meet the income eligibility requirements.
8. Does your project
    a. Promote quality of care and cost efficiency
        i. It does not promote quality of health care, nor its cost efficiency as a principal design. However, since it may eliminate stressors which can cause poor health outcomes, which may save money spent on care, and decrease the need for additional care.
    b. Address issues that affect Plan regulatory compliance or accreditation
        i. It does not.
    c. Expand best practices/evidence-based care
        i. While not directly providing any health care, this program is an evidence-based housing stabilization assistance model that has helped millions avoid evictions and the stress associated with housing insecurity. According to several studies referenced in a 2019 article from the Center on Budget and Policy Priorities show that rental assistance programs "reduces crowding, housing instability and homelessness," as well as "reduces poverty," while also improves "outcomes for children," and "improves adult well-being and can reduce health costs."
    d. Pilot a promising approach to address emerging health care issues

    i. The program does not directly pilot a promising approach to address emerging health care issues.

e. Provide social services and supports that impact health
    i. As mentioned above, under question 8-c, the assistance provided from this program would promote healthy outcomes by alleviating the source of a family's stress that often leads to dangerous health conditions.

f. Address health equity: a fair and just community where everyone has access to opportunities to be healthy
    i. This program would not address health equity directly, but would promote health equity tangentially address health equity, as described in answer to question 7-a (above).

g. Address health disparity: differences in outcomes by subgroups
    i. This program would address health equity, as described in answer to question 7-a (above).

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, August 25, 2022, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Michele Lew, Chair
Alma Burrell
Dave Cameron
Sarita Kohli

Members Absent
Sue Murphy

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Executive Finance Officer
Laurie Nakahira, D.O., Chief Medical Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Chelsea Byom, VP, Marketing, Communications & Outreach
Tyler Haskell, Interim Compliance Officer
Barbara Granieri, Controller
Khanh Pham, Director, Financial Reporting & Budgeting
Arlene Bell, Director Claims
Ashley Kerner, Manager, Administrative Services
Kris Cameron, Strategic Planning Project Manager
Lloyd Alaban, Copy Writer and Content Strategist
Nancy Aguirre, Administrative Assistant

Others Present
Kate Margolis, PhD, University of California San Francisco

1. Roll Call

Michele Lew, Chair, called the meeting to order at 10:34 AM. Roll call was taken and a quorum was established.

2. Public Comments

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

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

a. Approve July 28, 2022 **Executive/Finance Committee** minutes
b. Accept **Network Detection and Prevention Update**
c. Approve **Governance Policy** GO.01 v2 Organizational Policies
d. Approve **Claims Policies**
- CL.02 v4 Misdirected Claims
- CL.04 v3 Skilled Nursing Facility
- CL.07 v6 Emergency Room Services
- CL.10 v4 Provider Dispute Resolution
- CL.28 v2 Other Health Coverage Cost Avoidance and Post Payment Recovery

e. Approve **County of Santa Clara Reentry Resource Center sponsorship**

f. Approve **continued use of teleconferencing** without providing public access to each teleconference location pursuant to Government Code Section 54953 questions.

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

Motion: Ms. Kohli
Second: Mr. Cameron
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew
Absent: Ms. Murphy

4. **June 2022 Financial Statements**

Neal Jarecki, Chief Financial Officer, presented the unaudited financial statements for June 2022, which reflected a current month net surplus of $4.3 million ($4.3 million favorable to budget) and a year-to-date net surplus of $30.3 million ($21.7 million favorable to budget) for the fiscal year.

Enrollment increased by 5,120 members from the prior month to 306,382 members (3,745 members or 1.2% higher than budget, predominately due to the newly-eligible Medi-Cal undocumented Adult population, which was not budgeted. YTD member months of 3.5 million trailed budget by 81,555 member months or 2.3% due largely to fewer newly-eligible members having Other Health Coverage (OHC) than budgeted. Membership continues to grow due to the extended duration of the COVID public health emergency during which disenrollments have been suspended.

Revenue reflected a net unfavorable current month variance of $4.6 million (3.9%) due to several factors. Unfavorable variances resulted from: (1) the inclusion of Medi-Cal pharmacy throughout FY22 in the budget (pharmacy was carved-out of managed care effective January 1, 2022, which significantly reduced revenue (with a corresponding reduction to medical expense), (2) additional CMC medical loss ratio accruals payable to DHCS, and (4) retroactive DHCS recoupments for fiscal years 2011-2020. Positive variances resulted from: (1) higher current month enrollment, (2) favorable calendar year 2022 Medi-Cal non-dual & CCI rates versus budget, and (3) increased Medi-Cal supplemental revenue, (4) prior year Prop 56 reconciliation and (5) prior and current year CMC quality withhold reconciliations.

Medical Expense reflected a net favorable current month variance of $9.1 million (8.2%) largely due to the favorable offsets of key revenue items above (pharmacy carve-out and reduced OHC enrollment). Certain fee-for-service expense categories reflected unfavorable variances due to increased unit costs and higher supplemental services expenses than budgeted. Capitation expense was unfavorable to budget due to higher CY22 capitated rates true-up coupled with higher capitated enrollment vs. budget.

Administrative Expense was $302 thousand (4.3%) unfavorable to budget for the month largely due to the net effect of (1) lower headcount than budgeted and (2) an unfavorable variance in non-personnel expense due to the timing of certain expenses vs. budget.

The **Balance Sheet** reflected a Current Ratio, a key measure of liquidity, of 1.30:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $285.1 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $245.1 million.

Capital Investments of $1.2 million have been made year-to-date, predominately computer software licenses, versus the annual capital budget of $3.25 million, with certain, largely Medicare-related, projects deferred into the fiscal year 2022-2023.

It was moved, seconded, and the unaudited June 2022 Financial Statements were **unanimously approved.**

Motion: Mr. Cameron
Second: Ms. Burrell
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew
Absent: Ms. Murphy

5. Innovation Fund Expenditure Adjustment Request

Ngoc Bui-Tong, VP, Strategies & Analytics, presented a modification request from FIRST 5 Santa Clara County Integrated Behavioral Health Pilot Project. Modifications to the original funding request of $500,000 include extending the project timeline, reducing the number cohorts, and adding potential activities to be added to the scope of services. Ms. Bui-Tong introduced Kate Margolis of the University of California San Francisco, who was available for questions.

A discussion regarding the requested modifications ensued and an amendment to the motion was introduced by Ms. Lew.

It was moved, seconded, and the amended motion to delay the second payment installation until further progress is made and extend the contract period for the Integrated Behavioral Health Piolt Project to achieve the initial cohort number was **unanimously approved** as an expenditure from the Board Designated Innovation Fund.

Motion: Ms. Kohli
Second: Mr. Cameron
Ayes: Ms. Burrell, Mr. Cameron, Ms. Kohli, Ms. Lew
Absent: Ms. Murphy

Ms Kohli left the meeting at 11:08 a.m.

6. Government Relations Update

Tyler Haskell, Interim Compliance Officer, presented federal issues of note, including the Centers for Medicare and Medicaid Services (CMS) extension of the COVID-19 public health emergency.

Mr. Haskell discussed the impact of the recently-enacted Inflation Reduction Act, which gives Medicare the authority to negotiate prescription drug prices affecting costs for payers and consumers in the Part D Program. Mr. Haskell shared the new caps on out-of-pocket spending for insulin and other Part D drugs, and an extension of the enhanced subsidies for individual and family plans on the insurance exchanges.

Mr. Haskell presented state issues impacting the Plan. Mr. Haskell informed the members that the announcement on Medi-Cal reprocurement would come in later in the day. Mr. Haskell described the Medi-Cal Office of Health Care Affordability that has been created to collect data on total health care expenditures, analyze the health care market for cost trends and drivers of spending, create a state strategy for controlling the cost of health care, improve affordability for consumers and purchasers, and enforce annual state health care cost targets.

Mr. Haskell reported on three California Senate Bills. Mr. Haskell shared that Senate Bill 250, which would have required the waiving of prior authorization requirements for certain providers, will not move forward. Mr. Haskell then discussed Senate Bill 987, which would require health plans to connect qualifying Medi-Cal members with facilities specially designated to treat complex cancers. Mr. Haskell shared Senate Bill 858, which would give the Department of Managed Health Care (DMHC) increased authority to implement larger penalties for health plan noncompliance.

7. CEO Update

Christine Tomcala, Chief Executive Officer, reported that the Plan welcomed 6,455 newly eligible undocumented residents aged fifty and over who became eligible for full-scope medical and were “lifted and shifted” from emergency Medi-Cal during May through July. She indicated that the Plan partnerd with VMC to ensure continuity for care of members, resulting in 85% of individuals being assigned to a VHP primary care physician.

8. Adjourn to Closed Session

a. Contract Rates

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

13. Report from Closed Session

Ms. Lew reported that the Executive/Finance Committee met in Closed Session to discuss contract rates.

14. Adjournment

The meeting was adjourned at 11:38 AM.

_____

Sarita Kohli, Secretary

Santa Clara Family Health Plan™

Network Detection and Prevention Report

Aug 2022

Executive/Finance Committee Meeting

Firewall Background

The following network intrusion reports show the malicious activities that were prevented from accessing SCFHP's network. It is important to note that these attempts are not specifically targeted at SCFHP, but rather are common attempts against entire areas of the Internet. The results are typical of many organizations.

None of the intrusion attempts on the SCFHP network were successful.

The attempts have been categorized in three severity levels:

Critical/High

These attacks are the most dangerous. They can take down our entire network or disable servers. Can take the form of various Backdoor, DDoS (Distributed Denial of Service), and DOS (Denial of Service) attacks.

Medium

These attacks can cause disruption to the network, such as increased network traffic that slows performance. For example, various DNS (Domain Naming Service), FTP (File Transfer Protocol), and Telnet attacks.

Low/Informational

These attacks are characterized more as informational events, such as various scans (port and IP internet protocol address), RPC (Remote Procedure Call), and SMTP (Simple Mail Transfer Protocol) attacks. The new informational category is from the recently implemented Palo Alto Firewall. These events are of low to no threats and are more of an FYI for reporting.

Attack Statistics Combined

Apr/May/Jun/Jul

	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
Severity Level	Apr	May	Jun	Jul	Apr	May	Jun	Jul	Apr	May	Jun	Jul
Critical	19	12	32	21	819	5316	28,378	793	0.01	0.05	0.32	0.01
High	12	9	34	11	10,026	3,929,027	112,044	10,349	0.11	33.51	1.27	0.09
Medium	25	22	36	18	720,569	301,375	499,329	524,963	7.72	2.57	5.64	4.62
Low	10	9	18	11	2,966,538	1,126,650	1,313,310	660,057	31.79	9.61	14.84	5.80
Informational	36	29	36	31	5,633,743	6,362,068	6,898,134	10,171,786	60.37	54.26	77.93	89.48

Summary – Compare Jul 2022 to previous month of Jun 2022

- Critical Severity Level – number of threat attempts is **97.21%** lower
- High Severity Level - number of threat attempts is **90.76**% lower
- Medium Severity Level - number of threat attempts **5.13%** higher
- Low Severity Level - number of threat attempts is **49.74%** lower

8/17/2022

Top 5 Events for May/Jun/Jul

Critical Events – total 34,487 events

Top 5 Critical vulnerability events
- 18,526 events for “Apache Log4j Remote Code Execution Vulnerability” (**Code-Execution**)
- 5231 events for “Bash Remote Code Execution Vulnerability” (**Code-Execution**)
- 5159 events for “Realtek Jungle SDK Remote Code Execution Vulnerability” (**Code-Execution**)
- 3095 events for “TCP Flood” (**Code-Execution**)
- 844 events for “HTTP /etc/passwd Access Attempt” (**Code-Execution**)

High Events – total 4,051,420 events

Top 5 High vulnerability events
- 3,946,292 events for “HTTP Unauthorized Brute Force Attack” (**Brute Force**)
- 85,101 events for “SSH User Authentication Brute Force Attempt” (**Brute Force**)
- 7616 events for “Microsoft Windows win.ini Access Attempt Detected” (**Brute Force**)
- 2488 events for “SIP INVITE Method Request Flood Attempt” (**Brute Force**)
- 1888 events for “Microsoft IIS Escaped Characters Decoding Command Execution Vulnerability” (**Brute Force**)

Medium Events – total 1,325,667 events

Top 5 Medium vulnerability events
- 1,095,868 events for “SCAN: Host Sweep” (**Info-Leak**)
- 117,405 events for “SCAN: TCP Port Scan” (**Info-Leak**)
- 82,111 events for “SIPVicious Scanner Detection” (**Info-Leak**)
- 14,911 events for “RPC Portmapper DUMP Request Detected ” (**Info-Leak**)
- 7,827 events for “HTTP Directory Traversal Request Attempt” (**Info-Leak**)

Definitions:

Code-Execution – Attempt to install or run an application.
Brute Force – Vulnerability attempt to obtain user credentials.
Info-Leak – attempt to obtain user or sensitive information.
Botnet – used to perform distributed denial-of-service attack (DDoS attack), steal data and send spam.

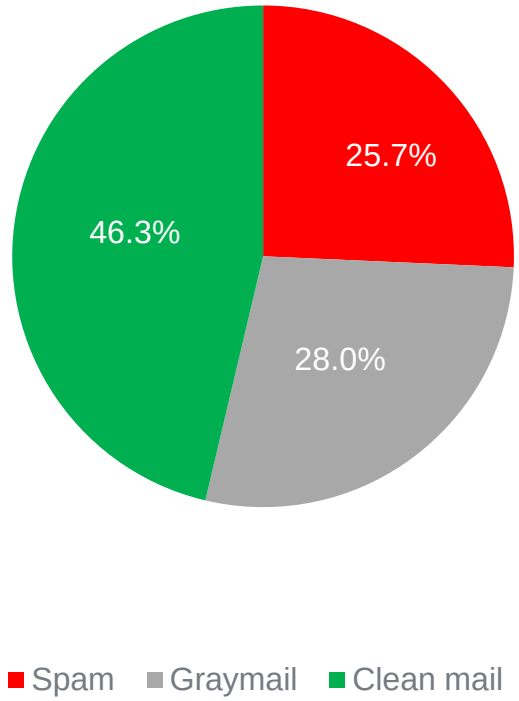
8/17/2022

Email Security – Monthly Statistics

Santa Clara Family Health Plan

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	12.2%	20.0k
Stopped by Domain Reputation Filtering	6.4%	10.5k
Stopped as Invalid Recipients	1.2%	1,894
Spam Detected	5.4%	8,827
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	142
Stopped by Content Filter	0.5%	760
Stopped by DMARC	2.6%	4,183
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**25.7%**	**42.1k**
Marketing Messages	15.8%	25.9k
Social Networking Messages	0.3%	506
Bulk Messages	11.9%	19.4k
Total Graymails:	**28.0%**	**45.8k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	46.3%	75.8k
Total Attempted Messages:		**163.7k**



July

During the month.

- 25.7% of threat messages had been blocked.
- 28.0% were Graymails *(Graymail is solicited bulk email messages that don't fit the definition of email spam).*
- 46.3% were clean messages that delivered.

8/17/2022

POLICY

Santa Clara Family Health Plan

Policy Title:	**Organizational Policies**	**Policy No.:**	GO.01 v2
Replaces Policy Title (if applicable):	Organizational Policies	**Replaces Policy No. (if applicable):**	GO.01 v1
Issuing Department:	Administration	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Medicare	

I. Purpose

To provide guidance across Santa Clara Family Health Plan (SCFHP) in the development of policies in order to ensure a consistent approach and compliance with the approval process.

II. Policy

Policies will be developed as concise formal statements of principles that indicate how SCFHP will act in a particular aspect of its operation. Policies regulate and direct actions and conduct, and act as the business rules and guidelines under which the organization is operated. Policies will be implemented in accordance with Procedures and supporting documents which provide instructions and set out processes to implement a Policy.

Policies will be created using a Policy Template approved by the Executive team, available in the policy system utilized by the organization.

Policies will be approved by first and second level approvers as defined in the associated Procedure(s).

For policies written or revised after January 1, 2023 policies will be:

- Approved by a Board Committee and ratified by the Governing Board; or
- Recommended for approval by a Board Sub-Committee, Approved by the Board Committee, and ratified by the Governing Board (e.g., Utilization Management Sub-Committee recommends approval by the Board Quality Improvement Committee), or
- Approved by the Governing Board of SCFHP.
- Policies will be considered officially approved and may be implemented upon action of the Board Committee.

III. Responsibilities

All department managers, directors and executives have responsibility to develop, maintain and approve of Policies in accordance with this Policy.

IV. References

N/A

Santa Clara Family Health Plan™

Annual Review of Claims Policies
August 25, 2022

Policy No.	Policy Title	Changes
CL.02 v4	Misdirected Claims	**Revised**
CL.04 v3	Skilled Nursing Facility	**Revised**
CL.07 v6	Emergency Room Services	**Revised**
CL.10 v4	Provider Dispute Resolution	**Revised**
CL.28 v2	Other Health Coverage Cost Avoidance and Post Payment Recovery	**Revised**

POLICY

Policy Title:	**Misdirected Claims**	**Policy No.:**	CL.02 ~~v3~~v4
Replaces Policy Title (if applicable):	Misdirected Claims	**Replaces Policy No. (if applicable):**	CL.02 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

To ensure that at least ninety-five percent (95%) of Misdirected Claims received by Santa Clara Family Health Plan (SCFHP) are sent to the payor who bears the financial responsibility for the claim within ten (10) working days of receipt.

II. Policy

Ninety-five percent (95%) of Misdirected Claims are to be forwarded to the payor who has the financial responsibility for the claim within ten (10) working days of the date of receipt. The Misdirected Claims Policy does not apply to:

- Cal ~~Medi-Connect~~MediConnect (CMC) line of business as SCFHP has full financial responsibility for all CMC claims.
- Split risk claims (combination of payable and denial claim lines items).

III. Responsibilities

A. The Information Technology Department is responsible to:

~~A.~~1. Post the outbound misdirected claims file 5010 837i / 837p to a secure FTP site for pick-up~~.~~ on a daily basis.

~~B.~~2. Validates and confirms that all outbound misdirected claims files are successfully transmitted on working days (Monday through Friday).

B. The Claims Department is responsible for overseeing the misdirected claims process. As part of its oversight role, the Claims Department:

~~C.~~3. May provide feedback to other departments and/or divisions within SCFHP to ensure that the misdirected claims process is operating effectively and efficiently.

~~D.~~4. Monitors that SCFHP is compliant at all times with the ten (10) working day turn-around time requirement.

~~E.~~5. Reviews and audits outbound misdirected claims files to ensure correct payer disbursement.

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(b) (2)
Claims Processing Time Limits and Measurements - Assembly Bill -AB1455

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~02/09/2021~~05/13/2022 Date	Neal Jarecki Chief Financial Officer ~~02/10/2021~~05/13/2022 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 - 02/24/2020	N/A	N/A	N/A
3	Revised	Executive/Finance	Approve / 02/25/2021	~~02~~Ratify / 03/25/2021
4	Revised	Executive/Finance	TBD / 08/25/2022	

POLICY

POLICY

Policy Title:	**Skilled Nursing Facility**	**Policy No.:**	CL.04 ~~v2~~v3
Replaces Policy Title (if applicable):	Skilled Nursing Facility	**Replaces Policy No. (if applicable):**	~~CL044~~CL.04 v2
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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 (MC) 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~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (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~~MC: For ~~Medi-Cal~~MC 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~~CMC: For CMC claims regarding SNF from non-contracted providers, SCFHP shall pay all 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.

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

F. Share of Cost

1. Certain MC members may have a Share of Cost (SOC) that they are required to pay the SNF prior to being reimbursed by the Plan. SCFHP will deduct any applicable SOC from the SNF reimbursement. CMC members do not have a SOC for SNF services.

III. Responsibilities

A. 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~~MC and CMC members.

B. The Claims Department is responsible for ensuring applicable rates, SOC, 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.

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~~MC 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

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~04/15/2021~~05/12/2022 Date	Neal Jarecki Chief Financial Officer ~~04/16/2021~~05/12/2022 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	Executive/Finance	Approve / 04/22/2021	~~4/22~~Ratify / 06/24/2021
3	Revised	Executive/Finance	TBD / 08/25/2022	

POLICY

Policy Title:	**Emergency Room Services**	**Policy No.:**	CL.07 ~~v5~~v6
Replaces Policy Title (if applicable):	~~Processing of~~ Emergency Room ~~Professional Fees by Delegated Sub-Contractors~~ ~~Reimbursement to Emergency Room Physicians~~ ~~Reimbursement of Emergency Department Claims (Non-Admission)~~ Services	**Replaces Policy No. (if applicable):**	~~CL0090_03~~ ~~CL026~~ ~~CL039~~CL.07 v5
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To accurately process claims regarding emergency room (ER) services in accordance with State and Federal regulatory requirements.

To describe the circumstances under which sub-contractors are responsible for professional and technical component services.

II. Policy

A. Timeframes

1. Contracted Providers

a. Medi-Cal: For Medi-Cal (MC) claims regarding ~~emergency room~~ER 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 (sixty-two (62) calendar days) of the date of receipt.

b. Cal ~~Medi-Connect~~MediConnect: For Cal ~~Medi-Connect~~MediConnect (CMC) claims regarding ~~emergency room~~ER 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~~MC: For ~~Medi-Cal~~MC claims regarding ~~emergency room~~ER services 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~~CMC: For ~~Cal Medi-Connect (~~CMC~~)~~ claims regarding ~~emergency room~~ER services from non-contracted providers, SCFHP shall pay all clean cleans within thirty (30) calendar days of the date of receipt.

3. Sub-contracted Providers

   a. ~~SCFHP to require~~Based on their Division of Financial Responsibility (DOFR), SCFHP requires the delegated sub-contracted providers be responsible for processing in-area ~~emergency room~~ER professional services with the exception of claims by Physician Medical Group of San Jose (PMGSJ) for ER physician groups or physicians billing emergency E&M codes for members participating in their network for the ~~Medi-Cal~~MC line of business.

B. Availability and Accessibility

   b. 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.

   c. SCFHP or its delegated groups is 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 reasonable person or a prudent layperson's definition of "emergency medical ~~condition,"~~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 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.

F. Reimbursement Rates

~~1.~~ Contracted Providers

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

1.

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

2. Non-Contracted Providers

a. ~~Medi-Cal~~MC: Non-contracted providers will be paid for covered services at not less than 100% of the ~~Medi-Cal~~MC 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. The Claims Department is responsible for ensuring applicable rates and interest payments are calculated accurately, applied correctly, and processed timely.

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

~~B.~~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.

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

POLICY

IV. References

Covered Services: Services set forth in Article 4, Chapter 3 (beginning with Section 51301), Sub-division 1, Division 3, Title 22, CCR, which are included as Covered Services under the State ~~Medi-Cal~~MC.
Title 22, California Code of Regulations, Section 51301

Title 22, California Code of Regulations, Section 53622
Title 28, California Code of Regulations, Section 1300.71
Title 28, California Code of Regulations, Section 1300.67.2© and 1300.67(g)(1)
CA Health and Safety Code section 1371.4(a)(b)
Medicare Managed Care Manual, Chapter 4 section 20.3
APL 17-017, Knox-Keene Act Standard For Determining Whether An "Emergency" Existed For Purposes Of Provider Reimbursement

V. Approval/Revision History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~12~~5/~~28/2020~~13/2022 Date	Neal Jarecki Chief Financial Officer ~~01~~5/~~21/2021~~13/2022 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 – 2/28/2018			
3	Revised - 2019			
4	Revised – 2/19/2020			
5	Revised	Executive-/Finance	Approve / 01/28/2021	~~1/28~~Ratify / 03/25/2021
6	Revised	Executive/Finance	TBD / 08/25/2022	

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POLICY

Policy Title:	**Provider Dispute Resolution**	**Policy No.:**	CL.10 ~~v3~~v4
Replaces Policy Title (if applicable):	Provider Dispute Resolution	**Replaces Policy No. (if applicable):**	CL.10 ~~v2~~v3
Issuing Department:	Claims	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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~~–~~ (MC) – 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~~MC – forty-five (45) working days or sixty-two (62) calendar days after receipt date.

C. Cal ~~Medi-Connect~~MediConnect (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.
2. Non-Contracted Providers – These are handled as an appeal by the Grievance & Appeals department.

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

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.

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

Santa Clara Family Health Plan™

POLICY

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)

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision/History

First Level Approval	Second Level Approval
Arlene Bell Director, Claims 05/13/2022 Date	Neal Jarecki Chief Financial Officer 05/13/2022 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~~Approve / 05/27/2021	~~N/A~~Ratify 06/24/2021
4	Revised	Executive/Finance	TBD 08/25/2022	

POLICY

Policy Title:	**Other Health Coverage Cost Avoidance and Post Payment Recovery**	**Policy No.:**	CL.28 ~~v1~~v2
Replaces Policy Title (if applicable):	~~N/A~~Other Health Coverage Cost Avoidance and Post Payment Recovery	**Replaces Policy No. (if applicable):**	~~N/A~~CL.28 v1
Issuing Department:	Claims	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ 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 (MC) member has other health coverage (OHC).

II. Policy

A. State law requires ~~Medi-Cal~~MC to be the payer of last resort for services in which there is a responsible third party. ~~Medi-Cal~~MC members with OHC must utilize their OHC for covered services prior to utilizing their ~~Medi-Cal~~MC benefits. Cost avoidance is the practice of requiring providers to bill liable third parties prior to seeking payment from the ~~Medi-Cal~~MC program.

B. SCFHP and its delegates utilize OHC information from the Department of Health Care ~~Services'~~Services (DHCS) ~~Medi-Cal~~MC 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.

D. Managed Care Plan (MCP) Retention of Provider Overpayments

The MCP shall retain all recoveries less than $25 million for all overpayments and recoveries of overpayments from the MCP to a network provider, including overpayments due to fraud, waste, or abuse, identified by the MCP. In the event an MCP recovers an overpayment to a provider of $25 million or more, DHCS and the MCP will share the recovery amount equally. Sixty (60) days after the date that the overpayment was identified, the MCP must report the overpayment to DHCS through their contract manager. DHCS will recoup the overpayment from the MCP capitated payment. The statement issued to the MCP will reflect the overpayment. The MCP shall submit the overpayment amount that

was recovered, the provider(s) information, and steps taken to correct future occurrences to the MCP's assigned Managed Care Operations Division Contract Manager.

III. Responsibilities

A. Information Technology (IT) is responsible for loading eligibility and OHC information into the claims system and for creating and submitting post payment recovery report.

B. Claims is responsible for denying claims without explanation of benefits (EOB) from OHC carrier for ~~Medi-Cal~~MC members with OHC.

C. ~~Finance~~Claims is responsible for receiving and processing of unsolicited post payment recovery of paid claims for ~~Medi-Cal~~MC members with OHC~~,~~ and for ~~reporting,~~reviewing and approving the monthly post payment recovery report.

~~C.~~D. Finance is responsible for reviewing and approving the monthly post payment recovery report of paid claims for MC members with OHC and repayment to DHCS of any recovery received on or after the 13th month of original claim payment.

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

IV. References

APL 17-003 Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Provider
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 ~~04/15/2021~~08/16/2022 Date	Neal Jarecki Chief Financial Officer ~~04~~08/16/~~2021~~2022 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	Approve	4/22/2021
2	Revised	Executive/Finance	Recommend	08/25/2022

MEMORANDUM

TO: SCFHP Executive/Finance Committee

FROM: Chelsea Byom, Vice President, Marketing, Communications, and Outreach

DATE: August 16, 2022

RE: Authorization for Sponsorship – County of Santa Clara Reentry Resource Center Rise Up and Run 5k Run/Walk

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Background

Santa Clara Family Health Plan (SCFHP) has received a request from the County of Santa Clara Reentry Resource Center to sponsor the Annual Rise Up and Run 5K Run/Walk on October 22, 2022 at Hellyer County Park in San Jose. Though SCFHP has sponsored this event in the past, this year's fiscal administrator is Valley Medical Center Foundation. On August 5, 2022, SCFHP's Chief Executive Officer (CEO) approved sponsorship for the Valley Medical Center Foundation's Tribute to Heroes Gala at $5,000. SCFHP's Donations and Sponsorships Policy (No. GO.04 v2) states that, "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." The policy further states, "Exceptions to these limits require approval by the Executive/Finance Committee."

Recommended Action

Authorize CEO to approve a $5,000 sponsorship to fiscal administrator Valley Medical Center Foundation to support the County of Santa Clara Reentry Resource Center Rise Up and Run 5K Run/Walk.

Santa Clara Family Health Plan™

Unaudited Financial Statements

For The Twelve Months Ended June 30, 2022

Agenda

Santa Clara Family Health Plan

Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$113.7 M		$1.56 B	
Medical Expense (MLR)	$102.5 M	90.2%	$1.45 B	93.3%
Administrative Expense (% Rev)	$7.3 M	6.4%	$76.2 M	4.9%
Other Income/(Expense)	$403K		$2.1 M	
Net Surplus (Net Loss)	**$4.3 M**		**$30.3 M**	
Cash and Investments			$551 M	
Receivables			$549 M	
Total Current Assets			$1.11 B	
Current Liabilities			$850 M	
Current Ratio			1.30	
Tangible Net Equity			$285 M	
% of DMHC Requirement			**821.0%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $4.3M is $4.3M or 11,875.3% favorable to budget of $36K surplus. YTD: Surplus of $30.3M is $21.7M or 251.2% favorable to budget of $8.6M surplus.
Enrollment	Month: Membership was 306,382 (3,745 or 1.2% higher than budget of 302,637). YTD: Member Months YTD was 3,517,799 (81,555 or 2.3% lower than budget of 3,599,354).
Revenue	Month: $113.7M ($4.6M or 3.9% unfavorable to budget of $118.3M). YTD: $1.56B ($153.8M or 11.0% favorable to budget of $1.40B).
Medical Expenses	Month: $102.5M ($9.1M or 8.2% favorable to budget of $111.7M). YTD: $1.45B ($134.7M or 10.2% unfavorable to budget of $1.32B).
Administrative Expenses	Month: $7.3M ($302K or 4.3% unfavorable to budget of $7.0M). YTD: $76.2M ($5.1M or 6.2% favorable to budget of $81.3M).
Tangible Net Equity	TNE was $285.1M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $1.2M vs. $3.3M annual budget, primarily software.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 306,382 members is 3,745 or 1.2% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 23,712 members or 8.4%.
- Medi-Cal & CMC enrollment have been increasing since March 2020 largely due to COVID. Beginning in March 2020, annual eligibility redeterminations were suspended and, as a result, enrollment continues to increase.
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 9.0%, Medi-Cal Dual enrollment has increased 4.8%, and CMC enrollment has grown 2.5%.

	For the Month June 2022				For Twelve Months Ending June 30, 2022					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY22 vs. FY21
Medi-Cal	296,050	291,767	4,283	1.5%	3,394,099	3,472,434	(78,335)	(2.3%)	3,137,271	8.2%
Cal Medi-Connect	10,332	10,870	(538)	(4.9%)	123,700	126,920	(3,220)	(2.5%)	116,365	6.3%
Total	**306,382**	**302,637**	**3,745**	**1.2%**	**3,517,799**	**3,599,354**	**(81,555)**	**(2.3%)**	**3,253,636**	**8.1%**

Santa Clara Family Health Plan Enrollment By Network
June 2022

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	39,155	13%	10,332	100%	49,487	16%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	148,655	50%	-	0%	148,655	49%
North East Medical Services	3,401	1%	-	0%	3,401	1%
Palo Alto Medical Foundation	7,423	3%	-	0%	7,423	2%
Physicians Medical Group	45,233	15%	-	0%	45,233	15%
Premier Care	16,346	6%	-	0%	16,346	5%
Kaiser	35,837	12%	-	0%	35,837	12%
Total	**296,050**	**100%**	**10,332**	**100%**	**306,382**	**100%**
Enrollment at June 30, 2021	272,590		10,080		282,670	
Net Δ from Beginning of FY22	8.6%		2.5%		8.4%	

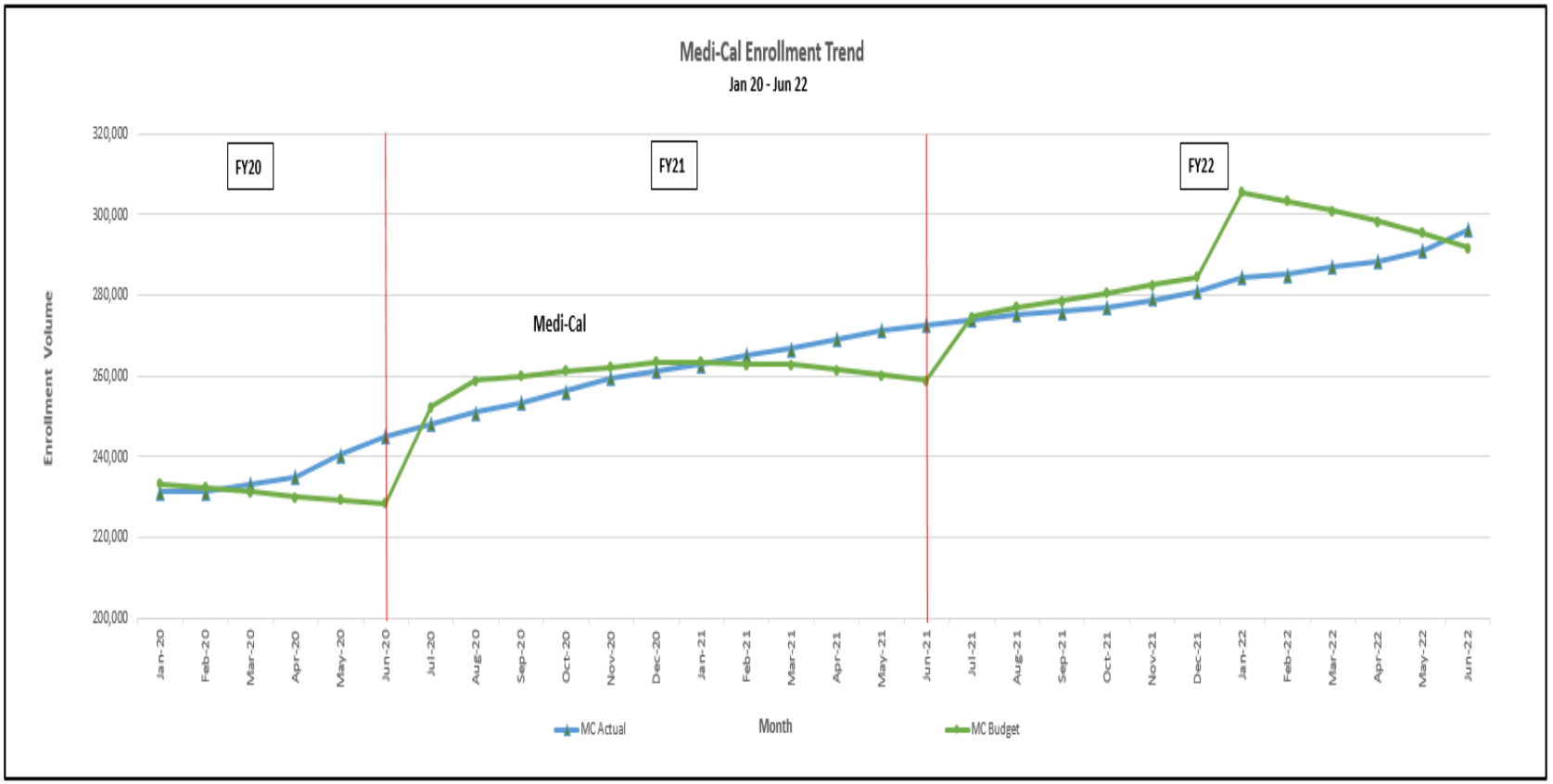
[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD JUNE - 2022

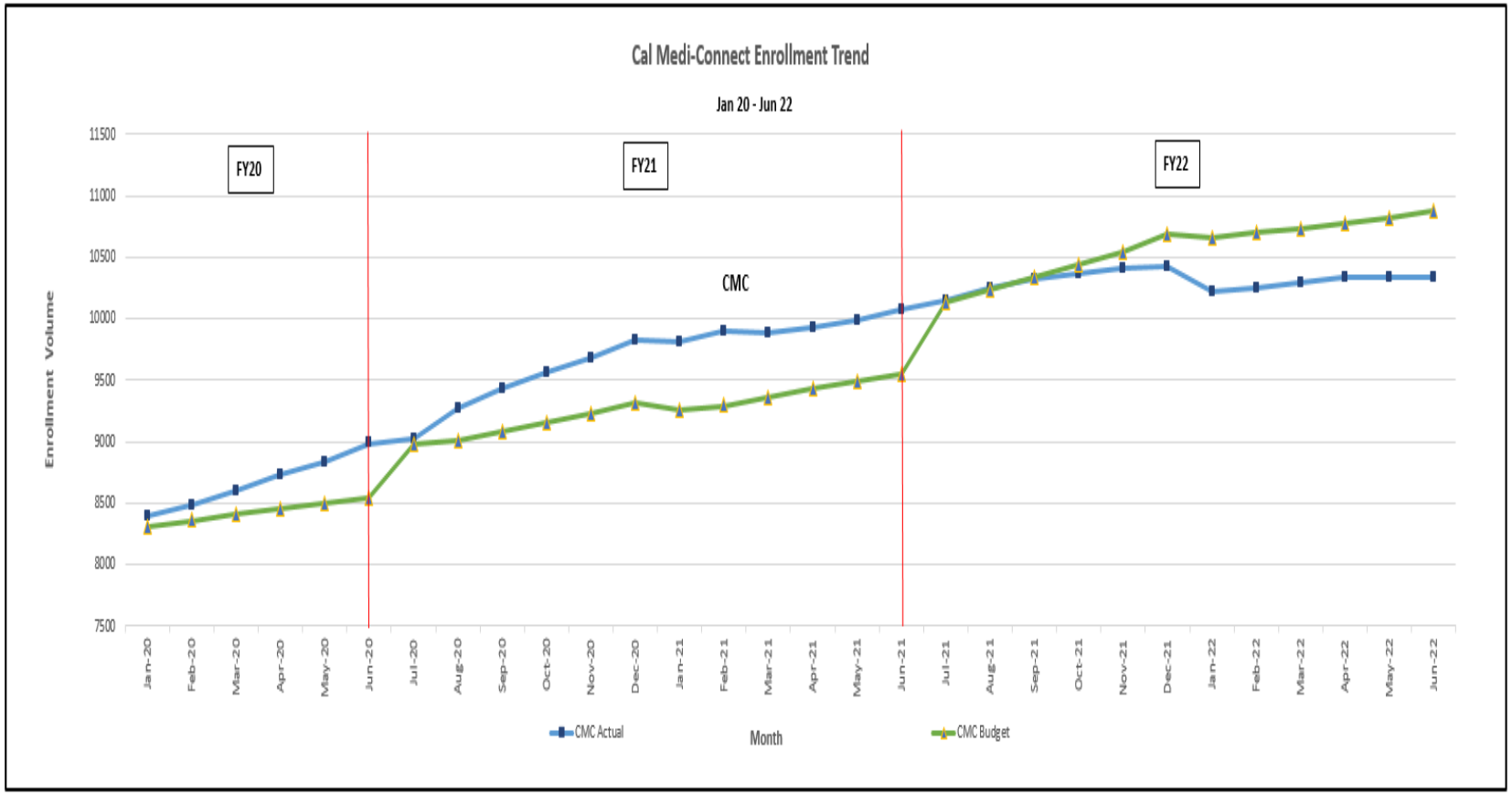
		2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	FYTD var	%
NON DUAL	Adult (over 19)	32,997	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	4,864	14.7%
	Child (under 19)	100,477	101,010	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	3,144	3.1%
	SPD	22,301	22,363	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	1,899	8.5%
	Adult Expansion	89,957	90,711	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	12,241	13.6%
	Long Term Care	365	414	408	401	391	385	392	391	403	395	393	397	398	33	9.0%
	Total Non-Duals	**246,097**	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**22,181**	**9.0%**
DUAL	Adult (over 21)	366	367	376	375	396	398	408	410	403	407	412	431	423	57	15.6%
	SPD	24,115	23,980	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	269	1.1%
	Long Term Care	1,060	1,127	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	88	8.3%
	SPD OE	952	1,063	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	865	90.9%
	Total Duals	**26,493**	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**1,279**	**4.8%**
	Total Medi-Cal	**272,590**	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**23,460**	**8.6%**
CMC	CMC Non-Long Term Care	9,895	9,939	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	232	2.3%
	CMC - Long Term Care	185	209	208	203	208	204	210	202	213	215	206	206	205	20	10.8%
	Total CMC	**10,080**	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**252**	**2.5%**
	Total Enrollment	**282,670**	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**23,712**	**8.4%**

Medi-Cal Enrollment Trend



- Actual enrollment, represented by the blue line, showed steeper initial COVID enrollment growth in FY21 followed by a lower growth in FY22 with continued public health emergency.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to sustained public health emergency. Current budget effective July 2021, the Budget included a higher projection of new mandatory Medi-Cal population having Other Health Coverage (OHC) starting Jan 2022.

Cal Medi-Connect Enrollment Trend

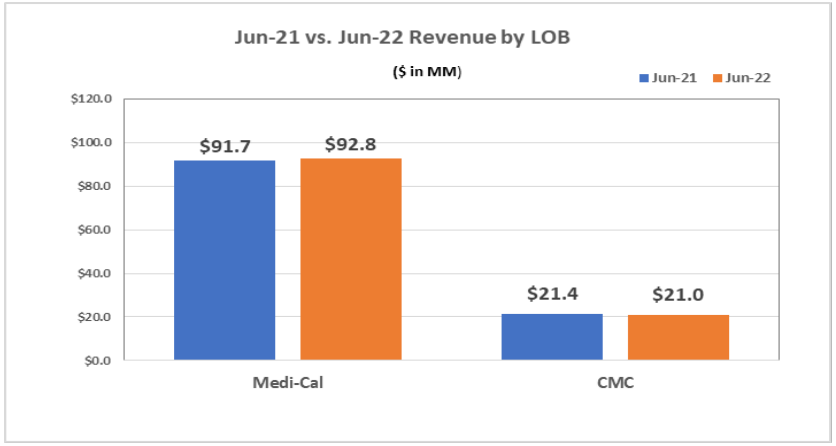


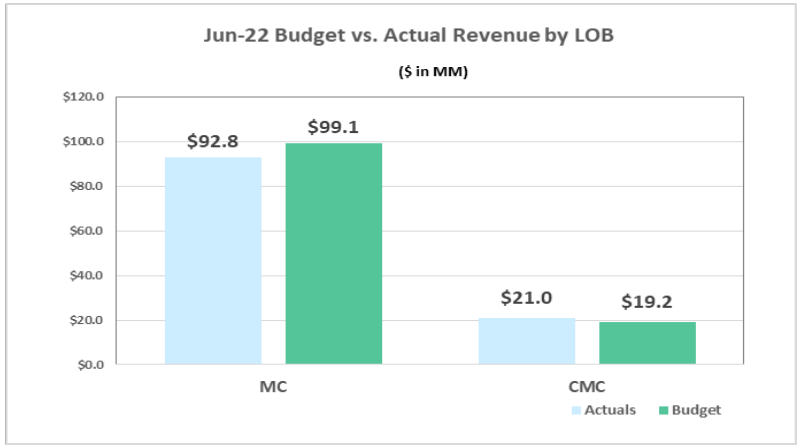
- Actual enrollment, represented by the blue line, showed steeper initial COVID enrollment growth in FY21 followed by a lower growth in FY22 with continued public health emergency.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to sustained public health emergency. Current budget effective July 2021 continues to increase.

Current Month Revenue

Current month revenue of $113.7M was $4.6M or 3.9% unfavorable to budget of $118.3M. The current month variance was primarily due to the following:

- Medi-Cal revenue was $7.5M unfavorable to budget due primarily to (1) the pharmacy benefit carve-out ($13.9M unfavorable), partly offset by (2) higher CY22 rates versus budget ($6.1M fav) and (3) higher enrollment ($278K favorable). The Budget anticipated the Medi-Cal pharmacy benefit would continue until the end of fiscal year but pharmacy carve-out began on Jan 1. Unfavorable pharmacy revenue is offset by favorable pharmacy expense. Prop 56 revenue was $1.9M favorable to budget due to prior year reconciliation. Other supplemental revenue was $754K unfavorable to budget due to budgeted Hep-C benefit carved-out and lower maternity deliveries.
- CMC revenue was $1.8M favorable to budget due to (1) CY21 Pt-D recon settlement ($1.8M fav) and (2) additional estimated 1% CY21 + CY22 QWH earn-back ($2M fav), offset by (3) CY20 medical loss ratio (MLR) accrual payables to DHCS & CMS ($1.1M unfavorable) and (4) lower enrollment versus budget ($866K unfavorable).

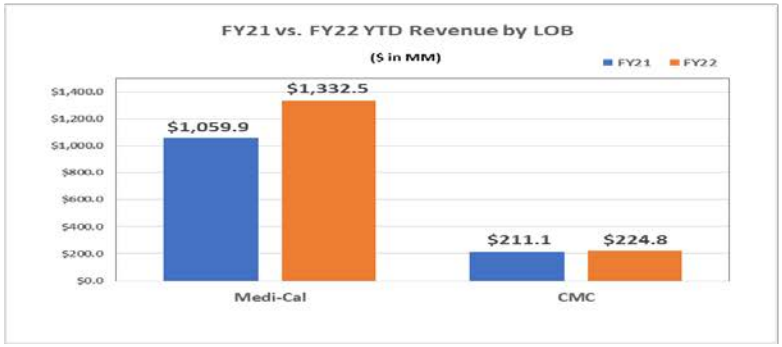


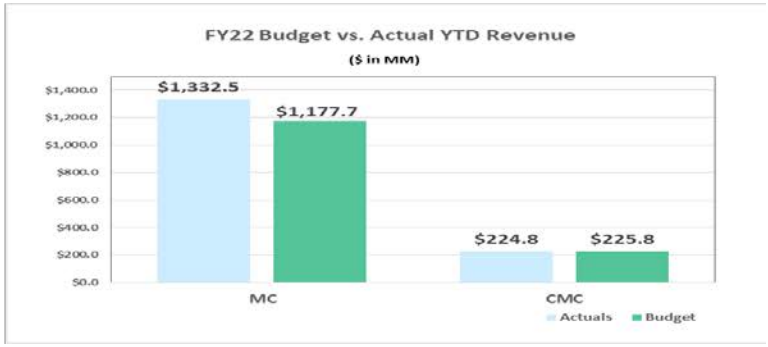


YTD Revenue

YTD revenue of $1.56B was $153.8M or 11.0% favorable to budget of $1.40B. The YTD variance was primarily due to the following:

- Due to a change in accounting prescribed by DHCS, hospital directed payments are now reported on the P&L resulting in a favorable current month revenue variance of $212.3M with an offsetting unfavorable medical expense.
- Medi-Cal revenue is $65.2M unfavorable largely due to the timing of the pharmacy benefit carve-out effective January 1st (the budget assumed the Rx benefit would continue through FY23). Lower pharmacy-related revenue is largely offset by lower pharmacy-related medical expense. Lower enrollment than anticipated from OHC contributes to the net unfavorable variance. Partially offsetting favorable variances pertained to higher CY22 rates versus budget and unbudgeted revenue associated with the COVID vaccine program (with associated expense). Supplemental revenue was $5.1M favorable to budget due to increased utilization in BHT, Health Homes, Hep-C, and higher maternity deliveries. Prop 56 revenue was $2.6M favorable due to prior year reconciliation.
- CMC revenue was $972K unfavorable to budget due to accrued CY20 Medical Loss Ratio reserves payable to DHCS & CMS and lower enrollment, offset by CY20 Part-D Reconciliation payment, CY20 + CY21 Part-C QWH earnback and higher CY21 & CY22 CCI rates versus budget.

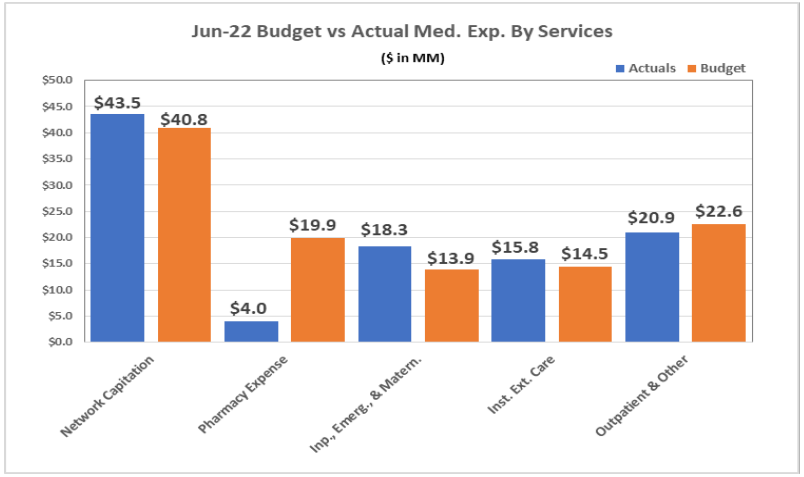


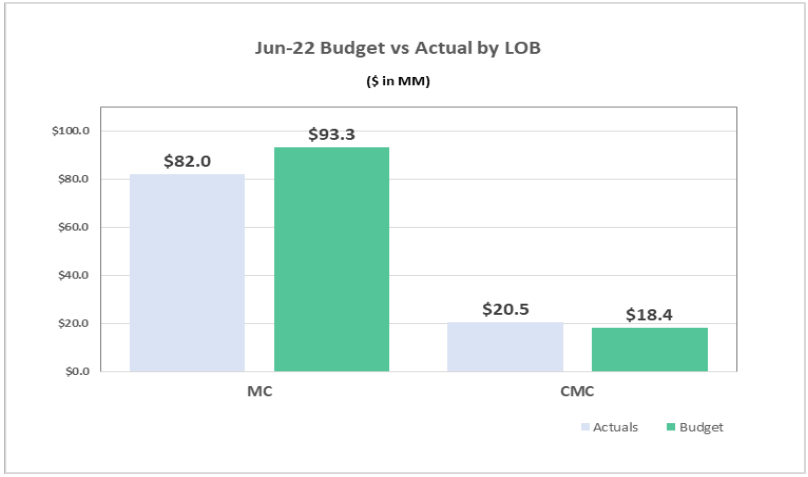


Current Month Medical Expense

Current month medical expense of $102.5M was $9.1M or 8.2% favorable to budget of $111.7M.
The current month variance was due largely to:

- Pharmacy expense was $15.9M favorable to budget primarily due to timing of the Medi-Cal carve-out (offsetting the unfavorable revenue variance of $13.9M). The budget assumed the Medi-Cal pharmacy benefit would continue through the end of fiscal year.
- Fee-For-Service expense was $4.2M or 8.8% unfavorable to budget due to (1) increased unit cost versus budget for Inpatient, LTC, Transportation, Outpatient, and Physician Specialty services and (2) increased supplemental services such as Behavioral Health Therapy (offset with favorable revenue variance), offset by (3) lower utilization in PCP, Emergency Room and Other MLTSS services.
- Capitation expense was $2.7M or 6.5% unfavorable to budget due to CY22 capitated rates true-up and higher enrollment.
- Reinsurance & Other expenses were $106K or 2.9% favorable to budget due to (1) timing of Board Designated Fund payments ($250K favorable), offset by (2) prior year Prop-56 payment adjustments ($74K unfavorable - offset with favorable revenue) and (3) lower claim recoveries ($70K unfavorable).

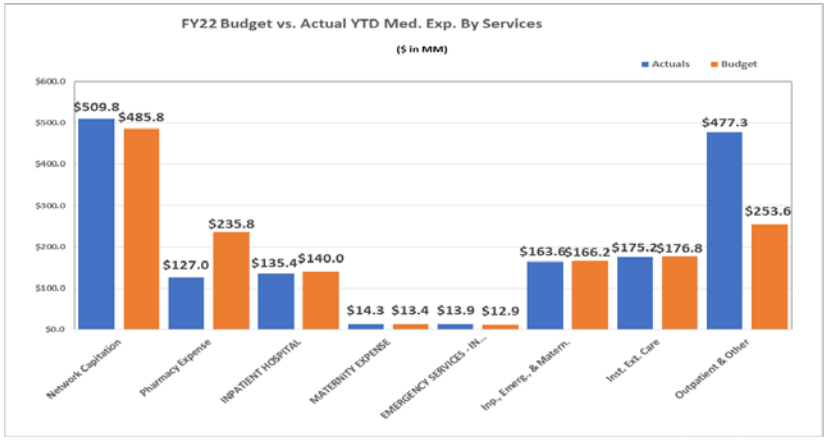


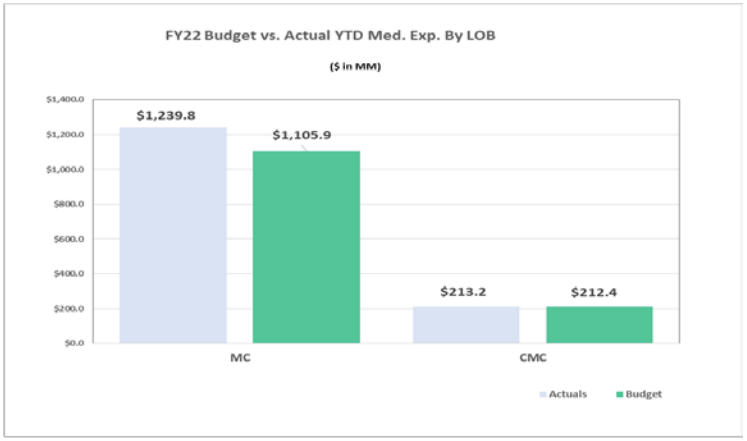


YTD Medical Expense

YTD medical expense of $1.45B was $134.7M or 10.2% unfavorable to budget of $1.32B. The YTD variance was due largely to:

- Due to a change in accounting prescribed by DHCS, hospital directed payments are now reported on the P&L resulting in an unfavorable medical expense of $212.3M with an offsetting favorable current month revenue variance.
- Pharmacy expenses were $108.8M or 46.1% favorable to budget because budget was projected to have pharmacy benefit continue until June 30 but it ended Jan 1 and lower enrollment from OHC than anticipated, thus lower overall pharmacy costs. Actual costs of diabetic drugs were also affected by lower enrollment. MC favorable pharmacy expenses were offset by unfavorable revenue.
- Capitation expense was $24.0M or 4.9% unfavorable to budget due to $22M accrued for VHP as one-time capitation payment for SPD utilization costs not reflected in original CY21 paid capitation rates. VHP is expected to pass the entire amount to VMC, offset by lower capitated MC enrollment.
- Fee-For-Service expense was $6.2M unfavorable to budget due to (1) increased unit cost versus budget in Outpatient, ER, Physician Specialty, PCP and Other Non MLTSS services and (2) increased supplemental services such as Behavioral Health Therapy, Health Homes, Maternity (offset with favorable revenue variance), offset by (3) lower utilization in Inpatient, LTC and Other MLTSS services.

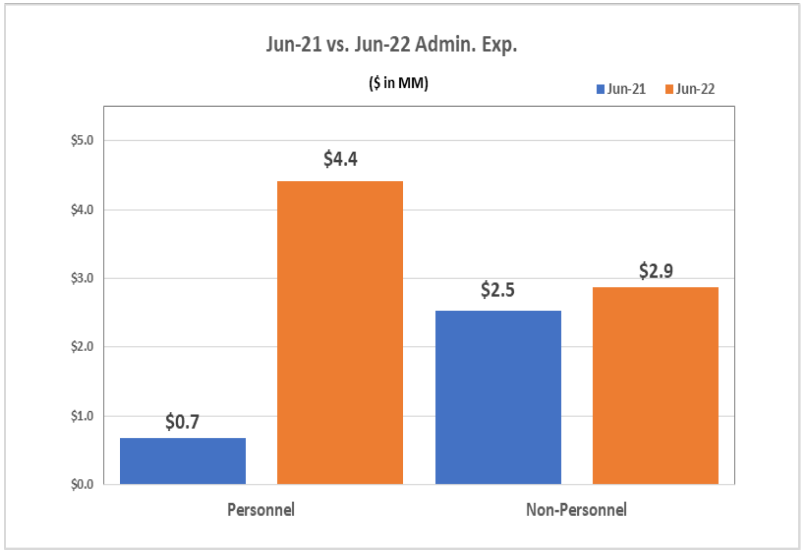


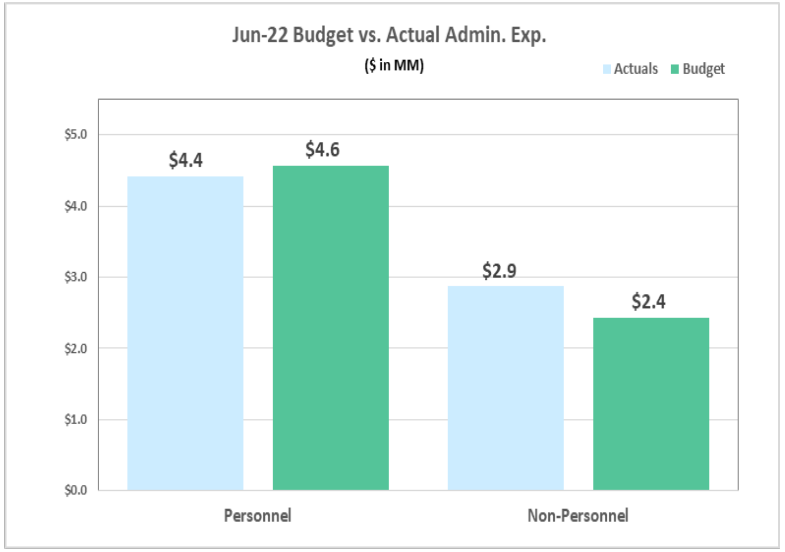


Current Month Administrative Expense

Current month expense of $7.3M was $302K or 4.3% unfavorable to budget of $7.0M. The current month variances were primarily due to the following:

- Personnel expenses were $142K or 3.1% favorable to budget due to lower headcount than budget which included payroll tax, benefit savings and CalPERS reconciliations.
- Non-Personnel expenses were $444K or 18.3% unfavorable to budget due to the timing of spending in certain expense categories (consulting, contract service, translation, and other fees). Other Expense also included unbudgeted COVID member incentive gift cards. (the unbudgeted COVID vaccination incentive program is funded by DHCS).

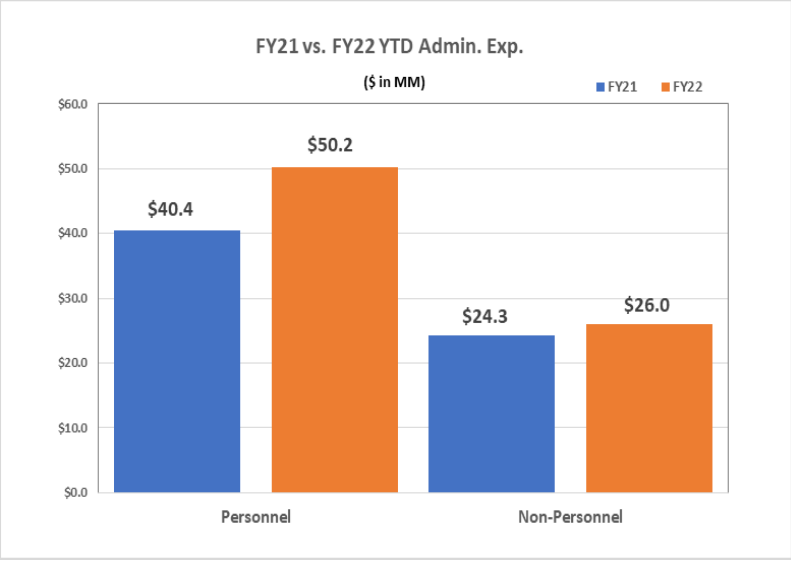


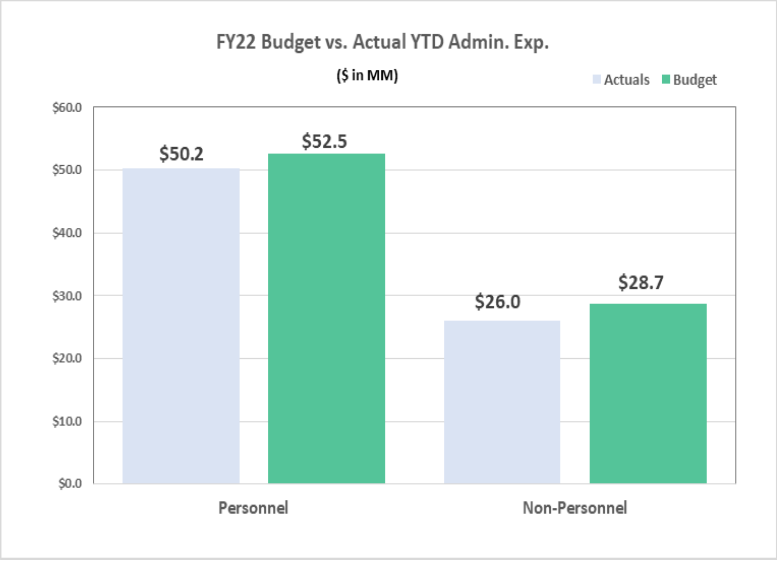


YTD Administrative Expense

YTD administrative expense of $76.2M was $5.1M or 6.2% favorable to budget of $81.3M. The YTD variance was primarily due to the following:

- Personnel expenses were $2.3M or 4.4% favorable to budget due to lower headcount than budget which included lower payroll tax, benefits and CalPERS reconciliations.
- Non-Personnel expenses were $2.8M or 9.6% favorable to budget due to the timing of budget spending in certain expenses (consulting, contract service, translation, advertising, information systems, and other fees). Other Expense included unbudgeted COVID member vaccination incentives under DHCS program.





Balance Sheet

- Current assets totaled $1.11B compared to current liabilities of $850.5M, yielding a current ratio (Current Assets/Current Liabilities) of 1.30:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance increased by $143.2M compared to the cash balance as of year-end June 30, 2021 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
Short-Term Investments				
County of Santa Clara Comingled Pool	$183,653,817	1.25%	$260,340	$1,454,918
Wells Fargo Investments	($20)	0.00%	$0	$34,513
City National Bank Investments	$296,007,444	1.23%	$97,623	$214,486
	$479,661,241		$357,962	$1,703,917
Cash & Equivalents				
Bank of the West Money Market	$0	0.00%	$0	$3,308
City National Bank Accounts	$66,495,397	0.01%	$610	$4,402
Wells Fargo Bank Accounts	$4,748,037	1.20%	$3,528	$9,460
	$71,243,435		$4,138	$17,170
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.01%	$3	$598
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$551,230,175**		**$362,104**	**$1,721,685**

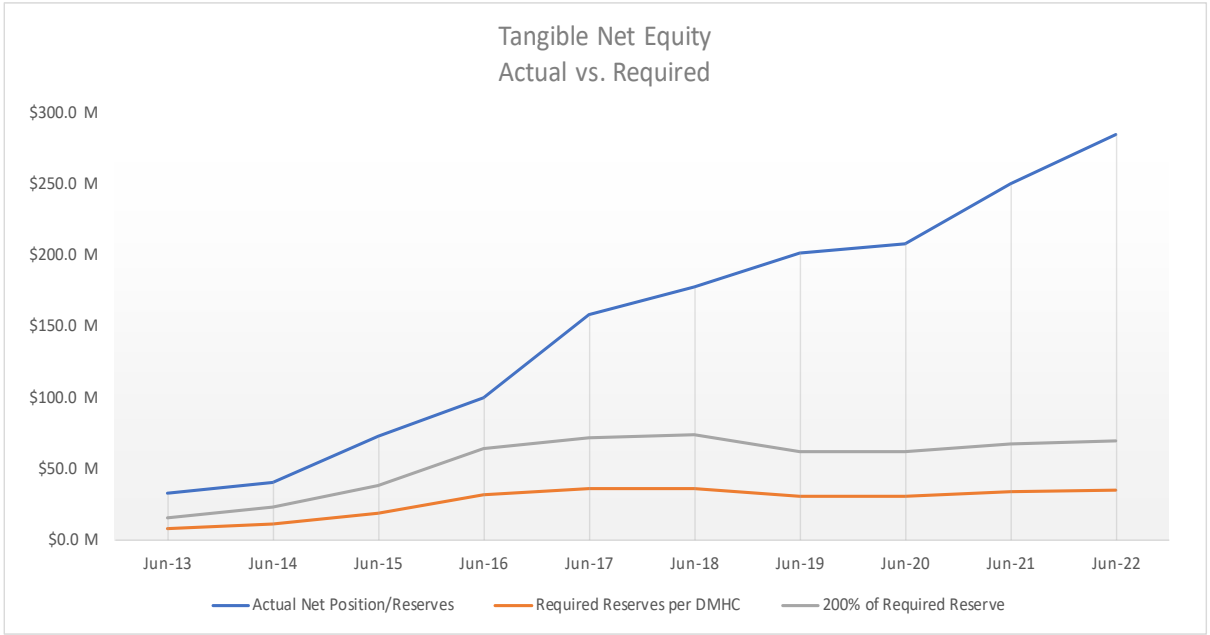
- Cash balances include balances payable to the State of CA for certain items.
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- The investment transition from Wells Fargo to City National Bank was largely completed in January.
- Overall cash and investment yield is lower than budget (1.09% actual vs. 1.4% budgeted).

Tangible Net Equity

- TNE was $285.1M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of June 30, 2022

	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	Jun-22
Actual Net Position/Reserves	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$285.1 M
Required Reserves per DMHC	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$34.7 M
200% of Required Reserve	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$69.5 M
Actual as % Required	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	821.0%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS JUNE 2022

Financial Reserve Target #1: Tangible Net Equity	Board Funds Committed	Approved Projects	Funds Expended	Balance
Unrestricted Net Assets				**$245,130,576** *
Board Designated Funds (Note 1):				
Special Project Funding for CBOs	$4,000,000	$739,995	$494,995	$3,505,005
Innovation & COVID-19 Fund	$16,000,000	$7,704,043	$3,917,591	$12,082,410
Subtotal	$20,000,000	$8,444,038	$4,412,585	$15,587,415
Net Book Value of Fixed Assets				$24,104,910
Restricted Under Knox-Keene Agreement				$325,000
Total Tangible Net Equity (TNE)				$285,147,901
Current Required TNE				$34,733,884
TNE %				821.0%
SCFHP Target TNE Range:				
350% of Required TNE (Low)				$121,568,592
500% of Required TNE (High)				$173,669,418
Total TNE Above/(Below) SCFHP Low Target				**$163,579,308**
Total TNE Above/(Below) High Target				**$111,478,483**
Financial Reserve Target #2: Liquidity				
Cash & Investments				$551,230,175
Less Pass-Through Liabilities:				
Hospital Directed Payments				(357,214)
MCO Tax Payable to State of CA				(35,019,123)
Prop 56 / Whole Person Care				(1,678,180)
Other Pass-Through Liabilities (Note 2)				(114,824,944)
Total Pass-Through Liabilities				**(151,879,462)**
Net Cash Available to SCFHP				399,350,714
SCFHP Target Liquidity (Note 3)				
45 Days of Total Operating Expense				(177,993,349)
60 Days of Total Operating Expense				(237,324,465)
Liquidity Above/(Below) SCFHP Low Target				**221,357,365**
Liquidity Above/(Below) High Target				**162,026,248**

- **Unrestricted Net Assets represents approximately 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 & COVID-19 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

- YTD Capital investments of $1.2M, largely due to software licensing, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$19,489	$55,800
Hardware	$306,491	$1,060,000
Software	$654,265	$1,896,874
Building Improvements	$181,445	$62,000
Furniture & Equipment	$14,192	$179,101
TOTAL	**$1,175,883**	**$3,253,775**

Certain hardware and software projects have been deferred to FY23.

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For Twelve Months Ending June 30, 2022

	Jun-2022 Actuals	% of Rev	Jun-2022 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Jun-2022 Actuals	% of Rev	YTD Jun-2022 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 92,777,745	81.6%	$ 99,135,001	83.8%	$ (6,357,256)	(6.4%)	$ 1,332,531,367	85.6%	$ 1,177,729,434	83.9%	$ 154,801,933	13.1%
CMC MEDI-CAL	3,457,349	3.0%	3,623,094	3.1%	(165,744)	(4.6%)	42,996,568	2.8%	44,183,885	3.1%	(1,187,317)	(2.7%)
CMC MEDICARE	17,493,343	15.4%	15,552,470	13.1%	1,940,873	12.5%	181,808,473	11.7%	181,593,328	12.9%	215,144	0.1%
TOTAL CMC	20,950,692	18.4%	19,175,564	16.2%	1,775,129	9.3%	224,805,041	14.4%	225,777,213	16.1%	(972,173)	(0.4%)
TOTAL REVENUE	**$ 113,728,437**	**100.0%**	**$ 118,310,565**	**100.0%**	**$ (4,582,127)**	**(3.9%)**	**$ 1,557,336,407**	**100.0%**	**$ 1,403,506,647**	**100.0%**	**$ 153,829,760**	**11.0%**
MEDICAL EXPENSES												
MEDI-CAL	$ 81,991,071	72.1%	$ 93,285,811	78.8%	$ 11,294,740	12.1%	$ 1,239,769,685	79.6%	$ 1,105,863,467	78.8%	$(133,906,218)	(12.1%)
CMC MEDI-CAL	3,133,519	2.8%	3,200,966	2.7%	67,447	2.1%	43,072,048	2.8%	37,030,224	2.6%	(6,041,824)	(16.3%)
CMC MEDICARE	17,408,764	15.3%	15,191,589	12.8%	(2,217,175)	(14.6%)	170,122,641	10.9%	175,365,334	12.5%	5,242,693	3.0%
TOTAL CMC	20,542,283	18.1%	18,392,555	15.5%	(2,149,728)	(11.7%)	213,194,689	13.7%	212,395,557	15.1%	(799,132)	(0.4%)
TOTAL MEDICAL EXPENSES	**$ 102,533,354**	**90.2%**	**$ 111,678,366**	**94.4%**	**$ 9,145,012**	**8.2%**	**$ 1,452,964,374**	**93.3%**	**$ 1,318,259,025**	**93.9%**	**$(134,705,349)**	**(10.2%)**
GROSS MARGIN	**$ 11,195,083**	**9.8%**	**$ 6,632,199**	**5.6%**	**$ 4,562,885**	**68.8%**	**$ 104,372,033**	**6.7%**	**$ 85,247,623**	**6.1%**	**$ 19,124,411**	**22.4%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 4,417,845	3.9%	$ 4,559,661	3.9%	$ 141,816	3.1%	$ 50,212,353	3.2%	$ 52,525,619	3.7%	$ 2,313,267	4.4%
RENTS AND UTILITIES	51,699	0.0%	42,067	0.0%	(9,632)	(22.9%)	472,820	0.0%	504,800	0.0%	31,981	6.3%
PRINTING AND ADVERTISING	145,387	0.1%	107,542	0.1%	(37,845)	(35.2%)	677,207	0.0%	1,292,500	0.1%	615,293	47.6%
INFORMATION SYSTEMS	438,229	0.4%	397,762	0.3%	(40,468)	(10.2%)	3,912,667	0.3%	4,643,691	0.3%	731,025	15.7%
PROF FEES/CONSULTING/TEMP STAFFING	1,487,671	1.3%	1,116,398	0.9%	(371,273)	(33.3%)	11,849,058	0.8%	13,474,461	1.0%	1,625,403	12.1%
DEPRECIATION/INSURANCE/EQUIPMENT	409,304	0.4%	455,815	0.4%	46,511	10.2%	4,850,269	0.3%	5,232,168	0.4%	381,899	7.3%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	51,361	0.0%	62,742	0.1%	11,382	18.1%	644,522	0.0%	748,007	0.1%	103,485	13.8%
MEETINGS/TRAVEL/DUES	98,387	0.1%	139,823	0.1%	41,437	29.6%	1,183,999	0.1%	1,640,679	0.1%	456,679	27.8%
OTHER	186,338	0.2%	102,057	0.1%	(84,282)	(82.6%)	2,393,699	0.2%	1,202,280	0.1%	(1,191,419)	(99.1%)
TOTAL ADMINISTRATIVE EXPENSES	**$ 7,286,221**	**6.4%**	**$ 6,983,867**	**5.9%**	**$ (302,355)**	**(4.3%)**	**$ 76,196,593**	**4.9%**	**$ 81,264,205**	**5.8%**	**$ 5,067,612**	**6.2%**
OPERATING SURPLUS/(LOSS)	**$ 3,908,862**	**3.4%**	**$ (351,668)**	**(0.3%)**	**$ 4,260,530**	**(1,211.5%)**	**$ 28,175,440**	**1.8%**	**$ 3,983,417**	**0.3%**	**$ 24,192,023**	**607.3%**
INTEREST & INVESTMENT INCOME	$ 362,104	0.3%	$ 350,000	0.3%	$ 12,104	3.5%	$ 1,721,685	0.1%	$ 4,200,000	0.3%	$ (2,478,315)	(59.0%)
OTHER INCOME	40,532	0.0%	37,671	0.0%	2,861	7.6%	400,174	0.0%	442,366	0.0%	(42,191)	(9.5%)
NON-OPERATING INCOME	**$ 402,635**	**0.4%**	**$ 387,671**	**0.3%**	**$ 14,964**	**3.9%**	**$ 2,121,860**	**0.1%**	**$ 4,642,366**	**0.3%**	**$ (2,520,506)**	**(54.3%)**
NET SURPLUS (LOSS)	**$ 4,311,497**	**3.8%**	**$ 36,003**	**0.0%**	**$ 4,275,494**	**11,875.3%**	**$ 30,297,300**	**1.9%**	**$ 8,625,783**	**0.6%**	**$ 21,671,516**	**251.2%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of June 30, 2022

	Jun-2022	May-2022	Apr-2022	Jun-2021
Assets				
Current Assets				
Cash and Investments	$ 551,230,175	$ 530,957,859	$ 498,171,830	$ 408,072,066
Receivables	548,791,748	546,977,941	547,688,913	512,219,525
Prepaid Expenses and Other Current Assets	6,854,698	7,304,447	7,979,786	8,716,504
Total Current Assets	**$ 1,106,876,622**	**$ 1,085,240,247**	**$ 1,053,840,528**	**$ 929,008,095**
Long Term Assets				
Property and Equipment	$ 52,698,754	$ 52,661,309	$ 52,541,558	$ 51,522,871
Accumulated Depreciation	(28,593,844)	(28,247,165)	(27,900,369)	(24,466,207)
Total Long Term Assets	24,104,910	24,414,144	24,641,189	27,056,664
Total Assets	**$ 1,130,981,532**	**$ 1,109,654,390**	**$ 1,078,481,717**	**$ 956,064,759**
Deferred Outflow of Resources	**$ 5,156,729**	**$ 5,379,606**	**$ 5,602,483**	**$ 7,413,357**
Total Assets & Deferred Outflows	**$ 1,136,138,261**	**$ 1,115,033,997**	**$ 1,084,084,200**	**$ 963,478,116**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 12,915,439	$ 11,108,109	$ 17,022,946	$ 8,452,671
Deferred Rent	43,785	44,567	45,349	48,331
Employee Benefits	4,559,004	4,270,614	4,105,609	3,127,996
Retirement Obligation per GASB 75	2,499,662	2,459,537	2,419,412	1,737,287
Whole Person Care	1,678,180	1,684,180	1,687,180	1,915,180
Prop 56 Pass-Throughs	53,418,561	63,768,752	61,850,674	42,086,557
HQAF Payable to Hospitals	4,715	4,751	(1,533)	103,819
Hospital Directed Payment Payable	352,499	352,688	434,325	472,944
Pass-Throughs Payable	24,557,190	20,485,300	16,381,877	181
Due to Santa Clara County Valley Health Plan and Kaiser	83,721,764	77,175,627	70,625,067	23,785,679
MCO Tax Payable - State Board of Equalization	35,019,123	24,890,650	14,776,148	31,975,622
Due to DHCS	90,267,754	88,077,172	85,754,920	58,509,648
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,990,933
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
DHCS Incentive Programs	7,718,646	7,718,646	0	0
Medical Cost Reserves	105,409,762	103,332,724	101,045,936	107,587,324
Total Current Liabilities	**$ 850,451,043**	**$ 833,658,276**	**$ 804,432,867**	**$ 708,088,197**
Non-Current Liabilities				
Net Pension Liability GASB 68	(0)	(0)	(0)	(0)
Total Non-Current Liabilities	**$ (0)**	**$ (0)**	**$ (0)**	**$ (0)**
Total Liabilities	**$ 850,451,042**	**$ 833,658,275**	**$ 804,432,866**	**$ 708,088,197**
Deferred Inflow of Resources	**$ 539,318**	**$ 539,318**	**$ 539,318**	**$ 539,318**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,505,005	$ 3,505,005	$ 3,720,000	$ 3,337,274
Board Designated Fund: Innovation & COVID-19 Fund	12,082,410	12,082,410	12,591,157	13,730,001
Invested in Capital Assets (NBV)	24,104,910	24,414,144	24,641,189	27,056,664
Restricted under Knox-Keene agreement	325,000	325,000	325,000	325,000
Unrestricted Net Equity	214,833,276	214,524,042	213,573,254	164,191,849
Current YTD Income (Loss)	30,297,300	25,985,802	24,261,415	46,209,814
Total Net Assets / Reserves	**$ 285,147,901**	**$ 280,836,403**	**$ 279,112,016**	**$ 254,850,601**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,136,138,261**	**$ 1,115,033,997**	**$ 1,084,084,200**	**$ 963,478,116**

Cash Flow Statement

Santa Clara Family Health Plan

	Jun-2022	Year-to-date
Cash Flows from Operating Activities		
Premiums Received	$ 124,233,685	$ 1,555,565,791
Medical Expenses Paid	(93,910,179)	(1,395,205,850)
Adminstrative Expenses Paid	(10,416,380)	(18,147,808)
Net Cash from Operating Activities	**$ 19,907,126**	**$ 142,212,133**
Cash Flows from Capital and Related Financing Activities		
Purchase of Capital Assets	$ (37,445)	$ (1,175,883)
Cash Flows from Investing Activities		
Interest Income and Other Income (Net)	402,635	2,121,860
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ 20,272,317**	**$ 143,158,110**
Cash & Investments (Beginning)	530,957,859	408,072,066
Cash & Investments (Ending)	**$ 551,230,175**	**$ 551,230,175**
Reconciliation of Operating Income to Net Cash from Operating Activities		
Operating Surplus/(Loss)	$ 3,908,862	$ 28,175,440
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities		
Depreciation	346,679	4,127,637
Changes in Operating Assets/Liabilities		
Premiums Receivable	(1,813,807)	(36,572,223)
Prepaids & Other Assets	449,749	1,861,807
Deferred Outflow of Resources	222,877	2,256,628
Accounts Payable & Accrued Liabilities	(4,149,463)	42,084,069
State Payable	12,319,055	34,801,607
IGT, HQAF & Other Provider Payables	6,546,137	59,936,085
DHCS Incentive Programs	0	7,718,646
Medical Cost Reserves & PDR	2,077,038	(2,177,562)
Total Adjustments	**$ 15,998,264**	**$ 114,036,693**
Net Cash from Operating Activities	**$ 19,907,126**	**$ 142,212,133**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Twelve Months Ending June 30, 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$1,332,531,367	$42,996,568	$181,808,473	$224,805,041	**$1,557,336,407**
MEDICAL EXPENSE	$1,239,769,685	$43,072,048	$170,122,641	$213,194,689	**$1,452,964,374**
(MLR)	93.0%	100.2%	93.6%	94.8%	93.3%
GROSS MARGIN	$92,761,682	($75,480)	$11,685,832	$11,610,352	**$104,372,033**
ADMINISTRATIVE EXPENSE	$65,197,442	$2,103,715	$8,895,436	$10,999,151	**$76,196,593**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$27,564,239	($2,179,195)	$2,790,396	$611,201	**$28,175,440**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$1,815,564	$58,583	$247,713	$306,295	**$2,121,860**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$29,379,804	($2,120,613)	$3,038,109	$917,496	**$30,297,300**
PMPM (ALLOCATED BASIS)					
REVENUE	$392.60	$347.59	$1,469.75	$1,817.34	**$442.70**
MEDICAL EXPENSES	$365.27	$348.20	$1,375.28	$1,723.48	**$413.03**
GROSS MARGIN	$27.33	($0.61)	$94.47	$93.86	**$29.67**
ADMINISTRATIVE EXPENSES	$19.21	$17.01	$71.91	$88.92	**$21.66**
OPERATING INCOME/(LOSS)	$8.12	($17.62)	$22.56	$4.94	**$8.01**
OTHER INCOME/(EXPENSE)	$0.53	$0.47	$2.00	$2.48	**$0.60**
NET INCOME/(LOSS)	$8.66	($17.14)	$24.56	$7.42	**$8.61**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	3,394,099	123,700	123,700	123,700	3,517,799
REVENUE BY LOB	85.6%	2.8%	11.7%	14.4%	100.0%

Santa Clara Family Health Plan™

Appendices

Statement of Operations by Line of Business – Current Month

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For the Month June 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$92,777,745	$3,457,349	$17,493,343	$20,950,692	**$113,728,437**
MEDICAL EXPENSE	$81,991,071	$3,133,519	$17,408,764	$20,542,283	**$102,533,354**
(MLR)	88.4%	90.6%	99.5%	98.1%	90.2%
GROSS MARGIN	$10,786,674	$323,830	$84,579	$408,410	**$11,195,083**
ADMINISTRATIVE EXPENSE	$5,943,977	$221,501	$1,120,743	$1,342,245	**$7,286,221**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$4,842,697	$102,329	($1,036,164)	($933,835)	**$3,908,862**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$328,463	$12,240	$61,932	$74,172	**$402,635**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$5,171,160	$114,569	($974,232)	($859,663)	**$4,311,497**
PMPM (ALLOCATED BASIS)					
REVENUE	$313.39	$334.63	$1,693.12	$2,027.75	**$371.20**
MEDICAL EXPENSES	$276.95	$303.28	$1,684.94	$1,988.22	**$334.66**
GROSS MARGIN	$36.44	$31.34	$8.19	$39.53	**$36.54**
ADMINISTRATIVE EXPENSES	$20.08	$21.44	$108.47	$129.91	**$23.78**
OPERATING INCOME/(LOSS)	$16.36	$9.90	($100.29)	($90.38)	**$12.76**
OTHER INCOME/(EXPENSE)	$1.11	$1.18	$5.99	$7.18	**$1.31**
NET INCOME/(LOSS)	$17.47	$11.09	($94.29)	($83.20)	**$14.07**
ALLOCATION BASIS:					
MEMBER MONTHS	296,050	10,332	10,332	10,332	306,382
REVENUE BY LOB	81.6%	3.0%	15.4%	18.4%	100.0%

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD JULY - 2022

		2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	FYTD var	%
NON DUAL	Adult (over 19)	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	39,310	1,449	3.8%
	Child (under 19)	101,010	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	103,866	245	0.2%
	SPD	22,363	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	25,130	930	3.8%
	Adult Expansion	90,711	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	106,715	4,517	4.4%
	Long Term Care	414	408	401	391	385	392	391	403	395	393	397	398	412	14	3.5%
	Total Non-Duals	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**275,433**	**7,155**	**2.7%**
DUAL	Adult (over 21)	367	376	375	396	398	408	410	403	407	412	431	423	424	1	0.2%
	SPD	23,980	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	24,491	107	0.4%
	Long Term Care	1,127	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	1,159	11	1.0%
	SPD OE	1,063	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	1,868	51	2.8%
	Total Duals	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**27,942**	**170**	**0.6%**
	Total Medi-Cal	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**303,375**	**7,325**	**2.5%**
CMC	CMC Non-Long Term Care	9,939	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	10,146	19	0.2%
	CMC - Long Term Care	209	208	203	208	204	210	202	213	215	206	206	205	208	3	1.5%
	Total CMC	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**10,354**	**22**	**0.2%**
	Total Enrollment	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**313,729**	**7,347**	**2.4%**

Santa Clara County Health Authority
Board Designated Innovation Fund Modification Request

Organization Name:	FIRST 5 Santa Clara County (FIRST 5)
Project Name:	Integrated Behavioral Health Pilot Project
Contact Name and Title:	Jennifer Kelleher Cloyd, CEO, FIRST 5 Santa Clara County
Original Requested Amount:	$500,000 ($250,000 per year for two years)
Original Time Period:	July 1, 2021 – June 30, 2023
Proposal Originally Submitted to:	Governing Board, 06/24/2021

Summary of Original Request:

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 Request Modification:

- Project time period from July 1, 2021-June 30, 2023 to October 1,2021-September 30, 2023
- Initial cohort from 7-10 high volume primary clinics down to 3 clinics due to lack of interest and available resources at the clinics to divert to the program. However, program can still accommodate 7-10 clinics if interested. Outreach was made to Lucille Packard Children's Hospital for participation but there was no capacity to partner with the program.
- First payment of $250,000 was released on October 11, 2021. Remaining half would be released upon demonstrating sufficient progress in the report due August 31, 2022. FIRST 5 indicated that the funding request does not change with the reduction of sites because the majority of project costs are independent of number of clinics included. Per FIRST 5: "Most of the staff time reflected in the budget is for developing the Technical Assistant scope of service

and associated activities. The effort required to develop materials, tools, and services for the first site takes most of the staff time. Then the model was set up to scale."

- FIRST 5 has indicated that they may be open to other work related to dyadic services not included in the original proposal to assist SCFHP in preparation of the benefit's launch in January 2023. Potential activities offered include:
    - Opening up a portion of trainings that are developed and facilitated as part of the cohort to other provider groups
    - Providing high-level consultation to sites not in the cohort
    - Hosting monthly office hours
    - Converting cohort materials to publicly available materials
    - Conducting a limited number of "stakeholder engagement" meetings for clinics with an interest in implementing dyadic services
- This project's initial total two-year budget was $1,368,302; however, it was amended to $1,160,000. As of July 31, 2022, the project has so far expended $160,089 of the total two-year $1,160,000 funding.

Santa Clara Family Health Plan

FIRST 5 Santa Clara County
Funding Request Modification to Santa Clara Family Health Plan (SCFHP)
For Integrated Behavioral Health Program

Follow-up questions from SCFHP

1. Initial funding was for 7-10 sites. The revised proposal has up to 3 only. Why does the funding amount requested remain the same with this reduction?

Most of the staff time reflected in the budget is for developing the TA scope of service and associated activities. The effort required to develop materials, tools, and services for the first site takes most of the staff time that was budgeted into our contract. Then, the model was set up to scale what was developed initially to additional sites. In the original proposed cohort structure, the initial development was intended to benefit 7-10 clinics. However, it is essentially the same amount of effort to deliver this to three clinics due to the initial investment required to develop the TA. Put more simply, the cost of supporting 7-10 sites is not much more than supporting 1-3 sites, which is why the cohort model was proposed to be able to scale to as many clinics as possible.

Examples of this include the time it takes to develop workflows, TA services templates (e.g., implementation plan), resources (e.g., billing guides and workflows), trainings is the same whether it is delivered to one site or 10 sites. The implementation of trainings is also the same, as UCSF had planned to deliver them to a cohort of clinics, not individually to clinics. Similarly, consultation groups with clinicians were going to be done as a group.

The area where UCSF is spending less time and effort, due to having a smaller cohort, is only in the area of reduction in monthly meetings for each site (7-10 clinics = 7-10 hours per month vs. 3-4 clinics = 3-4 hours per month in the original proposed model). According to the originally proposed model of 7-10 clinics, this means that UCSF is working 4-7 hours less per month with some added reduction in hours for the administrative efforts required in planning and follow-up for onsite meetings.

However, in order to ensure they are meeting the contracted commitment, UCSF has increased the intensity of TA (and number of meetings and between meetings contacts) to Tully to offset time we would have been spending with other sites. We believe these higher intensity supports will be an important investment that will allow VHC to scale the Tully model to other sites in their system much more independently. UCSF will take the same approach with the two additional sites. We have included snapshot of contacts we have had with Tully/VHC to demonstrate this increased intensity of TA supports through June and will include more detail in our August report.

Santa Clara Family Health Plan

Date	Participants	Purpose
4/14/22	Catherine Cummins Supriya Rao Julie Ho Mallory Andersen UCSF FIRST 5	Discuss Plan to Launch Tully. Discuss questions with HealthySteps Model and Clarify VHC Project Goals. (TA Implementation Support)
4/20/22	Mallory Andersen Jodi Pinn	Discuss HealthySteps and VHC PCBH Alignment
	UCSF	(TA Implementation Support)
4/25/22	Mallory Andersen Jodi Pinn UCSF/CCT	Discuss Billing for HealthySteps at VHC PCBH (TA Implementation Support)
5/2/22	Jodi Pinn Michelle de la Calle Jennifer Foreman Supriya Rao UCSF/CCT FIRST 5	Discuss HealthySteps and VHC Alignment Discuss Staffing Allocations Needed (TA Implementation Support) Outcome: Launch Tully with HealthySteps Model
5/6/22	Jennifer Foreman Supriya Rao UCSF	Discuss Pediatrics questions about HealthySteps Implementation (TA Implementation Support)
5/9/22	Catherine Cummins Julie Ho Mallory Andersen Philbert Espejo Sally Lawrence Supriya Rao UCSF FIRST 5	SCC Resource Link/Aunt Bertha Demo (TA Implementation Support)
6/8/22	Mallory Andersen Jodi Pinn UCSF FIRST 5	Plan for 6/13/22 Tully Kickoff Meeting
6/13/22	Tully Clinical Implementation Team Systems Implementation Team UCSF FIRST 5	VHC Tully Kickoff Implementation Meeting at Tully HC
6/23/22	Amy Huffer (HealthySteps) Mallory Andersen UCSF	Meeting with HealthySteps National Office and VHC Tully to begin HealthySteps Onboarding

6/29/22	Tully Clinical Implementation Team UCSF	2nd Implementation Planning Meeting with Tully
7/13/22	Systems Implementation Team UCSF	Meet with VHC Billing Services Team to discuss billing and reimbursement workflows
7/14/22	Systems Implementation Team UCSF	Open Office Hours for Implementation Q&A
7/14/22	Tully Clinical Implementation Team UCSF	Implementation Planning Meeting
7/21/22	VHC Systems Implementation Team UCSF	2nd Billing/Reimbursement Workflow meeting with VHC billing services & key project stakeholders
7/26/22	Tully LCSW & Clinical Implementation Team Members UCSF	Clinical training meeting with direct service providers to implement model
7/28/22	Tully Clinical Implementation Team HealthySteps National Office UCSF	2nd HealthySteps Onboarding meeting (To review Goodness of Fit assessment)

In addition to the fact that most of the time investment is up front, UCSF has adjusted allocation of time to staffing. Some staff that were originally budgeted 100% on the contract for the early months have had their FTE effort distributed to other projects. This will shift resources now to allow for more intensive support later in the grant period when more sites are participating. This will be reflected in the August Budget to Actuals report. Unspent funds now will be spent on staff time later in the grant period.

a. **Please reach out to PAMF and BACH as potential sites**

FIRST 5 can reach out to Bay Area Community Health, we know their Clinical Director, Dr. Seshadri. In the last meeting we discussed that the pediatric volume for PAMF is low and that it may not make the most sense to include them as a pilot site. Would you still like us to reach out to them? If so, do you have a contact at PAMF you could share to make a connection?

2. SCFHP will be launching dyadic benefits Jan 2023, can the project pivot to include below given the reduction in sites

a. **Assess SCFHP's Network Providers' capacity (content, number, and staffing) with regards to providing this service**

Please see attached summary of the data SCFHP provided to UCSF that focused on the clinics we are targeting (at this time) for recruitment into the pilot. UCSF can do some additional data analysis if the data is provided to us. Additionally, they are able inform questions for a landscape assessment but would not be able to administer the assessments. Depending on the detail needed, UCSF is open to discussing what this would look like and how we could dedicate resource to it.

b. **Develop recommendations on how to increase provider capacity**

UCSF will be doing this for our cohort sites and will be able to share materials that are created for this purpose with sites that are not participating.

c. **Develop and conduct trainings for SCFHP Network Providers on the service**

UCSF can open up a portion of trainings that are developed and facilitated as part of the cohort to other providers groups.

d. **Provide TA for the provider network until project end date in Oct 2023**

UCSF could likely provide some high-level consultation to sites not participating via a mechanism, such as monthly open office hours for Q&A on implementation of dyadic services, for example.

Additional ways UCSF could expand their reach:

- Open office hours for drop-in consultation on a monthly basis
- Convert materials we create and share with the cohort to publicly available materials that can be shared with other providers.
- Conduct a limited number of "stakeholder engagement" meetings for clinics who are exploring implementing dyadic services but who need help engaging their leadership and getting buy-in and resources to dedicate to the initiative.

Regular Meeting of the

Santa Clara County Health Authority
Compliance Committee

Wednesday, August 31, 2022, 2:00 PM – 3:00 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Sue Murphy, Chair
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, DO, Chief Medical Officer
Chris Turner, Chief Operating Officer
Chelsea Byom, VP, Marketing, Communications & Outreach
Ngoc Bui-Tong, VP, Strategies & Analytics
Teresa Chapman, VP, Human Resources
Tyler Haskell, Interim Compliance Officer

Members Absent
Jonathan Tamayo, Chief Information Officer

Staff Present
Daniel Quan, Director, Compliance, Compliance
Anna Vuong, Manager, Compliance, Compliance
Ashley Kerner, Manager, Administrative Services
Alicia Zhao, Compliance Audit Program Manager, Compliance
Alejandro Rodriguez, Compliance Analyst, Compliance
Megha Shah, Compliance Analyst, Compliance
Sue Won, Compliance Audit Program Manager, Compliance
Amy O'Brien, Administrative Assistant

1. Roll Call
Sue Murphy, Chair, called the meeting to order at 2:00 PM. Roll call was taken and a quorum was established

2. Public Comment
There were no public comments.

3. Meeting Minutes
Ms. Murphy reviewed the May 26, 2022 Compliance Committee minutes.

It was moved, seconded, and the May 26, 2022 Compliance Committee minutes were unanimously approved.

Motion: Mr. Haskell
Second: Mr. Jarecki
Ayes: Ms. Murphy, Ms. Tomcala, Mr. Jarecki, Ms. Nakahira, Ms. Turner, Ms. Byom, Ms. Bui-Tong, Ms. Chapman, Mr. Haskell
Absent: Mr. Tamayo

4. Compliance Activity Report

Tyler Haskell, Interim Compliance Officer discussed the status of regulatory audits, related corrective action plans, and other compliance issues.

Mr. Haskell stated the Compliance Department has been preparing for the onsite Department of Managed Health Care (DMHC) routine survey, scheduled for October, 2022.

Mr. Haskell reported on the conclusion of the triennial DMHC financial audit resulting in no deficiencies.

Mr. Haskell shared the Plan has not yet received a written preliminary report from the annual Department of Health Care Services (DHCS) audit.

Mr. Haskell informed the members that the Compliance Department has prepared the first set of DHCS 2024 contract readiness documents.

Mr. Haskell shared the annual Medicare data validation audit has concluded, with the Advent team submitting a 100% validation for the Plan to the U.S. Centers for Medicare & Medicaid Services (CMS) in July.

Mr. Haskell concluded his report by stating the Plan has partnered with Health Alliance Plan (HAP) of Michigan to conduct a peer review Compliance Program Audit. The audit started in August and a preliminary audit report is expected by early September 2022.

5. Oversight Activity Report

Daniel Quan, Director, Compliance reviewed the FY 2021 – 2022 compliance dashboard, oversight audits and corrective action plans.

Mr. Quan, shared the Plan is at 90.2% for recorded metrics, with 958 of 1,062 measures being compliant with, the fiscal year goal of reaching 95%.

Mr. Quan highlighted the Medi-Cal (MC) and Cal MediConnect (CMC) claims metrics and a discussion ensured regarding the historically low percentage for Initial Health Assessments (IHAs) completed within 120 calendar days of enrollment. Ms. Nakahira outlined the barriers to scheduling appointments and Tyler indicated the reoccurring issue of providers not completing the required paperwork.

Mr. Quan reported updates on the 2022 audit work plan status highlighting the cession of the external audit of the “Silver & Fit” program due to contract termination.

Mr. Quan presented the 2021 Valley Health Plan (VHP) Annual Audit noting there were 16 findings and 3 observations during the audit period, compared to 22 findings in previous years’ audit.

Mr. Quan provided a summary of corrective action plans noting there were 4 CAPs closed since last Compliance Committee meeting. He also highlighted a concern with incidents with member transportation with driver no shows. Mr. Haskell added the Plan would be monitoring transportation issues closely moving forward to avoid sanctioning by the State.

6. **Fraud, Waste, and Abuse Report**
Mr. Haskell, presented the Fraud, Waste, and Abuse Report activities and investigations.

Mr. Haskell shared there are a total of 28 reported leads for the year 2022 comprised from CMC, Medi-Cal, and CMC Medi-Cal. Mr. Haskell stated the majority of the reported leads came from Medi-Cal followed by CMC with the majority of the allegation sources originating from members for services not rendered.

Mr. Haskell concluded his presentation by sharing an updated chart of SCFHP open investigations.

7. **Health Insurance Portability and Accountability Act of 1996 (HIPAA) Policies**
Mr. Haskell reported on the annual review of HIPAA policies indicating routine updates were made to existing HIPAA policies.

It was moved, seconded, and the HIPAA policies were unanimously approved.

Motion:	Mr. Haskell
Second:	Ms. Bui-Tong
Ayes:	Ms. Murphy, Ms. Tomcala, Mr. Jarecki, Ms. Nakahira, Ms. Turner, Ms. Byom, Ms. Bui-Tong, Ms. Chapman, Mr. Haskell
Absent:	Mr. Tamayo

8. **Adjournment**
The meeting was adjourned at 2:50 PM.

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Sue Murphy, Secretary

Santa Clara Family Health Plan™

Compliance Dashboard

Governing Board Meeting - September 22, 2022

Santa Clara Family Health Plan

Compliance Summary 2021-2022

FY 2021-2022 PLAN FOCUS - At least 95% of Metrics on Compliance Dashboard in Compliance

Fiscal Year to Month: **Jun-22**

958 out of 1062 measures were compliant = **90.2%**

LOB	Category	2021						2022						FY to Date
		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
CMC (49 measures)	Met	40	43	44	41	33	36	39	35	37	42	40	41	471
	Monthly Count*	43	44	46	45	43	43	43	43	43	43	43	43	522
	% Met	93.0%	97.7%	95.7%	91.1%	76.7%	83.7%	90.7%	81.4%	86.0%	97.7%	93.0%	95.3%	90.2%
Medi-Cal (38 measures)	Met	29	31	32	31	25	29	30	29	30	31	29	28	354
	Monthly Count*	35	35	34	35	34	34	34	33	34	33	33	33	407
	% Met	82.9%	88.6%	94.1%	88.6%	73.5%	85.3%	88.2%	87.9%	88.2%	93.9%	87.9%	84.8%	87.0%
General Compliance (14 measures)	Met	11	11	11	11	11	12	11	11	11	11	11	11	133
	Monthly Count*	11	11	11	11	11	12	11	11	11	11	11	11	133
	% Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Combined (101 measures)	Met	80	85	87	83	69	77	80	75	78	84	80	80	958
	Monthly Count*	89	90	91	91	88	89	88	87	88	87	87	87	1,062
	% Met	89.9%	94.4%	95.6%	91.2%	78.4%	86.5%	90.9%	86.2%	88.6%	96.6%	92.0%	92.0%	90.2%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
CLAIMS					
Non-Contracted Providers					
Clean Claims from Non-Contracted Providers paid or denied within thirty (30) calendar days	95%	99.4%	98.5%	98.1%	98%
All Other Claims from Non-Contracted Providers or enrollees must be paid or denied within sixty (60) calendar days	100%	100.0%	100%	99.9%	99.8%
Contracted Providers					
Clean Claims from Contracted Practitioners paid or denied within thirty (30) calendar days	90%	100%	99.5%	99.2%	96%
Clean Claims from Contracted Providers paid or denied within ninety (90) calendar days	99%	99.9%	99.5%	98.9%	100%
CUSTOMER SERVICE					
Call Stats					
Member Queue					
Member Average Hold Time in Seconds	≤120 Seconds	40	40	39	49
Incoming calls that are answered within 30 seconds	80% in ≤30 sec	73.2%	79.2%	82.1%	74%
Disconnect Rate from CMS Quarterly Report (part C)	≤5%	0.0%	n/a	0.0%	n/a
ENROLLMENT					
Enrollment Materials					
New member materials mailed within 10 calendar days of receipt of enrollment confirmation on TRR or by last calendar day of the month prior to the effective date, whichever occurs later	100%	99.8%	99.8%	99.8%	99.7%
Out of Area Members					
% of compliance with member outreach process within 10 calendar days of notification of possible OOA for members	100%	100%	100%	100%	99.3%
FINANCE					
Monthly submission of encounter data	100%	100%	100%	100%	100%

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
CLAIMS					
All Claims					
Misdirected Claims forwarded within ten (10) working days	95%	91.4%	98.5%	95.2%	96.7%
Processed Claims that receive acknowledgement timely	95%	100.0%	99.9%	99.6%	99.9%
All Claims paid or denied to ALL providers within forty-five (45) working days	95%	99.8%	99.5%	99.2%	99.7%
Clean Claims					
Clean Claims paid or denied to Practitioner within thirty (30) calendar days	90%	99.8%	98.2%	96.5%	98.7%
Clean Claims paid or denied to All Providers within ninety (90) calendar days	95%	100.0%	100.0%	99.8%	100.0%
Provider Claim Dispute Requests					
Provider Disputes acknowledged within fifteen (15) working days	95%	99.0%	98.9%	99.3%	99.0%
Provider Disputes resolved within forty-five (45) working days/sixty-two (62) calendar days	95%	99.8%	100.0%	99.9%	100.0%
Overturned Cases					
Overturned Cases with check provided within five (5) working days	95%	99.7%	100.0%	98.8%	99.7%
CUSTOMER SERVICE					
Call Stats					
Member Queue					
Member calls that are answered in ≤ 10 minutes	100%	99.2%	99.1%	99.7%	99.0%
ENROLLMENT					
Enrollment Materials					
New member Information mailed within 7 calendar days of the effective date of member's enrollment, or within 7 calendar days of receipt of enrollment, if enrollment is retroactive	100%	100%	100%	100%	100%
New member ID mailed within 7 calendar days of the effective date of member's enrollment, or within 7 calendar days of receipt of enrollment, if enrollment is retroactive	100%	100%	100%	100%	100%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - CASE MANAGEMENT					
HRAs and ICPs					
Total ICP Completion	100%	98.0%	96.3%	99.7%	98.9%
Total HRA Completion	100%	100.0%	96.9%	99.7%	99.8%
Members with timely annual HRA completion	100%	89.6%	98.3%	85.2%	99.7%
HEALTH SERVICES - MEDIMPACT/PHARMACY					
Standard Part D Authorization Requests					
Standard Prior Authorization requests (part D) completed within seventy-two (72) hours of request	100%	100.0%	100.0%	100.0%	100.0%
Expedited Part D Authorization Requests					
Expedited Prior Authorization requests (part D) completed within twenty-four (24) hours of request	100%	100.0%	100.0%	100.0%	100.0%
Non Part D Drugs Authorization Requests					
Non Part D Drugs Prior Authorization completed within twenty-four (24) hours of request	100%	96.6%	100.0%	100.0%	100.0%
Call Monitoring					
Provider/Pharmacy Average Hold Time in Seconds	≤120 Seconds	14	7	17	19
Provider/Pharmacy Service Level	80% in ≤30 sec	85.0%	92.0%	87.3%	83.0%
Disconnect Rate	≤5%	0.5%	0.5%	0.0%	0.0%
HEALTH SERVICES - UTILIZATION MANAGEMENT					
Concurrent Organization Determinations					
Concurrent Review of Authorization Requests (part C) completed within five (5) working days of request	100%	99.8%	100.0%	99.6%	99.7%
Pre-Service Organization Determinations					
Standard Part C					
Standard Pre-Service Prior Authorization Requests (part C) completed within five (14) calendar days	100%	99.6%	99.4%	88.3%	98.8%

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - CASE MANAGEMENT					
HRAs and ICPs for SPDs					
Newly enrolled SPD members who were due for risk stratification and were statified timely during the reporting month	100%	100%	100%	100%	100%
Total High Risk SPD HRA Completion	100%	75.0%	100%	100%	100%
Total Low Risk SPD HRA Completion	100%	96.0%	75.0%	74.5%	100%
Total High Risk SPDs with ICP completion	100%	50.0%	100%	100%	100%
HEALTH SERVICES - PHARMACY					
Standard Authorization Request					
Standard Prior Authorization requests (RX) completed within twenty-four (24) hours	100%	99.5%	99.5%	n/a	n/a
Expedited Authorization Request					
Expedited Prior Authorization requests (RX) completed within twenty-four (24) hours of request.	100%	99.3%	99.0%	n/a	n/a
HEALTH SERVICES - QUALITY					
Facility Site Reviews and Initial Health Assessment					
Annual Managed Care Division Facility Site Reviews/Physical-Accessibility Report submitted by Aug 1 each year	100%	100%	n/a	n/a	n/a
IHAs completed within 120 calendar days of enrollment	100%	44.6%	47.5%	45.2%	38.6%
HEALTH SERVICES - UTILIZATION MANAGEMENT					
Medical Authorizations					
Conncurrent Review					
Concurrent Review of Authorization Requests completed within 5 working days of request	100%	99.0%	99.8%	99.1%	99.6%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - UTILIZATION MANAGEMENT (cont.)					
Pre-Service Organization Determinations (cont.)					
Expedited Part C					
% of Expedited Pre-Service Prior Authorization Requests (part C) completed within sevety-two (72) hours	100%	99.3%	98.9%	87.6&%	96.0%
Post Service Organization Determinations					
Retrospective Requests (part C) completed within thirty (30) calendar days	100%	99.6%	99.4%	93.6%	99.6%
Part B Drugs Organization Determinations					
Standard Prior Authorization Requests (part B drugs) completed within seventy-two (72) hours of request	100%	100.0%	98.4%	87.2%	100.0%
Expedited Prior Authorization requests (part B drugs) completed within twenty-four (24) hours of request	100%	100.0%	92.0%	89.3%	100.0%

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
HEALTH SERVICES - UTILIZATION MANAGEMENT (cont.)					
Medical Authorizations (cont.)					
Routine Authorizations					
Routine Prior Authorization Requests completed within five (5) working days of request	100%	99.6%	99.4%	98.9%	99.0%
Expedited Authorizations					
Expedited Prior Authorization Requests completed within seventy-two (72) hours of request	100%	99.8%	99.8%	99.5%	99.7%
Retrospective Review					
Retrospective Requests completed within thirty (30) calendar days of request	100%	100.0%	99.8%	99.5%	99.9%
Member Notification of UM Decision					
Member Notification of UM decision in writing within two (2) working days of the decision.	100%	99.5%	99.3%	99.5%	99.3%
Provider Notification of UM Decision					
Provider Notification of UM decision by phone, fax or electronic mail and then in writing within 24 hours of making the decision	100%	97.9%	98.2%	98.9%	98.4%

GRIEVANCE & APPEALS					
Grievances, Part C	**Goal**				
Standard Grievances Part C					
Standard Grievances (Part C) that provided Acknowledgment Letters within five (5) calendar days	100%	98%	95.5%	99.4%	99.3%
Standard Grievances (Part C) that provided Resolution Letters within thirty day calendar (30) days	100%	99.6%	99.4%	99.5%	100%
Expedited Grievances Part C					
Expedited Grievances (Part C) that provided Verbal or Written Resolution within twenty-four (24) hours	100%	100%	100%	100%	100%
Grievances, Part D					
Standard Grievance Part D					
Standard Grievances (Part D) that provided Acknowledgment Letters within five (5) calendar days	100%	100%	100%	100%	100%
Standard Grievances (Part D) that provided Resolution Letters within thirty (30) calendar days	100%	100%	100%	100%	100%
Expedited Grievance Part D					
Expedited Grievances (Part D) provided Verbal OR Written Resolution within twenty-four (24) hours	100%	100%	100%	100%	100%
Reconsiderations, Part C					
Standard Pre-Service Part C					
Standard Pre-Service Reconsiderations (Part C) that provided Acknowledgment Letters within five (5) calendar days	100%	100%	91.4%	92.6%	96.9%
Standard Pre-Service Reconsiderations (part C) that provided Resolution Letters within thirty (30) calendar days	100%	100%	100%	100%	100%
Standard Post-Service Part C					
Standard Post-Service Reconsiderations resolved within 60 days	100%	100%	92.9%	98.5%	98.3%

GRIEVANCE & APPEALS					
Grievances					
Standard Grievances					
Standard Grievances that provided Acknowledgement Letters within five (5) calendar days	100%	97.9%	95.1%	98.5%	98.4%
Standard Grievances that provided Resolution Letters within thirty (30) calendar days	100%	99.4%	98.9%	100.0%	99.9%
Expedited Grievances					
Expedited Grievances that provided Verbal AND Written Notifications within seventy-two (72) hours	100%	100.0%	100.0%	94.4%	89.3%
Appeals					
Standard Appeals					
Standard Appeals that provided Acknowledgement Letters within five (5) calendar days	100%	97.3%	93.0%	95.0%	95.7%
Standard Appeals that provided Resolution Letters within thirty (30) calendar days	100%	99.5%	94.7%	100.0%	99.1%
Expedited Appeals					
Expedited Appeals that provided Verbal AND Written Notifications within seventy-two (72) hours	100%	100.0%	85.7%	92.9%	100.0%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GRIEVANCE & APPEALS (cont.)					
Reconsiderations, Part C (cont.)					
Expedited Pre-Service Part C/Part B Drug					
Expedited Reconsiderations (part C) that provided Verbal AND Written Resolution within seventy-two (72) hours	100%	100%	100%	100%	100%
Expedited Pre-Service Part C/Part B Drug (cont.)					
Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	100%	100%	100%	100%
Appeals, Part B					
Part B Drug Appeals that provided Verbal OR Written Resolution within seven (7) calendar days	100%	100%	100%	50%	100%
Redeterminations, Part D					
Standard Part D					
% of Standard Redeterminations (part D) that provided Resolution Letters within seven (7) calendar days	100%	100%	95.7%	100%	100%
Expedited Part D					
Expedited Redeterminations (part D) that provided Verbal AND Written Resolution within seventy-two (72) hours	100%	100%	100%	100%	100%
Untimely Expedited Redeterminations (part D) submitted to IRE within twenty-four (24) hours of decision	100%	100%	100%	100%	100%
Direct Member Reimbursement Redeterminations (Part D) resolved within fourteen (14) calendar days	100%	100%	100%	100%	100%
Complaint Tracking Module (CTM) Complaints					
CTM Conplaints Resolved Timely	100%	100%	100%	100%	100%
MARKETING					
Required Materials posted to the Plan's website by the first of each month	100%	100%	100%	100%	100%
Required Member Materials posted to the Plan's website by October 15 each year	100%	n/a	100%	n/a	n/a
Annual member materials distributed or notified by October 15 each year	100%	n/a	100%	n/a	n/a
MEDICARE OUTREACH					
Annual Medicare Communications & Marketing Guidelines training completed by September 30 each year	100%	100%	n/a	n/a	n/a
PROVIDER NETWORK MANAGEMENT					
PROVIDER DATABASE & REPORTING					
Provider Directories updated monthly by the first day of the month	100%	100%	100%	100%	100%
Annual Health Service Delivery Tables submitted by September 30 of each year	100%	100%	n/a	n/a	n/a

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GRIEVANCE & APPEALS					
MARKETING					
Training and certification for Marketing Representatives completed timely	100%	100%	100%	100%	100%
Medi-Cal Provider Directory posted on the Plan's website by the first of the month	100%	100%	100%	100%	100%
INFORMATION TECHNOLOGY					
Encounter Files Successfully Submitted to DHCS by end of month	100%	100%	100%	100%	100%
Monthly Eligibility Files successfully submitted to Delegates Timely	100%	100%	100%	100%	100%
PROVIDER NETWORK MANAGEMENT					
PROVIDER NETWORK RELATIONS					
% of New Providers who received orientation within ten (10) working days after being placed on active status	100%	100%	100%	100%	100%
PROVIDER NETWORK ACCESS & DATABASE					
Annual Network Certification submitted by March 31 of each year	100%	n/a	n/a	n/a	n/a
Timely Access Compliance Report submitted by March 31 of each year	100%	n/a	n/a	0%	n/a

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan.

Compliance Summary 2021-2022

Cal MediConnect

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GENERAL COMPLIANCE					
Exclusion Screenings					
Individual Exclusion Screening					
New Eligible Individuals screened prior to start date	100%	100%	100%	100%	100%
Eligible Individuals who are screened monthly	100%	100%	100%	100%	100%
FDR Exclusion Screening					
Initial Exclusion Screening Completed for FDRs prior to contracting	100%	100%	100%	100%	100%
Monthly Exclusion Screening Completed for existing FDRs	100%	100%	100%	100%	100%
Provider Monthly Screenings					
Monthly Exclusion Screening completed for the Plan's Contracted Providers	100%	100%	100%	100%	100%
Monthly Exclusion Screening completed for Non-Contracted Providers	100%	100%	100%	100%	100%
Compliance Training					
New Eligible Employees completed trainings within ninety (90) days of initial hiring (SCFHP's operational standard = 5 working days)	100%	100%	100%	100%	100%
Annual Employee Training completed within sixty (60) calendar days of issuance	100%	n/a	100%	n/a	n/a
Annual Board Training completed within sixty (60) calendar days of issuance	100%	n/a	n/a	100%	n/a
Standards Of Conduct And Compliance Policies					
New Eligible Employees receive Standards of Conduct and P&Ps within five (5) working days of initial hiring	100%	100%	100%	100%	100%
Current Employees receive Standards of Conduct and Compliance P&Ps annually	100%	n/a	100%	n/a	n/a

Medi-Cal

Measure	Goal	Q3-21	Q4-21	Q1-22	Q2-22
GENERAL COMPLIANCE					
Personnel Filings					
Key Personnel filings completed within five (5) calendar days of effective date	100%	100%	100%	100%	100%
Department Of Fair Employment & Housing Training					
Employees who complete the CA harassment training course once every two years	100%	n/a	n/a	n/a	n/a
Temporary Employees completed the CA harassment training within 30 calendar days from start date or 100 hours of work	100%	100%	100%	100%	100%

Yellow = at least 98% for measures with a goal of 100%

Santa Clara Family Health Plan™

Annual Review of HIPAA Policies
September 22, 2022

Policy No.	Policy Title	Changes
HI.01 v2	Privacy Officer Assignment and Responsibilities	Revised
HI.02 v2	Privacy Training Requirements	Revised
HI.03 v2	Minimum Necessary Standards	Revised
HI.06 v3	Request for Access	Revised
HI.07 v3	Amendments to Protected Health Information	Revised
HI.08 v2	Accounting of Disclosures	Revised
HI.10 v3	Uses by and Disclosures to Business Associates and Third Parties	Revised
HI.11 v3	De-Identification of Health Information	Revised
HI.12 v3	Uses and Disclosures of Limited Data Sets	Revised
HI.13 v2	Requests for Restrictions on Uses and Disclosures	Revised
HI.14 v2	Request for Confidential Communications	Revised
HI.16 v2	Reporting and Responding to Privacy Complaints	Revised
HI.18 v2	Safeguards	Revised
HI.19 v3	Notice of Privacy Practices	Revised
HI.20 v3	Personal Representatives	Revised
HI.22 v2	Individual Caller Identification	Revised
HI.24 v2	Communications with Minors	Revised
HI.25 v2	Leaving Message with PHI	Revised
HI.26 v2	Uses and Disclosures of Protected Health Informaiton	Revised
HI.46 v2	Photographing, Video Recording, Audio Recording and Other Imaging	Revised
HI.51 v2	Breach Notification Requirements	Revised

POLICY

Policy Title:	**Privacy Officer Assignment and Responsibilities**	**Policy No.:**	HI.01 ~~v1~~ v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC D-SNP~~Medicare	

I. Purpose

To assure the assignment of a Privacy Officer for the purpose of overseeing Santa Clara Family Health Plan's (SCFHP) obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and the HIPAA Regulations.

II. Policy

SCFHP assigns a Privacy Officer responsible for all SCFHP's privacy matters including Privacy and Breach Notification Policies and Procedures and for assuring that all SCFHP's workforce members comply with such requirements.

III. Responsibilities

All SCFHP Employees, Temporary Staff, and Consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530
Omnibus Final Rule

Santa Clara Family Health Plan

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~ Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim ~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised ~~2022~~	Compliance Committee		

POLICY

Policy Title:	**Privacy Training Requirements**	**Policy No.:**	HI.02 ~~v1~~v2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define Santa Clara Family Health Plan (SCFHP) privacy training requirements for SCFHP staff, temporary help, consultants, providers/delegates and vendors in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to ensure appropriate privacy training for all SCFHP staff, temporary help, consultants, providers/delegates and vendors to assure that they understand the privacy requirements established under state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(b)
Omnibus Final Rule

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim ~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Minimum Necessary Standards**	**Policy No.:**	HI.03 v3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which the minimum necessary amount of Protected Health Information (PHI) will be used, disclosed or requested in accordance with state and federal privacy laws and the HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI by developing and implementing policies and procedures to reasonably limit used, disclosures and requests of PHI to the minimum necessary to carry out the purpose of the use, disclosure, or request.

III. Responsibilities

All SCFHP employees, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(b)
45 C.F.R. §164.514(d)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	~~Jordan Yamashita~~Daniel Quan	~~Robin Larmer~~Tyler Haskell

Santa Clara Family Health Plan™

POLICY

Compliance Manager	Compliance Director ~~& Privacy Officer~~	Interim ~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer
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)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**Request for Access**	**Policy No.:**	HI.06 v~~2~~3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which an individual is entitled to inspect and obtain copies of their Protected Health Information (PHI) maintained by Santa Clara Family Health Plan (SCFHP) and how SCFHP will respond to requests for access in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow individuals to inspect and obtain copies of their PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.524
Omnibus Final Rule

Santa Clara Family Health Plan

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**Amendments to Protected Health Information**	**Policy No.:**	HI.07 v~~2~~3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which an individual is entitled to amend their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will respond to, and implement, amendment requests in accordance with state and federal privacy laws, and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow amendments to be made to an individual's PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.526
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~	~~Robin Larmer~~Tyler Haskell Interim ~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer

POLICY

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)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised 2022	Compliance Committee		

POLICY

Policy Title:	**Accounting of Disclosures**	**Policy No.:**	HI.08 v~~1~~2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which an individual may obtain an Accounting of Disclosures of their Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to provide an Accounting of Disclosures of an individual's PHI when requested by the individual in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.528
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~	~~Robin Larmer~~Tyler Haskell Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer

Santa Clara Family Health Plan™

POLICY

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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised ~~2022~~	Compliance Committee		

POLICY

Policy Title:	**Uses by and Disclosures to Business Associates and Third Parties**	**Policy No.:**	HI.10 v~~2~~3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC/D SNP~~Medicare	

I. Purpose

To define the relationship and respective commitments, responsibilities and obligations of Santa Clara Family Health Plan (SCFHP) and any Business Associates of SCFHP who use or disclose Protected Health Information (PHI) on behalf of SCFHP in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to require Business Associates and other third parties who use or disclose PHI on behalf of SCFHP to provide satisfactory assurance that they will protect PHI which will be documented through a written Business Associate Agreement or other agreement that meets the requirements of state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §160.103
45 C.F.R. §164.500(a) and (c)
45 C.F.R. §164.502(a), (b) and (e)
45 C.F.R. § 164.504(e)
45 C.F.R. §164.532(a), (b) and (d)
Omnibus Final Rule

V. Approval/Revision History

POLICY

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim ~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**De-Identification of Health Information**	**Policy No.:**	HI.11 v~~2~~3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~ Medicare	

I. Purpose

The define the circumstances under which Santa Clara Family Health Plan (SCFHP) may create and use or disclose De-identified Health Information in accordance with state and federal laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to ensure that any De-identified Health Information used or disclosed on its behalf meets the requirements of this policy and is in accordance with state and federal privacy laws and HIPAA Regulations. When reasonably practical, SCFHP will use and disclose de-identified health information, rather than Protected Health Information (PHI).

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.502(d)
45 C.F.R. §164.514
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	~~Jordan Yamashita~~Daniel Quan	~~Robin Larmer~~Tyler Haskell

POLICY

Compliance Manager Date	Compliance Director ~~& Privacy Officer~~ Date	Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**Uses and Disclosures of Limited Data Sets**	**Policy No.:**	HI.12 v~~2~~3
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define how Santa Clara Family Health Plan (SCFHP) may create and use disclosure Limited Data Sets as set forth in this policy and in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to use and disclose Limited Data Sets for Research, public health, and Health Care Operations in accordance with state and federal privacy laws and HIPAA Regulations.

SCFHP will only use or disclose a Limited Data Set if SCFHP obtains satisfactory assurance in the form of a Data Use Agreement or Business Associate Agreement, that the recipient will only use or disclose the Protected Health Information (PHI) for limited purposes.

III. Responsibilities

All SCFHP staff, temporary help, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(e)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**Requests for Restrictions on Uses and Disclosures**	**Policy No.:**	HI.13 v~~1~~2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which an individual has the right to request restrictions on uses or disclosures of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will consider and implement restriction requests in accordance with state and federal laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to consider requested restrictions on the use or disclosure of an individual's PHI and, if those restrictions are approved, to comply with the individual's request in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.522(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	~~Jordan Yamashita~~Daniel Quan	~~Robin Larmer~~Tyler Haskell

POLICY

Compliance Manager Date	Compliance Director ~~& Privacy Officer~~ Date	Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Request for Confidential Communications**	**Policy No.:**	HI.14 v~~1~~2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which an individual has the right to request changes in the method of communications of their Protected Health Information (PHI) and how Santa Clara Family Health Plan (SCFHP) will grant and implement confidential communication requests in accordance with state and federal privacy laws and HIPAA.

II. Policy

A. It is the SCFHP policy to permit individuals to request that communications of protected health information for sensitive services be directed to alternative locations or delivered by alternative means.

B. As a Health Plan, SCFHP must accommodate reasonable requests to receive communications of PHI for sensitive services from the Health Plan by alternative means or at alternative locations~~, if the individual clearly states that the disclosure of all or part of that information could endanger the individual~~.

~~B.~~C. SCFHP shall communicate directly with the individual for communications related to PHI, including sensitive services, by naming and addressing the individual directly.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.522(b)
Omnibus Final Rule
Civil Code sections 56.05, 56.35, and 56.107

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Reporting and Responding to Privacy Complaints**	**Policy No.:**	HI.16 v~~1~~2
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMCD SNP~~Medicare	

I. Purpose

To define the circumstances under which Santa Clara Family Health Plan (SCFHP) accepts and responds to concerns or complaints by individuals regarding SCFP's Privacy Policies or Procedures or privacy practices in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to allow and encourage individuals to express concerns and complaints regarding SCFHP's Privacy Policies or Procedures or privacy practices and to respond to such concerns and complaints in a timely and appropriate manner. SCFHP shall not retaliate against individuals who exercise their privacy rights and shall not require individuals to waive such rights as a condition to receiving treatment, payment, enrollment in a program, or eligibility for covered benefits.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530~~(a) and (d)~~
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~	~~Robin Larmer~~Tyler Haskell Interim~~Chief~~ Compliance ~~& Regulatory Affairs~~ Officer
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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Safeguards**	**Policy No.:**	HI.18 v21
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC~~Medicare	

I. Purpose

To establish workplace controls required of all Santa Clara Family Health Plan's (SCFHP) staff, temporary staff, consultants, providers/delegates and vendors so as to ensure adherence to privacy requirements in keeping with SCFHP's obligations to maintain the privacy or Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to ensure that reasonable safeguards are implemented, that all staff, temporary help, consultants, providers/delegates and vendors are trained on and follow documented policies and procedures to prevent intentional or unintentional, impermissible use or disclosure of PHI in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary staff, consultants, providers/delegates and vendors must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.530(c)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong ~~Compliance~~ Manager, Medi-Cal Compliance **Date**	~~Jordan Yamashita~~Daniel Quan ~~Compliance Director & Privacy Officer~~Director, Compliance Date	~~Robin Larmer~~Tyler Haskell ~~Chief~~ [Interim] Compliance ~~& Regulatory Affairs~~ & Privacy ~~Officer~~ 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	Compliance Committee	Approved 03/02/2022	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Notice of Privacy Practices**	**Policy No.:**	HI.19 v3~~2~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC~~Medicare	

I. Purpose

To ensure that Santa Clara Family Health Plan (SCFHP) adopts and implements Notices of Privacy Practices that meets the requirements of the HIPAA Privacy Rule.

II. Policy

It is the policy of SCFHP to ensure that appropriate individuals, at appropriate time, are provided with a Notice of Privacy Practices that describes how SCFHP may use and disclose their Protected Health Information (PHI), their rights with respect to PHI and the legal obligations of SCFHP and that meets the requirements of the HIPAA Privacy Rule.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.520
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	~~Jordan Yamashita~~ Daniel Quan Compliance Director ~~& Privacy~~	~~Robin Larmer~~Tyler Haskell ~~Chief~~ [Interim] Compliance & ~~Regulatory~~

POLICY

	~~Officer~~	~~Affairs~~ Privacy Officer
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)
v2	Revised	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v3	Revised	Compliance Committee		

POLICY

Policy Title:	**Personal Representatives**	**Policy No.:**	HI.20 v3~~2~~
Replaces Policy Title (if applicable):	~~P&P for Health Information Privacy~~	**Replaces Policy No. (if applicable):**	~~CP.20~~
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC~~Medicare	

I. Purpose

To define the methods by which Santa Clara Family Health Plan (SCFHP) will receive and handle requests from an individuals to treat persons as Personal Representatives of individuals in keeping with SCFHP's obligations to maintain the privacy of Protected Health Information (PHI) in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to comply with requests for designation of Personal Representative by an individual and to allow the Personal Representative to exercise privacy rights on behalf of the individual when authorized by the individual or when the individual is not able to do so personally, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

A. All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong	~~Jordan Yamashita~~Daniel Quan	~~Robin Larmer~~Tyler Haskell

POLICY

Compliance Manager Date	Compliance Director ~~& Privacy Officer~~ Date	~~Chief~~ Interim Compliance ~~& Regulatory Affairs~~ Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	Revised	Compliance Committee	Approved 3/2/2020	Ratify 3/26/2020
V3	Reviewed	Compliance Committee		

POLICY

Policy Title:	**Individual Caller Identification**	**Policy No.:**	HI.22 v2~~1~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒~~CMC~~ Medicare	

I. Purpose

To describe a process for verifying the authority and identity of a caller requesting ~~-~~Protected Health Information (PHI) of an individual prior to disclosing it, in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and to verify the authority and identity of callers requesting PHI prior to disclosing it, in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary ~~help~~staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.514(h)(1) and (2)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager	~~Jordan Yamashita~~Daniel Quan ~~Compliance Director &~~	~~Robin Larmer~~Tyler Haskell ~~Chief~~ [Interim] Compliance ~~& Regulatory~~

POLICY

Date	~~Privacy~~Director, Compliance ~~Officer~~ Date	~~Affairs~~and Privacy Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Communications with Minors**	**Policy No.:**	HI.24 v21
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ CMCMedicare	

I. Purpose

To describe the process for Santa Clara Family Health Plan's (SCFHP) staff, temporary helpstaff, and consultants to provide services to individuals who are Minors and unable to make health care decisions (as determined by the laws of the state where the individual resides), in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to provide services to individuals who are Minors and unable to make their own health care decisions in accordance with state and federal privacy laws and HIPAA Regulations.

SCFHP shall not require a minor member to obtain parental or authorized representative authorization to receive sensitive services or to submit a claim for sensitive services if the minor legally has the right to consent to care.

SCFHP shall direct, protect, and accommodate confidential communication requests from minors related to their health information on sensitive services that the minor legally has the right to consent to

III. Responsibilities

All SCFHP staff, temporary helpstaff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

Cal. Bus. & Prof. Code § 2397
Cal. Family Code § 6922(a)
Cal. Family Code §§ 6925 – 6928
Cal. Family Code §6929(b)

Cal. Penal Code§ 11171.2
Cal. Family Code § 7050(e)
45 C.F.R. §164.502(g)
Omnibus Final Rule
DHCS Contract (Exhibit A, Attachment 9, Section D)
Civil Code sections 56.05, 56.35, and 56.107

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell ~~Chief~~ [Interim] Compliance & ~~Regulatory Affairs~~Privacy Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
v2	Revised	Compliance Committee		

POLICY

Policy Title:	~~**Permission to**~~ **Leave~~e~~ing Message with PHI**	**Policy No.:**	HI.25 v2~~1~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMC/ D-SNP~~Medicare	

I. Purpose

To protect an individual's confidentiality and privacy when ~~Protected Health Information (PHI) is recorded~~ leaving a message on an approved telephone answering machine, voice mail, or is provided to a caregiver designated by the individual in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of Santa Clara Family Health Plan (SCFHP) to protect PHI and individual confidentiality and privacy by not leaving PHI on messaging services, answering machine, voicemails or through another person~~caregivers~~, unless authorized and ~~only as designated, and~~ consented to by the individual and in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include written warning, suspension, or termination.

IV. References

45 C.F.R. §164.508(a)
45 C.F.R. §164.522(a) and (b)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

POLICY

Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell ~~Chief~~ Interim Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
~~V~~v2	Revised	Compliance Committee		

POLICY

Policy Title:	**Uses and Disclosures ~~for Treatment Purposes~~of Protected Health Information**	**Policy No.:**	HI.26 v2~~1~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	HI. 05, HI. 09, HI. 21, HI. 23, HI.~~27~~ 27 ~~–~~ HI. 48
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMC/D-SNP~~Medicare	

I. Purpose

To describe the circumstances under which Santa Clara Family Health Plan (SCFHP) will use or disclose Protected Health Information (PHI) ~~for Treatment purposes~~ in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to protect PHI and to use and disclose PHI only for Treatment, Payment, and Health Care Operation purposes in accordance with state and federal privacy laws and HIPAA Regulations.

All other use and disclosure of PHI may require authorization from the protected individual in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary ~~help~~staff, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include, but not limited to, written warning, suspension, or termination.

IV. References

45 C.F.R. §164.500 - §164.534~~1~~
~~45 C.F.R. §164.502(a)~~
~~45 C.F.R. §164.506~~
~~45 C.F.R. §164.508~~
~~45 C.F.R. §164.522~~
Omnibus Final Rule

V. Approval/Revision History

Santa Clara Family Health Plan

POLICY

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell ~~Chief~~ Interim Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
V2	Revised	Compliance Committee		

POLICY

Policy Title:	**Photographing, Video Recording, Audio Recording and Other Imaging ~~of Individuals, Visitors and Workforce Members~~**	**Policy No.:**	HI.46 v2~~1~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒ ~~CMC/D-SNP~~Medicare	

I. Purpose

To establish guidelines for situations when, where, and how individuals, including Santa Clara Family Health Plan (SCFHP) staff, temporary help, and consultants, may or may not ~~be~~ photograph~~ed~~, video or audio record~~,ed~~ or capture other~~wise~~ image~~d~~ in accordance with state and federal privacy laws and HIPAA Regulations.

II. Policy

It is the policy of SCFHP to take reasonable steps to protect individuals ~~, including SCFHP Staff, temporary help, and consultants~~ from unauthorized photography, video or audio recordings, or other images in accordance with state and federal privacy laws and HIPAA Regulations.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include, but not limited to, written warning, suspension, or termination.

IV. References

45 C.F.R. §160.103
45 C.F.R. §164.502(a)
45 C.F.R. § 164.514(a)
Omnibus Final Rule

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval

Santa Clara Family Health Plan™

POLICY

Anna Vuong Compliance Manager	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~	~~Robin Larmer~~Tyler Haskell ~~Chief~~Interim Compliance ~~& Regulatory Affairs~~ Officer
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	Compliance Committee	Approved 03/02/2020	Ratify 03/26/2020
V2	Revised	Compliance Committee		

POLICY

Policy Title:	**Breach Notification Requirements**	**Policy No.:**	HI.51 v2~~1~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	HI. 15; HI.50
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ ~~CMC~~Medicare	

I. Purpose

To describe the process for the timely and complete notification requirements following the discovery of a Breach in accordance with state and federal laws governing notifications to individuals, the media, to the Department of Health & Human Services Secretary, to law enforcement and notices made by Business Associates.

II. Policy

All Santa Clara Family Health Plan (SCFHP) staff, temporary help, consultants, contractors, and Business Associates, shall report any suspected or confirmed impermissible uses or disclosures of Protected Health Information (PHI) to the Privacy Officer immediately upon discovery.

S~~anta Clara Family Health Plan~~CFHP ~~is~~ shall ~~committed to~~ comply~~ing~~ with the notification requirements following the discovery of an impermissible ~~an unauthorized breach~~ disclosure of unsecured ~~Protected Health Information (~~PHI~~)~~. S~~anta Clara Family Health Plan~~CFHP will ensure that notifications are made to impacted protected individuals, the general public, media, and regulatory agencies, as applicable, ~~whose~~ when PHI or Personally Identifiable Information (P~~H~~II) has been breached as required by state and federal privacy laws, HIPAA Regulations, and the Breach Notification Rule.

III. Responsibilities

All SCFHP staff, temporary help, and consultants must comply with this policy. Violations of this policy will result in disciplinary action based on the seriousness of the offense or other factors. Disciplinary action may include, but not limited to, written warning, suspension, or termination.

IV. References

45 C.F.R. §164.404
45 C.F.R. §164.406
45 C.F.R. §164.408

POLICY

45 C.F.R. §164.410
45 C.F.R. §164.412
45 C.F.R. §164.414
45 C.F.R. §164.530

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Anna Vuong Compliance Manager Date	~~Jordan Yamashita~~Daniel Quan Compliance Director ~~& Privacy Officer~~ Date	~~Robin Larmer~~Tyler Haskell ~~Chief~~ Interim Compliance ~~& Regulatory Affairs~~ Officer 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	Compliance Committee	Approved 3/2/2020	Ratify 3/26/2020
V2	Revised	Compliance Committee		

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Tuesday, August 9, 2022, 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
N/A

Specialty
Geriatrics
Adult & Child Psychiatry
Pediatrics
Pediatrics
Internist

Staff Present
Tyler Haskell, Interim Compliance Officer
Lori Andersen, Director, Long Term Services and Support
Mai Chang, Director, Quality & Process Improvement
Angela Chen, Director, Case Management & Behavioral Health
Tanya Nguyen, Director, Customer Service
Lucille Baxter, Manager, Quality & Health Education
Charla Bryant, Manager, Clinical Quality & Safety
Karen Fadley, Manager, Provider Data, Credentialing and Reporting
Claudia Graciano, Manager, Provider Access Program Manager
Robert Scrase, Manager, Process Improvement
Victor Hernandez, QA Program Manager, Grievance & Appeals
Amy Johnson Veazey, Accreditation Program Manager
Udari Perera, Process Improvement Project Manager
Cecilia Le, HEDIS Project Manager
Olivia Pham, Process Improvement Project Manager
Parina Mosley, Medical Management Personal Care Coordinator
Nancy Aguirre, Administrative Assistant

1. Roll Call

Ria Paul, MD, Chair, called the meeting to order at 6:00pm. Roll call was taken and a quorum was established.

Laurie Nakahira, D.O., Chief Medical Officer (CMO), welcomed back Mai Chang to Santa Clara Family Health Plan (SCFHP) as the Director of Quality and Process Improvement. Previously, Ms. Chang served as a Manager for the Quality Improvement (QI) department. Dr. Nakahira welcomed additional new hires, Parina Mosley, Medical Management Personal Care Coordinator; Olivia Pham, Process Improvement Project Manager; Amy Johnson, Accreditation Program Manager; and Udari Perera, Process Improvement Project Manager.

2. Public Comment

There were no public comments.

3. Meeting Minutes

Meeting minutes of the 06/14/2022 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the draft minutes of the 06/14/2022 QIC meeting were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman

4. Chief Executive Officer Update

Christine Tomcala, CEO, announced the Plan's membership is currently 315,281. Membership continues to grow while we remain in a public health emergency.

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5. Compliance Report

Tyler Haskell, Interim Compliance Officer, presented the Compliance Report. In May, the Plan recently received notice of a routine Department of Managed Health Care (DMHC) survey to be held onsite in October. This survey will cover the overall performance of the Plan against State health plan licensing regulations.

Mr. Haskell noted the Plan underwent its annual Department of Health Care Services (DHCS) audit in March, and has not yet received a written preliminary report.

Mr. Haskell announced DHCS has recently initiated a process to ensure Medi-Cal (MC) managed care plans' operational readiness for the requirements of the new 2024 contract. Between August 2022 and December 2023, plans will be required to submit documents demonstrating readiness to implement the revised contract. Compliance is working with internal business units to prepare submissions.

Mr. Haskell added, the Plan is currently undergoing the Compliance Effectiveness Audit required by CMS. This audit reviews the effectiveness of our Compliance Program and must be completed annually.

In response to Dr. Paul's question regarding the last DMHC audit and outcome, Mr. Haskell noted the last DMHC audit took place in 2019, with a follow up audit in early 2021. There were a low number of findings.

6. Cal MediConnect (CMC) Availability of Practitioners Evaluation

Claudia Graciano, Manager, Provider Access Program Manager, presented the CMC Availability of Practitioners Evaluation. The goal of this evaluation is to ensure there is adequate network to meet member's needs. The 2022 CMC results reflect all Provider Type goals were met, as well as the goals for Providers Accepting New Patients.

Ms. Graciano reviewed the metrics and standards for Maximum Driving Time & Distance (MTD), and noted the Plan met all performance goals.

Jennifer Foreman, MD, joined the meeting at 6:25pm.
Nayyara Dawood, MD, joined the meeting at 6:30pm.
Ali Alkoraishi, MD, joined the meeting at 6:31pm.

It was moved, seconded and the CMC Availability of Practitioners Evaluation was **unanimously approved.**

Motion: Dr. Nakahira
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

7. Annual E-Mail Quality and Analysis Report

Tanya Nguyen, Director, Customer Service, reviewed the Annual E-Mail Quality and Analysis Report. SCFHP has a responsibility to ensure the information shared via e-mail to members is accurate and timely. This is accomplished by measuring and evaluating the quality and timeliness of information.

There are two factors used to evaluate e-mail quality and timeliness of information. They include, E-Mail Turnaround-Time; and Response's Quality and Comprehensiveness. Also reviewed were the qualitative analyses for both factors.

Ms. Nguyen concluded by reviewing the opportunities for improvement and the interventions implemented.

In response to Dr. Paul's question regarding the kind of e-mails received from members, and if e-mails are encrypted, Ms. Nguyen noted the e-mails received from members come in a variety of inquiries such as, billing statement assistance, PCP selection, benefit explanation, etc. Ms. Nguyen confirmed the emails sent from SCFHP are encrypted.

It was moved, seconded and the Annual E-Mail Quality and Analysis Report was **unanimously approved.**

Motion: Ms. Tomcala
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Pail, Ms. Tomcala
Absent: None

8. Santa Clara Family Health Plan (SCFHP) Member Experience, including Behavioral Health (BH): 2021 Analysis

Victor Hernandez, Quality Assurance Program Manager, Grievance & Appeals, reviewed the Member Experience Report for CY2021. The data collected is aggregated into five categories – 1) Quality of Care, 2) Access, 3) Attitude/Service, 4) Billing/Financial, and 5) Quality of Practitioner Office Site. Mr. Hernandez reviewed the goals for each category as well as the quantitative and qualitative analyses. Areas with opportunities for improvement were reviewed.

Angela Chen, Director, Case Management and Behavioral Health, presented the Member BH Experience Survey Results on behalf of Jamie Enke, Program Manager. The purpose of this survey is to assess the member's perception of their access to care and quality of care.

Ms. Chen reviewed the qualitative analysis, unmet goals, as well as the opportunities for improvement.

It was moved, seconded and the SCFHP Member Experience, including BH: 2021 Analysis was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

9. HEDIS Reporting

Cecilia Le, HEDIS Project Manager, presented the HEDIS Report. Ms. Le reviewed the HEDIS timeline, achievements and challenges, performance results for MC Managed Care Accountability Set (MCAS) Measures, and Cal MediConnect (CMC) measure results. Ms. Le highlighted MC met the Minimum Performance Level (MPL) for 13 of 15 MCAS measures, and for CMC, the rates increased for majority of hybrid measures from previous year.

Ms. Le noted a decline in the MC MCAS immunization measure (CIS10). Moreover, this decline is in line with the statewide decrease in the immunizations due to COVID-19.

Jennifer Foreman, MD, Santa Clara Valley Medical Center, noted the decrease for measure CIS10 is likely due to the recent addition of the influenza vaccine in the combination. As a result, the same vaccines are not being compared for vaccination status, as in previous years. Unfortunately, the influenza vaccine is often times declined by families, as it is not required by schools or daycare centers.

Additionally, Dr. Foreman shared the difficulty in reaching measure W30A-6 (Well-Child Visits in the First 15 Months of Life – 6 or more visits), as most infants initially share their mother's MC coverage. This poses an issue, as recognition of the initial Well-Child visit(s) is/are not recorded under the infant's membership.

Ms. Le shared the next steps and opportunities for improvement. Some of which include, increase in home assessments, member outreach using bilingual staff, and interdepartmental collaboration on focused measures.

10. Annual Review of QI Policies

Angela Chen, Director, Case Management & Behavioral Health, presented policies QI.17, QI.18, QI.21, and QI.25. Ms. Chen noted the minor changes of each policy.

a. QI.17 Behavioral Health Care Coordination
b. QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors
c. QI.21 Information Exchange Between SCFHP & SCCBHSD
d. QI.25 Palliative Care

It was moved, seconded and policies QI.17, QI.18, QI.21, and QI.25 were **unanimously approved.**

Motion: Dr. Nakahira
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

e. QI.34 Housing and Homelessness Incentive Program

Lori Andersen, Director, Long Term Services & Supports, presented a new policy – QI.34, specific to the Housing and Homelessness Incentive Program (HHIP). This policy reflects the APL 22-007, including how the health plan will participate in and implement the HHIP program, including the achievement of metrics and collaboration with the Coordinated Entry System and Continuum of Care (CoC) to address the needs of those who are unhoused or housing insecure in Santa Clara County. This is an opportunity for the health plan to partner very closely with the CoC, stakeholders, and providers to build on the existing County Plan to End Homelessness.

It was moved, seconded and policy QI.34 was **unanimously approved.**

Motion: Dr. Nakahira
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

11. Quality Dashboard

Charla Bryant, Manager, Clinical Quality and Safety, presented the Quality Dashboard beginning with the Initial Health Assessment (IHA) results. Reports indicate a slight decrease in completion rates when comparing June – July 2021 to 2022. Ms. Bryant noted DHCS had temporarily suspended the requirement to complete IHAs for members within 120 days of enrollment until the COVID-19 emergency declaration is rescinded. DHCS required all Primary Care Providers (PCPs) to resume IHA activities on 10/01/2021.

Ms. Bryant noted between June – July 2022, 14 Facility Site Reviews (FSRs) were completed. Certified Master Trainers (CMT) and QI Nurses continue to conduct FSRs to ensure sites operate in compliance with all applicable local, State, and federal laws and regulations.

Ms. Bryant reviewed the Potential Quality of Care Issues (PQIs), noting 52.3% of PQIs due from June – July 2022 closed on time (within 90 days). Also reviewed were the results for the Outreach Call Campaign, an internal program where staff conduct calls to members to promote health education. A total of 12,602 calls were made from June – July 2022.

In an effort to improve the HEDIS MC and CMC rates, alerts have been loaded into QNXT, so that internal staff can remind members about screenings and/or visits they are due for. A total of 3,084 QNXT Gaps in Care (GIC) alerts were terminated between June – July 2022.

Ms. Bryant noted Health Education (HE) mailing occurs July through November to remind members to complete missing services by the end of the year. A total of 28,202 letters were mailed to members, and 629 of which were mailed to CMC members.

12. Pharmacy & Therapeutics Committee (P&T)

The draft Open minutes of the 06/16/2022 P&T Committee meeting were reviewed by Jimmy Lin, MD, Chair, P&T Committee.

It was moved, seconded and the 06/16/2022 draft Open P&T Committee meeting minutes were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

13. Utilization Management Committee (UMC)

The draft minutes of the 07/20/2022 UMC meeting were reviewed by Dr. Lin, Chair, UMC.

It was moved, seconded and the 07/20/2022 draft UMC meeting minutes were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

14. Credentialing Committee Report

Dr. Nakahira reviewed the 06/01/2022 Credentialing Committee Report.

It was moved, seconded and the 06/01/2022 Credentialing Committee Report was **unanimously approved.**

Motion: Dr. Nakahira
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman, Dr. Lin, Dr. Nakahira, Dr. Paul, Ms. Tomcala
Absent: None

15. Adjournment

The next regular QIC meeting will be held on October 11, 2022. The meeting was adjourned at 7:30pm.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan
Availability of Provider Network

Cal-MediConnect - 2022

Prepared by:

Claudia Graciano, Provider Network Access Program Manager

For review and approval by the Quality Improvement Committee

July 2022

INTRODUCTION

Santa Clara Family Health Plan (SCFHP) covers residents of Santa Clara County, officially the County of Santa Clara, which is California's 6th most populous county, with a population of 1,914,400 , per worldpopulationreview.com (2022). The county seat and largest city is San Jose, the 10th most populous city in the United States, California's 3rd most populous city and the most populous city in the San Francisco Bay Area.

Santa Clara County is part of the San Jose-Sunnyvale-Santa Clara, CA Metropolitan Statistical Area as well as the San Jose-San Francisco-Oakland, CA Combined Statistical Area. Located on the southern coast of San Francisco Bay, the urbanized Santa Clara Valley within Santa Clara County is also known as Silicon Valley. Santa Clara is the most populous county in the San Francisco Bay Area and in Northern California.

Counties which border with Santa Clara County are, clockwise, Alameda County, San Joaquin (within a few hundred feet at Mount Boardman), Stanislaus, Merced, San Benito, Santa Cruz, and San Mateo County.

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.

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 to monitor how effectively the network meets the needs and preferences of its members.

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 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.

DEFINITIONS

Primary Care Providers (PCP) are defined as Family/General Practice, Internal Medicine and Pediatrics.

***Pediatrics is not applicable for the population represented in this report.

High **Volume** Specialists (HVS) - encounter data is used to identify providers that provide services to the largest segment of members. HVS providers may be located in high-volume geographic areas and/or practice in a high-volume specialty. HVS assessments at minimum includes gynecology.

High **Impact** Specialists (HIS) are specialists who treat conditions that have high mortality and morbidity rates and where treatment requires significant resources**.** HIS assessments at minimum includes hematology/oncology.

High **Volume** Behavioral Health (HVBH) - encounter data is used to identify behavioral health providers that provide services to the largest segment of members. HVBH providers may be located in high-volume geographic areas and/or practice in a high-volume behavioral health specialty.

Provider to Member Ratios: Number of network providers to meet minimum number required to allow adequate healthcare access for beneficiaries.

A. SCFHP— Member Enrollment Count

Data Source: ICAT

LINE OF BUSINESS	Enrollment Count
Cal MediConnect (CMC)	10,354

B. Provider to Member Ratios

Methodology:

SCFHP follows Centers for Medicare & Medicaid Services (CMS) guidelines where the Provider and Facility Health Service Delivery (HSD) process is used to demonstrate network adequacy. Access to each specialty type is assessed using quantitative standards based on the availability of providers to ensure there are a sufficient number of providers to meet the health care needs of SCFHP Cal-MediConnect (CMC) members.

SCFHP uses CMS's established ratios of providers that reflect the utilization patterns based on the Medicare population. Specifically, the network adequacy criteria includes a ratio of providers required per 1,000 beneficiaries for the provider specialty types identified as required to meet network adequacy criteria. These ratios vary by county type and are published for the applicable specialty types in the HSD Reference File, as reflected in SCFHP's metrics in Tables I-III below.

The automated HPMS process, conducts an assessment on SCFHP's ability to meet the minimum provider numbers based on the providers listed on the HSD tables submitted to CMS by the Plan. Network providers must be within the maximum travel time and distance of at least one beneficiary residing in the county being assessed in order for the provider to count towards the minimum number requirements.

Through the HSD process, a final determination is made on whether the Plan is operating in compliance with current CMS network adequacy criteria. CMS submits an ACC report to the Plan which reports if the Plan is operating in compliance with CMS's network adequacy criteria. If the Plan passes its network review, then CMS and SCFHP will take no further action. If the Plan fails its network review, CMS and SCFHP will take appropriate compliance actions.

As shown in the metrics Tables I-III below, SCFHP's performance goal is to ensure that at least 90% of beneficiaries residing in its service area have access to the minimum number for each provider type as required by CMS.

Metrics (Tables I – III)**:**

Table I: Primary Care Provider

Provider Type (PCP)	Measure	Standard	Performance Goal
Family/General Practice 238 Internal Medicine (IM) 258	Family/General Provider to Member IM Provider to Member	1:87 1:87	90% 90%

Table II. High Volume / High Impact Specialists

Provider Type	Measure:	Standard	Performance Goal
Cardiology (HVS) Gynecology (HVS)	Cardiology Provider to Member Gynecology Provider to Member	1:300 1:1200	90% 90%
Ophthalmology (HVS)	Ophthalmology Provider to Member	1:300	90%
Hematology/Oncology (HIS)	Oncology Provider to Member	1:400	90%

Table III: Behavioral Health Provider

Provider Type	Measure:	Standard	Performance Goal
Psychiatry (HVBH)	Psychiatry Provider to Member	1:600	90%
Licensed Clinical Social Worker (LCSW) (HVBH)	LCSW Provider to Member	1:600	90%
Marriage/Family Therapy (LCMFT) (HVBH)	LCMFT to Member	1:600	90%

C. Maximum Time and Distance

Methodology:
SCFHP follows CMS guidelines where the Provider and Facility Health Service Delivery (HSD) process is used to demonstrate network adequacy. Access to each specialty type is assessed using quantitative standards based on the availability of providers to ensure there are a sufficient number of providers to meet the health care needs of SCFHP CMC members.

The maximum time and distance criteria were developed using a process of mapping beneficiary locations with provider practice locations. The time and distance metrics speak to the access requirements pertinent to the approximate locations of SCFHP members, relative to the locations of network providers. Through an automated HPMS process that is driven by time and distance criteria, CMS uses the provider information submitted by SCFHP through HSD tables to assess SCFHP's ability to meet maximum travel time and distance standards.

Through the HSD process, a final determination is made on whether the Plan is operating in compliance with current CMS network adequacy criteria. CMS submits an ACC report to the Plan which reports if the Plan is operating in compliance with CMS's network adequacy criteria. If the Plan passes its network review, then CMS and SCFHP will take no further action. If the Plan fails its network review, CMS and SCFHP will take appropriate compliance actions.

As shown in the metrics Tables I-III below, SCFHP requires that at least 90% of CMC members can access care within specific travel time and distance maximums where at least one in-network provider should be located within driving time and distance standards. Network adequacy is assessed at the county level and Santa Clara County's designation type is "Large Metro".

Metrics (Tables I-III)**:**

Table I: Primary Care Provider

Provider Type	Measure: Driving Time and Distance	Performance Goal
Family/General Practice Internal Medicine	10 minutes and 5 miles 10 minutes and 5 miles	90% 90%

Table II: High Volume / High Impact Specialists

Provider Type	Measure: Driving Time and Distance	Performance Goal
Cardiology Gynecology	20 minutes and 10 miles 30 minutes and 15 miles	90% 90%
Ophthalmology	20 minutes and 10 miles	90%
Hematology/Oncology	20 minutes and 10 miles	90%

Table III: Behavioral Health Provider

Provider Type	Measure: Driving Time and Distance	Performance Goal
Psychiatry Licensed Clinical Social Worker (LCSW)	20 minutes and 10 miles 20 minutes and 10 miles	90% 90%
Marriage/Family Therapy (LCMFT)	20 minutes and 10 miles	90%

*SCFHP follows HSD maximum driving time/distance standards published via the MMPHSD Criteria Reference Table and LCSW's and LCMFT's are not included, thus the Plan uses Medicaid standards for these provider types.

D. Results – (Tables I-III):

Table I: Provider to Member Ratios – Providers (All)

Provider Type	Provider #	Member #	Standard	Result	Goal	Met/Not Met
Primary Care Provider						
Family/General Practice	238	10,354	1:87	1:43	90%	Met
Internal Medicine	258	10,354	1:87	1:40	90%	Met
Total (PCP's combined)	496	10,354	1:87	1:21	90%	Met
High Volume Specialists						
Cardiology	133	10,354	1:300	1:78	90%	Met
Gynecology	266	10,354	1:1200	1:39	90%	Met
Ophthalmology	199	10,354	1:300	1:52	90%	Met
High Impact Specialist						
Hematology - Oncology	118	10,354	1:400	1:88	90%	Met
High Volume Behavioral Health Providers						
Psychiatry	174	10,354	1:600	1:59	90%	Met
Marriage/Family Therapy	17	10,354	1:600	1:609	90%	NA*
Clinical Social Worker	50	10,354	1:600	1:207	90%	Met

Table II: Provider to Member Ratios -- Providers Accepting New Patients

Provider Type	# of Providers	Total Open	% Open	Goal	Provider to Member Ratio	Met/Not Met
Primary Care	517	187	36%	1:87	1:55	Met
Cardiology	139	135	97%	1:300	1:76	Met
Gynecology	266	215	80%	1:1200	1:48	Met
Ophthalmology	199	190	95%	1:300	1:54	Met
Hematology/Oncology	118	98	83%	1:400	1:105	Met
Psychiatry	174	172	99%	1:600	1:60	Met
Marriage/Family Therapy	17	17	100%	1:600	1:609	Not Met*
Clinical Social Worker	54	53	99%	1:600	1:195	Met

*Marriage/Family Therapy is not a Medicare covered benefit

Table III: Maximum Driving Time & Distance (MTD)

Provider Type	Members with Access	Members without Access	Standard (Time and Distance)	& of Members with Access	*Goal	Met/Not Met
Primary Care (PCP)	10,099	26	5 miles and 10 mins	99.70%	90%	Met
Cardiology	10,054	71	10 miles and 20 mins	99.30%	90%	Met
Gynecology	10,125	0	15 miles and 30 mins	100%	90%	Met
Ophthalmology	10,120	5	10 miles and 20 mins	99.90%	90%	Met
Hematology - Oncology	10,029	96	10 miles and 20 mins	99.10%	90%	Met
Psychiatry	10,125	0	10 miles and 20 mins	100%	90%	Met
Marriage / Family Therapy	9,455	670	10 miles and 20 mins	93.40%	90%	Met
Clinical Social Worker	10,120	5	10 miles and 20 mins	99.90%	90%	Met

***Goal:** 90% of members will have access

Quantitative Analysis: As shown in **Tables I & II**, SCFHP is able to demonstrate that provider to member ratios are met against its performance goals on all providers (Table I) and providers who are accepting new patients (Table II). SCFHP achieved the same results in PY2021 where provider to member ratios met the Plan's performance goals across all provider types included in the assessment. *Please note that Marriage/Family Therapy (MFT)was not met, this provider type is not a Medicare covered benefit. SCFHP monitors this provider type for CMC members as it remains a Medi-Cal benefit, this allows the Plan to monitor all specialty types under the coordination of benefits.

Further review showed that PCP providers accepting new patients in 2022 decreased by 12 from 2021, cardiology increased by 12, oncology/hematology, Marriage/Family Therapy, Clinic Social Worker showed no change and gynecology increased by 8, ophthalmology decreased by 2, while Psychiatry increased by 32. Other than a notable increase in open Psychiatrist, overall results indicate that provider to member ratios across all provider types remain steady.

As shown in **Table III** maximum time and distance standards are being met across all provider types. Performance goals were exceeded in all provider types at 93.4% (lowest) and 100% (highest). Members shown without access represents the number of members that do not have access within maximum time and distance (MTD) standards. As shown in the table, the total number of members without access is 873

at 8.6%.

*Marriage/Family Therapy is not a Medicare covered benefit, the reporting was included to reflect a Medi-Cal covered benefit.

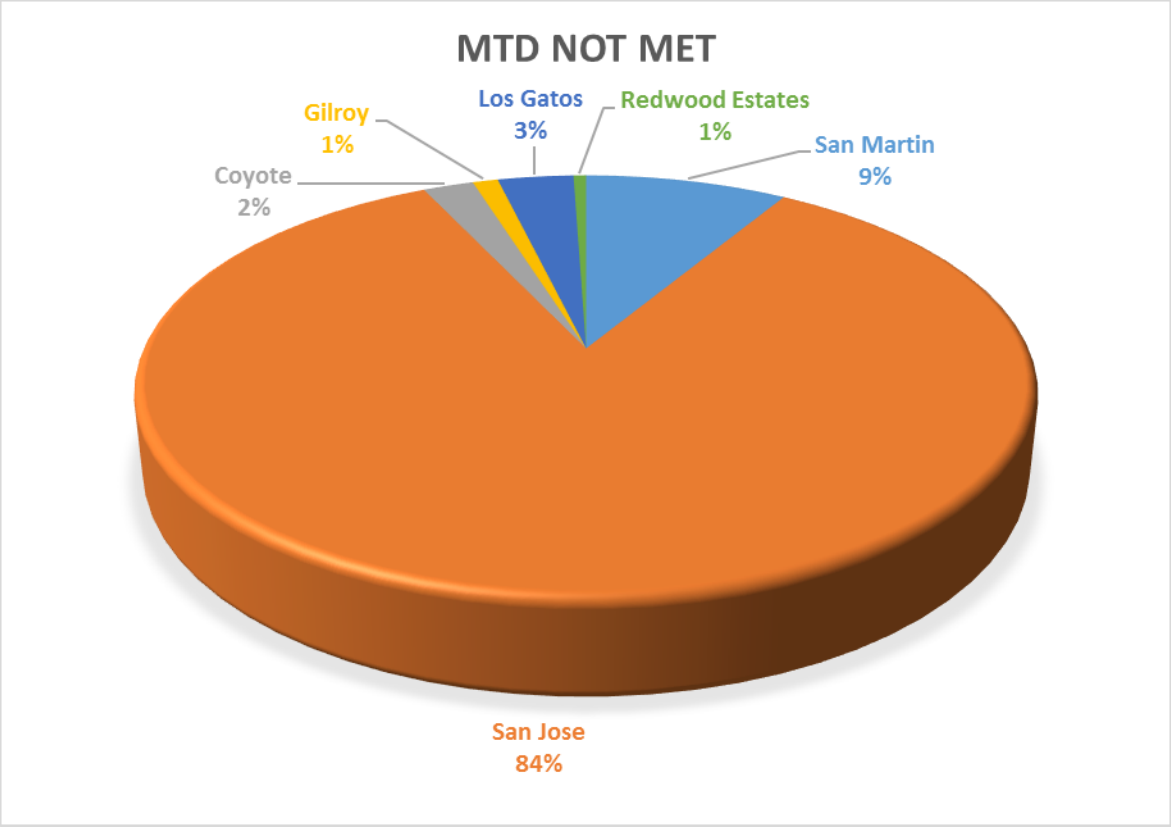
SCFHP further examined access detail reports and maps to identify the top 3 cities/zips where MTD standards were not met. The sample review included the provider types from each category (PCP, HVS, HIS and HVBH) with the highest number of members without access within MTD standards. Note that the sample review covered all PCP types (FP and IM). The assessment revealed the following –

Table A: Top 3 Cities/Zips MTD Not Met

Provider Type	Total # without	City (1)	Zip	# without	City (2)	Zip	# without access	City (3)	Zip	# without access
Primary Care (PCP)	26	San Martin	95046	16	Los Gatos	95033	3	Coyote	95013	2
Cardiology	74	San Jose	95139	30	San Jose	95138	23	San Jose	95119	16
Ophthalmology (HVS)	5	Coyote	95013	2	Gilroy	95020	1	San Jose	95138	1
Hematology - Oncology (HIS)	96	San Jose Hill	95138	35	San Jose	95139	30	San Jose	95119	21
Clinical Social Worker (HVBH)	5	Los Gatos	95033	3	Gilroy	95020	1	Redwood	95044	1

Table A shows that the top 3 cities/zips where maximum time and distance standards were not met for Family/General Practice/Internal Medicine (PCP), Ophthalmology (HVS), Hematology/Oncology (HIS), Cardiology and Clinical Social Worker (HVBH). The sample pulled were from primary care and the highest number of members without access under each provider category (HVS, HIS and HVBH). The table also includes the total number of members without access under each city/zip. As shown above in section D. Results, Table III, the total number of members without access is 2022 and the total in the cities/zips is 185 (shown in Table A above), which accounts for 8.6% of members without access within MTD standards.

Table B: Cities & Percentages – MTD Not Met



As shown in Table B, the sample assessment identified 5 cities where MTD is not met on the provider types with the highest number of members without access within MTD standards. The assessment indicated that San Jose had the most members without access at 84%, followed by San Martin at 9%, Los Gatos at 3%, Coyote at 1% and Gilroy at 2%, all of which are situated in rural communities in the southeast area of Santa Clara County.

Following are the assessments conducted on each zip code within those five (5) cities where MTD standards were not met; all of which are within rural areas –

Coyote – Zip Code 95013

Zip code 95013 in the city of Coyote has a population of 34 (2020 US Census) and is situated on the southeast tip of Silicon Valley in a rural area. SCFHP has a total of 2 members that reside in Coyote Valley (Zip 95013). The assessment showed that MTD standards were not met for Family/General Practice, and Ophthalmology.

Gilroy – Zip Code 95020

Zip code 95020 in the city of Gilroy has a population of 57,549 (2020 US Census) and is situated south of Morgan Hill on the southeast tip of Silicon Valley in a rural area. SCFHP has a total of 461 members that reside in Gilroy (Zip 95020). The assessment showed that MTD standards were not met for Ophthalmology, and Clinical Social Worker.

San Jose – Zip Codes 95119, 95138 and 95139

According to the 2020 US Census, the population totals in the city of San Jose (SJ) within the zip codes with the highest number of members without access are 95119 =45, 95138 = 81 and 95139 = 28. The assessment showed that MTD standards were not met for Cardiology, Ophthalmology, and Hematology/Oncology. The SJ area for zip code 95139 is situated in the southeast area of SJ in a rural area. These areas of SJ are described as having a less than average population density compared to other parts of SJ.

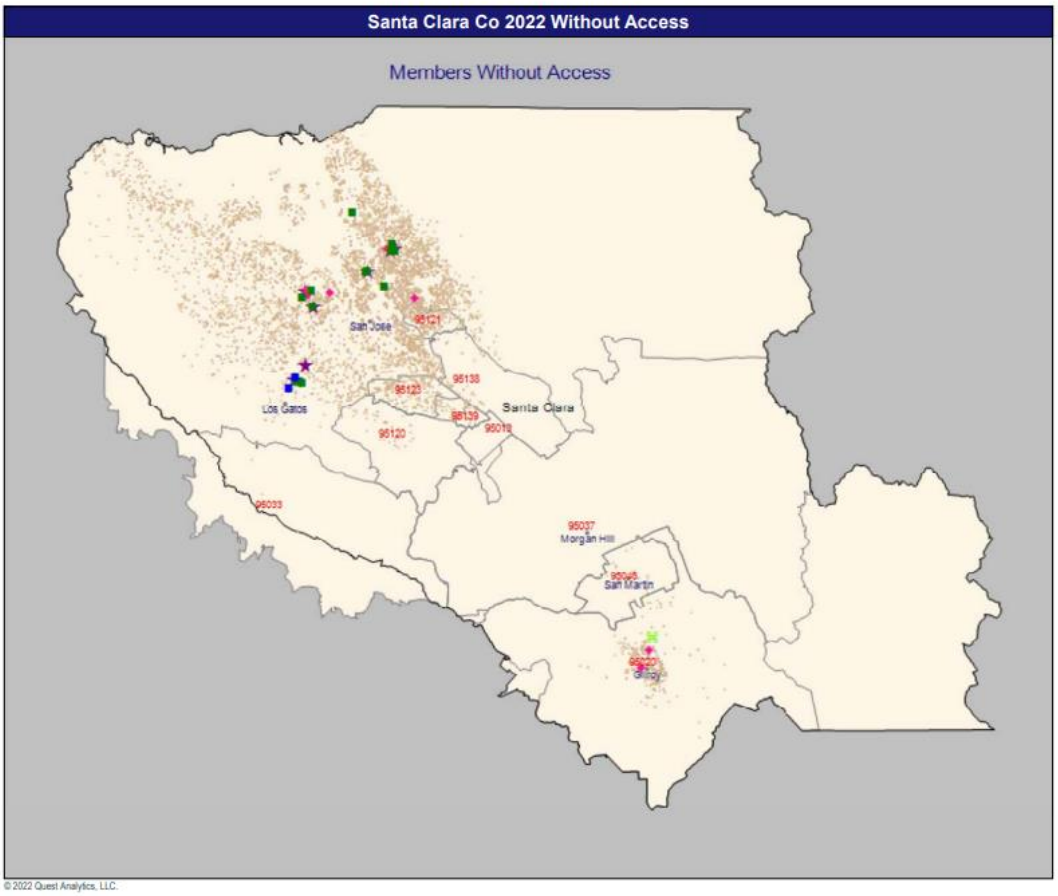
San Martin – Zip Code 95046

Zip code 95046 in the city of San Martin has a population of 6,417 (2020 US Census) and is situated to the south of Morgan Hill and north of Gilroy in a rural area. SCFHP has a total of 37 members that reside in San Martin. The assessment showed that MTD standards were not met for Family/General Practice.

Redwood Estates – Zip Code 95044

The city of Redwood Estates has an approximate population of 1,233 (2020 US Census) and is situated to the south of rural unincorporated community along State Route 17 in the coastal Santa Cruz Mountains in Los Gatos. SCFHP has a total of 1 member that resides in Redwood Estates. The assessment showed that MTD standards were not met for Certified Social Worker.

MAP – Members of Gilroy, Los Gatos, Coyote, San Jose, and Redwood Estates to Table A providers (members without access)



Qualitative Analysis:

Overall the analysis revealed that SCFHP standards for provider availability are realistic for the communities and delivery system within Santa Clara County, and also supports a clinically safe environment.

The majority of SCFHP members dwell in an urban environment and a small fraction of members reside in rural communities. SCFHP recognizes that rural communities often face challenges maintaining an adequate provider network, making it difficult for Plans to meet maximum time and distance standards and/or provider to member ratios. SCFHP will continue to assess and monitor recruitment activities and contractual opportunities in the southeast area of Santa Clara County and other areas of the county as necessary to ensure CMC members have adequate access to health care providers.

When necessary, SCFHP will continue to re-direct members to out-of-network specialists and behavioral health providers to ensure timely access standards of care are met. SCFHP will also continue to provide transportation free of cost to its members.

SCFHP ensures access and availability to services in accordance with its availability policies & procedures, as well as maintaining and monitoring appropriate availability and access to network providers. Following the procedure to submit network tables through the HDS process, SCFHP received an ACC report, which identifies the providers that passed or failed to meet Medicare network standards. The ACC report for this reporting period showed that SCFHP providers passed Medicare network standards and that no deficiencies were identified.

The analysis showed that the percentage of SCFHP providers accepting new patients is more than sufficient to provide additional capacity for both new members and members who would like to change their primary care provider. Additionally, member requests for a PCP not accepting new patients are accommodated readily by SCFHP. The Plan also recognizes that the provider data reflects a snapshot in time and provider panels could change day by day. As a course of continued network adequacy oversight, the Plan will continue to adjust the network to meet the demands of the Plan's enrollment in real time.

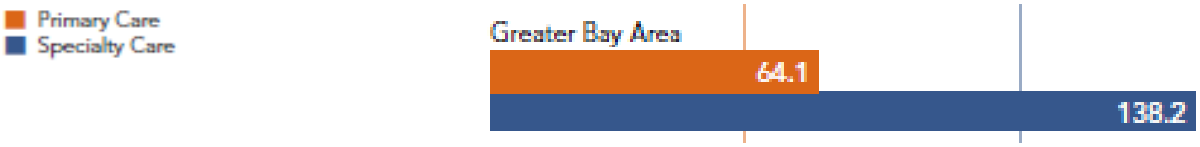
The analysis also demonstrates that members are not unduly burdened with travel time and distance to network providers. SCFHP time and distance metrics speak to the access requirements pertinent to the approximate locations of members, relative to the locations of network providers, and the assessment showed that more than 90% of members have access within time and distance standards across all provider types included in this report.

Where applicable, SCFHP implements interventions to address opportunities for improvement and measures the effectiveness of those interventions. Analysis results and related interventions are reviewed/approved by SCFHP's Quality Improvement Committee.

To ensure awareness of any major demographic trends that may drive an increase in demand for health care in California (specifically in Santa Clara County), SCFHP reviewed the CA Physician Supply (2018) study that was conducted by the Medical Board of California. The study showed that the state's total population is projected to increase by 6.4 million people between 2015 and 2035, and the population age 65 or older is projected to increase by 4.9 million. With an aging population, patient health needs will likely increase in complexity and severity. The authors of the study believe that to anticipate the state's ability to respond to these demographic trends, California policymakers need to understand the current supply of active physicians, the number providing patient care, and how they are distributed across the state.The study also showed that the distribution of physicians varied by county. The supply of primary care physicians per 100,000 people ranged from a low of zero (0) in Alpine County to a high of 113 in Napa

County. Similarly, the supply of specialty physicians per 100,000 people ranged from a low of 0 in Alpine County and Sierra County to a high of 234 in Napa County. Several counties had no or few physicians in specific specialties, including geriatric medicine, endocrinology, psychiatry, pulmonary care, and rheumatology. Not having any physicians in a specialty in a county poses a barrier to access, especially in California, where many counties cover large geographic areas. **Figure 5** below represents the Greater Bay Area region, which is within SCFHP's service area in Santa Clara County which shows the number of Physicians between 100,000 residents PC vs SPC

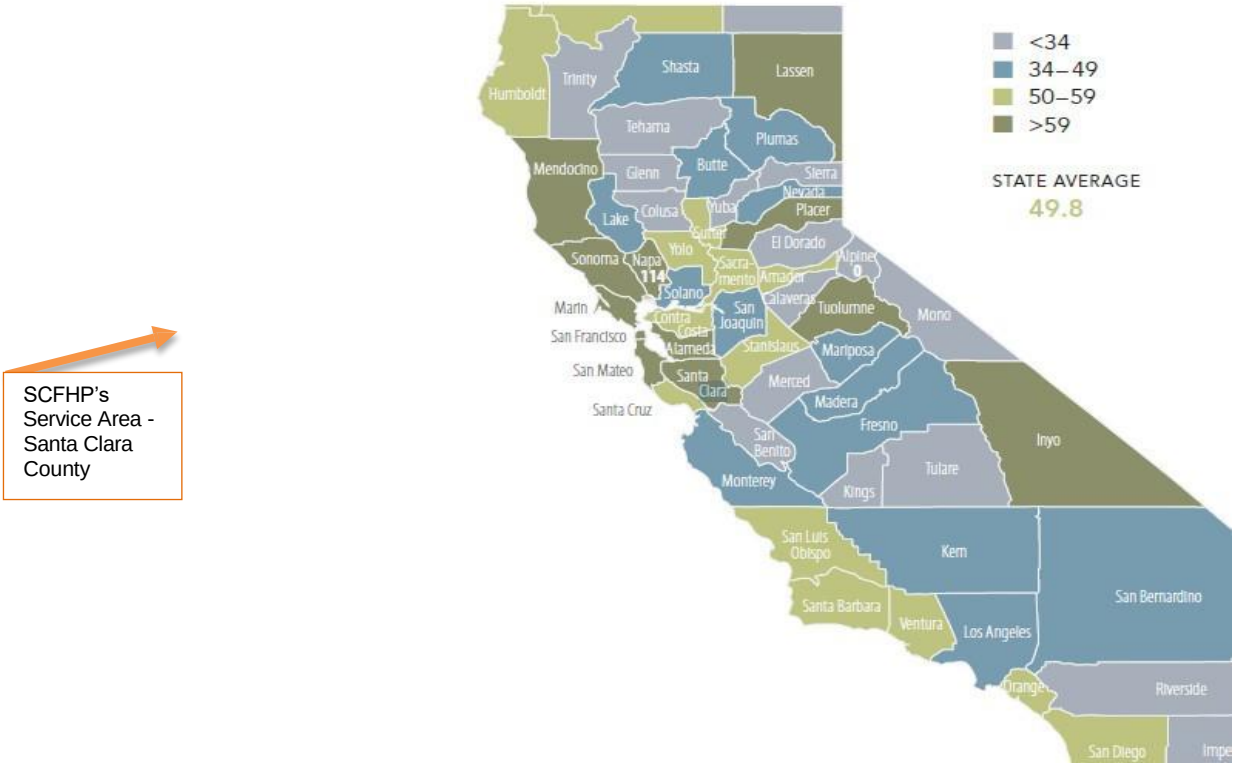
Figure 5. Physicians per 100,000 Residents by Region PCP vs SPC



The Greater Bay Area ranked the highest in number of Primary Care Providers and Specialty Care. For example, the lowest number for PCP was 34.5 and SPC was 64.3

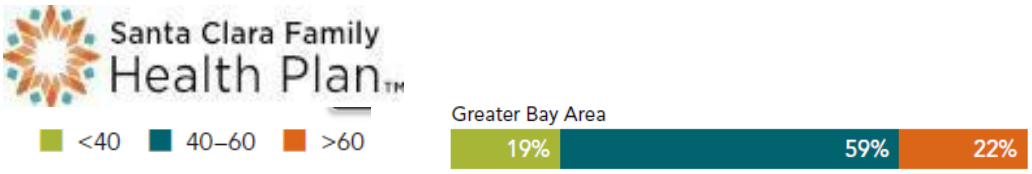
Figure 6 below represents CA counties PCP count per 100,000 residents and it appears that SCFHP's service area in Santa Clara County is among the counties with a higher PCP count per 100,000 residents.

Figure 6: PCP per 100,000 Residents by County



Another area of concern expressed in the study were findings on the number of active Physicians that are

over the age of 60. There was a figure that showed the age of active physicians by region and following is a breakdown from the study on physician ages in the Greater Bay Area which is within SCFHP's service area in Santa Clara County:



As noted in the study, with the general population, the population of physicians is aging, and older physicians will likely continue to scale back on patient care activities, and although the future of health insurance coverage remains unclear, coverage does not confer access without a health care workforce to provide care.

While SCFHP found that Santa Clara County is one of the least compromised compared to other counties within CA, the Plan will continue to assess the supply of physicians in California, specifically in its service area to ensure awareness of growth in the Santa Clara County area and the demands for medical care due to population growth and aging.

Conclusion:
Santa Clara Family Health Plan is able to demonstrate its ability to meet performance goals 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.

The Cal Medi-Connect program will sunset effective December 31, 2022. Effective January 01, 2023, SCFHP will participate in a Dual Eligible Special Needs Plans (D-SNPs). This program will go by "Dual Connect".

SCFHP is committed to ensure its members have access to timely, efficient and patient-centered quality health care. SCFHP efforts to contract with available providers within Santa Clara County, especially in the southeast area of rural communities is an on-going effort across all provider types.

SCFHP Personalized Information on Health Plan Services:

2022 E-mail Response Evaluation

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee (QIC) on
August 09,2022

I. Overview

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

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

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

II. Methodology: E-mail

Member and member's authorized representative may submit e-mail inquiries by sending them to CallCenterManagement@scfhp.com. This is the only method in which members can communicate to the plan via e-mails. E-mail inquiries come directly to Customer Services email (Outlook) inbox. A dedicated staff member in Customer Service checks the e-mail inbox intermittently throughout each business day. The staff member will respond to the sender's inquiry with a thorough response within one business day via Outlook. The Call Center collects and documents the contact in the QNXT Call Tracking System using the appropriate contact code. The documentations will include the content of the e-mail inquiry and the response provided to the sender.

SCFHP audits the turnaround time and quality of the email response on a quarterly basis to be able to identify opportunities to improve based on data collected and analyzed. Data included in this analysis was captured from July 1, 2021 through June 30, 2022. Both the Training & Quality Manager and Training & Quality Associate generate the data collection on all of the e-mails directed to the health plan from members and member's authorized representatives. Since the volume of e-mails received was low, all of the emails received were selected for review. The auditor reviewed each e-mail samples carefully and entered the results on a scorecard. The result of these data are being submitted to the Customer Service Manager and Director at the end of the review period to conduct the annual analysis.

Factor 1: Email Turnaround-Time

- Numerator: Number of emails with goals met from July2021 through June2022
- Denominator: Total number of emails received from July2021 through June2022
- Goal: 100% of emails are collected and responded to within one business day

Factor 2: Response's Quality and Comprehensiveness

- Numerator: Number of emails with goals met from July2021 through June2022
- Denominator: Total number of emails received from July2021 through June2022
- Goal: 100% of emails comprehensively address the member's request

III. Analysis

A. Results

Table 1: Scorecard on Timeliness and Quality of E-mail Responses from July 2021 (Q3-2021) through June 2022 (Q2-2022):

Element D: Email Response Evaluation					
QUARTERS	Q3 -2021	Q4 -2021	Q1 -2022	Q2 -2022	Total
TOTAL E-MAILS RECEIVED PER QUARTER	16	12	11	24	63
GOAL	100%	100%	100%	100%	100%
	TOTAL E-MAILS THAT MET GOALS FOR EACH FACTOR				
Factor 1: Timeliness in responding to member email inquiries					
1. The response was sent to member within one-business day	16	11	8	23	58
	100%	92%	73%	96%	90%
Factor 2: Quality of email responses					
1. The action taken & response provided comprehensively addresses the member request	16	12	10	23	61
	100%	100%	91%	96%	97%
2. If the e-mail inquiry requires additional time for research, an acknowledgment sent to the member indicating further investigation is required and a follow-up was provided to the member	NA	NA	NA	NA	N/A

Table 2: Annual Results on Timeliness and Quality of E-mail Responses from July 2021 (Q3-2021) through June 2022 (Q2-2022):

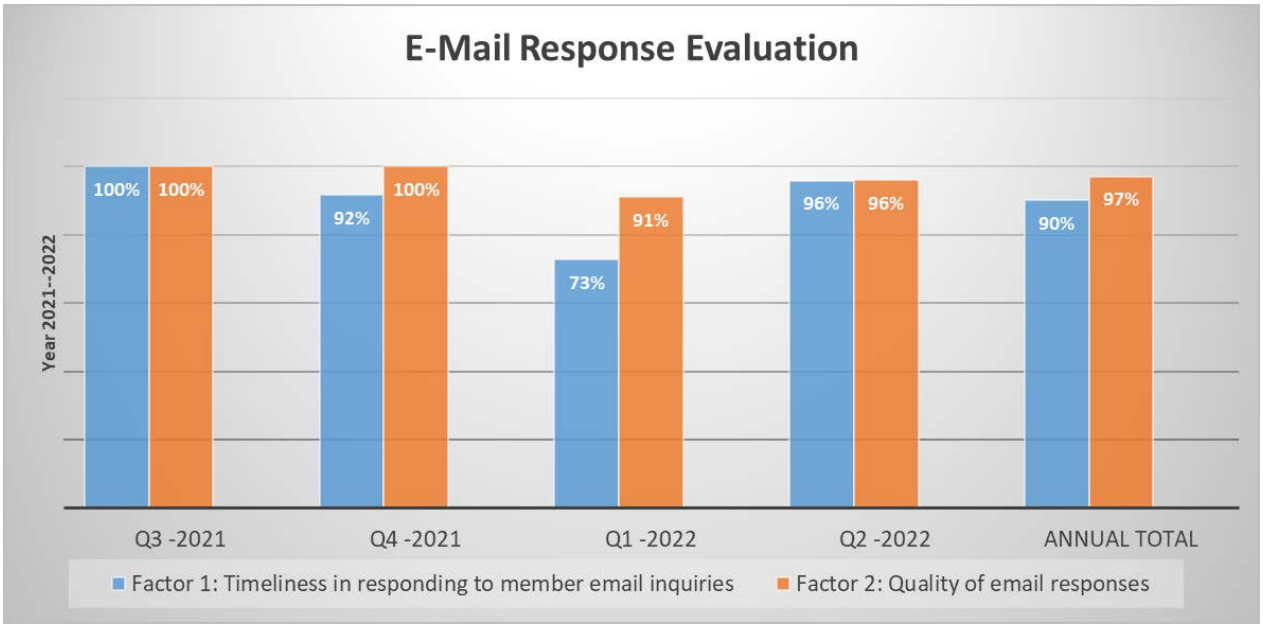


Table 3: Timeliness of E-mail Response Result compared to previous year (July 2020-June 2021 vs July 2021- June 2022):

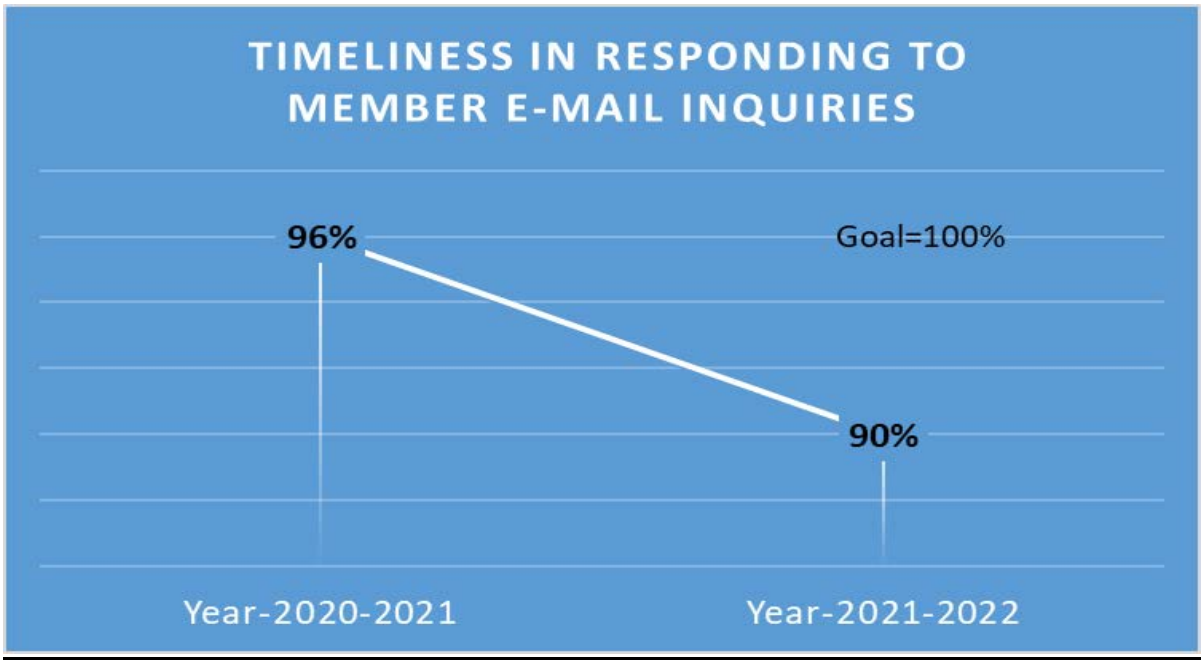
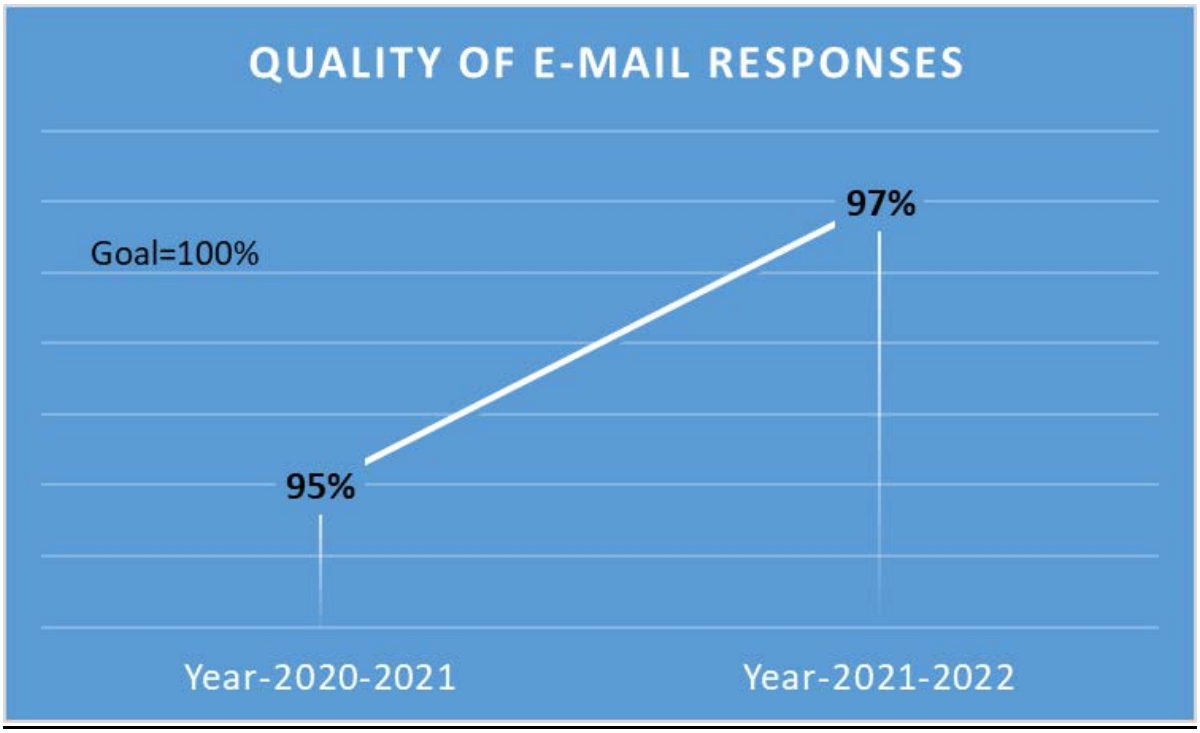


Table 4: Quality of E-mail Response Result compared to previous year (July 2020-June 2021 vs July 2021- June 2022):



B. Quantitative Analysis

A total of sixty-three (63) e-mails were received from members and member's authorized representatives during this audit period (July 2021-June 2022), compared to ninety-five (95) e-mails from the previous audit period (July 2020- June 2021). The volume had decreased by 33% compared to the prior year. The decrease in volume may most likely due to several factors such as language barriers, medical conditions, technological barriers, and economic background. We concluded that our elder population prefers to speak via the telephone with our live representatives.

For this measurement period, the Plan was at 90% for timeliness in responding to member e-mails in compared to 96% from the previous year. This was a 6% decrease percentage point and those deficiencies occurred between Q4-2021 and Q2-2022. For quality of email responses, the department reported 97%, compared to 95% for the prior review period, which result of 2% percentage point improvement in the area of quality. During the review period, there were no e-mail requests that require additional time for research; therefore, item two under factor 2 were non-applicable.

C. Qualitative Analysis

The preliminary audit results were reviewed and analyzed by the Customer Service Manager and were presented to the Customer Service Director. It is important to note that although the department monitors these data on a quarterly basis, the compiled data were also reviewed and discussed. Findings and recommendations are shared with Customer Service staff and also reported to the cross-functional Quality Improvement Committee (QIC), which includes representatives from Customer Service, Quality Improvement, Provider Network, Regulatory Compliance, and Behavioral Health.

As shown in Table 3, we received 90% in factor 1, timeliness in email response, compared to 96% for the previous year. We missed the targeted goal (100%) by 10 percentage points compared to 4 percentage points from the previous year. The Plan noted on multiple occurrences where the members were provided a thorough response to their e-mail request via the telephone but not via e-mail communication. We also identified one case that had a missed timeframe due to an oversight from the designated staff.

As displayed in table 4, we received 97% on factor 2, quality of email response, compared to 95% for the previous year. This improvement caused a rise by 2 percentage points from the

previous year. Although this year's result is 3 percentage points away from the target goal (100%), there is evidence of improvement in this area.

The Customer Service Manager and Director reviewed the cases that did not meet the timeliness and/or quality requirements, and discovered the following during this audit period:

- Desktop resources missing an element as outlined in the NCQA standards: The oversight of responding to member's e-mails timely was led by our new supervisor and team lead who were still in their learning curve. Instead of sending a written response via e-mail they proactively reached out to the members and provided assistance via the telephone. Therefore, we missed the timeliness since the responses were not sent to the member in writing.

- Prioritization: The oversight of responding to member's e-mails timely was led by the newly hired staff during Q4-2021 who was in the process of getting adjusted to the responsibilities and new role. Although the e-mails received were provided a complete and thorough response, they were not sent in the required timeframe.

- Lack of knowledge: The newly hired staff provided an incomplete response to a member on the agency contacts when needing to update member demographic information. In addition, another newly hired staff provided an inaccurate response to a member on the next steps as established by our inter-department when the appointment of representative form is submitted.

Based on the review, it was concluded that our desktop resources regarding e-mail response need to include the elements outlined in the NCQA standards so that new staff who are still learning their roles could refer to them as needed. Our designated staff also need to be mindful of the turn-around time and set priority to process all incoming requests in a timely manner. SCFHP recognizes the importance of providing high quality and timely responses to members via emails. Based on the annual analysis and the barriers identified, the Customer Service

Department has proposed the following interventions to ensure timely, adequate, and quality responses to all inquiries.

D. 2022 Barrier and Opportunity Analysis Table

Barriers	Opportunities	Intervention	Selected for 2022	Date Initiated
1. Desktop resources missing an element as outlined in the NCQA standards: The oversight of responding to member's e-mails timely was led by our new supervisor and team lead who were still in their learning curve. Instead of sending a written response via e-mail they proactively reached out to the members and provided assistance via the telephone. Therefore, we missed the timeliness since the responses were not sent to the member in writing.	Re-educate staff on the timeliness of responding to e-mails in writing vs verbally via the telephone	• Update the existing desktop procedures to include NCQA elements • Re-educate staff that a written e-mail response is required per NCQA standards • A refresher training on the E-mail Communication Policies & Procedures was provided to the designated staff members	x	9/2022
2. Prioritization: The oversight of responding to member's e-mails timely was led by the newly hired staff during Q4-2021 who was in the process of getting adjusted to the responsibilities and new role. Although the e-mails received were provided a complete and thorough response, they	Re-educate staff on meeting timeliness requirement	• A refresher training on the E-mail Communication Policies & Procedures was provided to the designated staff members	x	7/14/22

Barriers	Opportunities	Intervention	Selected for 2022	Date Initiated
were not sent in the required timeframe.				
3.Lack of knowledge: The newly hired staff provided an incomplete response to a member on the agency contacts when needing to update member demographic information. In addition, another newly hired staff provided an inaccurate response to a member on the next steps as established by our inter-department when the appointment of representative form is submitted.	Share desktop resources with staff	• Individual coaching was provided to the staff person via in email	X	06/7/22 7/19/22

E. Reporting

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee	8/09/22	

Santa Clara Family Health Plan™

NCQA ME7 Member Experience Report

Grievance & Appeals, Santa Clara Family Health Plan

August 2022

Non-BH Grievances CY2020

Complaint / Grievance Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020)	Grievances / per 1,000 members 9,069 = 2020 average membership
Quality of Care	35 3.86	27 2.98	35 3.86	39 4.30	136	14.996
Access	37 4.07	37 4.07	37 4.07	44 4.85	155	17.091
Attitude/Service	118 13.0	78 8.60	104 11.5	91 10.0	391	43.114
Billing/Financial	139 15.3	128 14.1	132 14.6	146 16.1	545	60.095
Quality of Practitioner Office Site	4 0.44	0	0	0	4	0.441
Total	333	270	308	320	1231	135.737

Non-BH Grievances CY2021

Complaint / Grievance Category	1Q-2021	2Q-2021	3Q-2021	4Q-2021	(Jan. 1-Dec. 31, 2021)	Grievances / per 1,000 members 10,125 = 2021 average membership
Quality of Care	49 4.84	49 4.84	39 3.85	47 4.64	184	18.173
Access	57 5.63	59 5.83	59 5.83	54 5.33	229	22.617
Attitude/Service	118 11.7	110 10.9	170 16.8	168 16.6	566	55.901
Billing/Financial	148 14.6	96 9.48	118 11.7	103 10.2	465	45.926
Quality of Practitioner Office Site	2 0.20	0	0	0	2	0.198
Total	374	314	386	372	1446	142.815

Access to Care – Timely Access to PCP

- PQI: 7 cases
- % Increase from CY2020: +114% (28 → 60)
- Providers with multiple grievances:
  - 1 provider with 4 grievances
  - 1 provider with 3 grievances
  - 3 providers with 2 grievances each

Access to Care – Provider Telephone Access

- PQI: 2 cases
- % Increase from CY2020: +61% (36 → 58)
- Providers with multiple grievances:
  - 3 providers with 2 grievances each

Quality of Care – Inappropriate Provider Care

- PQI: 39 cases
- % Increase from CY2020: +51% (80 → 121)
- Providers with multiple grievances:
  - 1 provider with 7 grievances
  - 2 providers with 3 grievances each
  - 11 providers with 2 grievances each

Quality of Care – Inappropriate Provider Care

Description of grievance	Definition	Number of cases
Treatment issues	Member has complaints about the treatment given or not given to them	37
Not submitting requests	Member has complaints about a delay or a refusal to submit a prescription or request	35
Not answering questions	Member has complaints about the provider not answering questions or not listening to them	31
Did not see member	Member has complaints about not being seen by the provider	18

Attitude/Service - Transportation Services

- PQI cases: 0 cases
- Increase since CY2020: +86% (105 → 195)
- Providers with multiple grievances:
  - 1 provider with 141 grievances
  - 1 provider with 28 grievances

Attitude/Service - Transportation Services

Description of grievance	Definition	Number of cases
Late Pick-up	Member's taxi cab arrived late.	59
No Show	Member's taxi cab did not arrive at all.	26
Driver Attitude	Member had an issue with the taxi cab's driver.	20
Safety Concern	Member was concerned about their safety in some way.	18
Driver Availability	Member's taxi cab did not arrive or arrived late because of a lack of drivers available at that time.	17

Billing/Financial – Balance Billing

- PQI cases: 0 cases
- Decrease since CY2020: -16% (454 → 381)
- Providers with multiple grievances:
  - 1 provider with 47 grievances
  - 2 providers with 31 grievances each
  - 1 provider with 26 grievances
  - 1 provider with 23 grievances
  - 1 provider with 17 grievances
  - 1 provider with 11 grievances
  - 1 provider with 10 grievances

Non-BH Appeals CY2020

Appeals Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	(Jan. 1-Dec. 31, 2020) Total Appeals	Appeals / per 1,000 members 9,069 = 2020 average membership
Quality of Care	0	0	0	0	0	0.000
Access	76 8.38	73 8.05	91 10.0	94 10.4	334	36.829
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	27 2.98	21 2.32	20 2.21	24 2.65	92	10.144
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	103	94	111	118	426	46.973

Non-BH Appeals CY2021

Appeals Category	1Q-2021	2Q-2021	3Q-2021	4Q-2021	(Jan. 1-Dec. 31, 2021) Total Appeals	Appeals / per 1,000 members 10,125 = 2021 average membership
Quality of Care	0	0	0	0	0	0.000
Access	91 8.99	113 11.2	94 9.28	75 7.41	373	36.840
Attitude/Service	0	0	0	0	0	0.000
Billing/Financial	79 7.80	37 3.65	28 2.77	45 4.44	189	18.667
Quality of Practitioner Office Site	0	0	0	0	0	0.000
Total	170	150	122	120	562	55.506

Access to Care – Pre-Service Appeals

- Overall Overturn Ratio: 40.7%
  - CY2020 Overall Overturn Ratio: 60.7%

- Pre-Service Part C:
  - Overturn Ratio: 43.1%

  - Services under Overturn Ratio:
    - Outpatient: 27
      - 14 of these 27 cases are related a test or scan.
    - DME: 12
    - Transportation: 6
    - Home Health: 5
    - Continuity of Care: 3
    - Inpatient: 1

Access to Care – Pre-Service Appeals

- Pre-Service Part D
  - Overturn Ratio: 37.8%

  - Services under Overturn Ratio:
    - Opioids: 5
      - Oxycodone 5mg: 1
      - Oxycodone HCL 10mg: 1
      - Oxycodone HCL 20mg: 1
      - Methadone HCL 5mg: 1
      - Hydrocodone-Acetaminophen 7.5-325mg: 1

Access to Care – Post-Service Appeals

- Overall Overturn Ratio: 79.9%
  - Overall Overturn Ratio in CY2020: 76.6%
- Reasons for Overturn:
  - Medical Necessity Met: 79
  - Plan Directed Care: 59
  - Courtesy/One-Time Exception: 42
  - Medical Necessity Met w/ Additional Information: 11

BH Grievances CY2020

Behavioral Health Complaint / Grievance Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	Total Grievances	BH Grievances/per 1,000 members 9,069 = 2020 average membership
Quality of Care	0	0	0	0	0	0
Access	2	0	0	0	2	0.221
Attitude/Service	0	0	1	0	1	0.110
Billing/Financial	1	0	0	0	1	0.110
Quality of Practitioner Office Site	0	0	0	0	0	0
Total	3	0	1	0	4	0.441

BH Grievances CY2021

Behavioral Health Complaint / Grievance Category	1Q-2021	2Q-2021	3Q-2021	4Q-2021	Total Grievances	BH Grievances/per 1,000 members 10,125 = 2021 average
Quality of Care	0	1	0	0	1	0.099
Access	0	1	0	1	2	0.198
Attitude/Service	0	3	6	2	11	1.086
Billing/Financial	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	0
Total	0	5	6	3	14	1.383

BH Appeals CY2020

Behavioral Health Appeal Category	1Q-2020	2Q-2020	3Q-2020	4Q-2020	Total Appeals	BH Appeals/per 1,000 members 9,069 = 2020 average membership
Quality of Care	0	0	0	0	0	0
Access	1	0	0	0	1	0.110
Attitude/Service	0	0	0	0	0	0
Billing/Financial	0	0	3	2	5	0.551
Quality of Practitioner Office Site	0	0	0	0	0	0
Total	1	0	3	2	6	0.662

BH Appeals CY2021

Behavioral Health Appeal Category	1Q-2021	2Q-2021	3Q-2021	4Q-2021	Total Grievances	BH Grievances/per 1,000 members 10,125 = 2021 average
Quality of Care	0	0	0	0	0	0
Access	0	0	0	1	1	0.099
Attitude/Service	0	0	0	0	0	0
Billing/Financial	1	3	2	2	8	0.790
Quality of Practitioner Office Site	0	0	0	0	0	0
Total	1	3	2	3	9	0.889

Santa Clara Family Health Plan™

Victor Hernandez, QA Program Manager
Grievance & Appeals Department

Santa Clara Family Health Plan™

2022 Member Behavioral Health Experience Survey Results

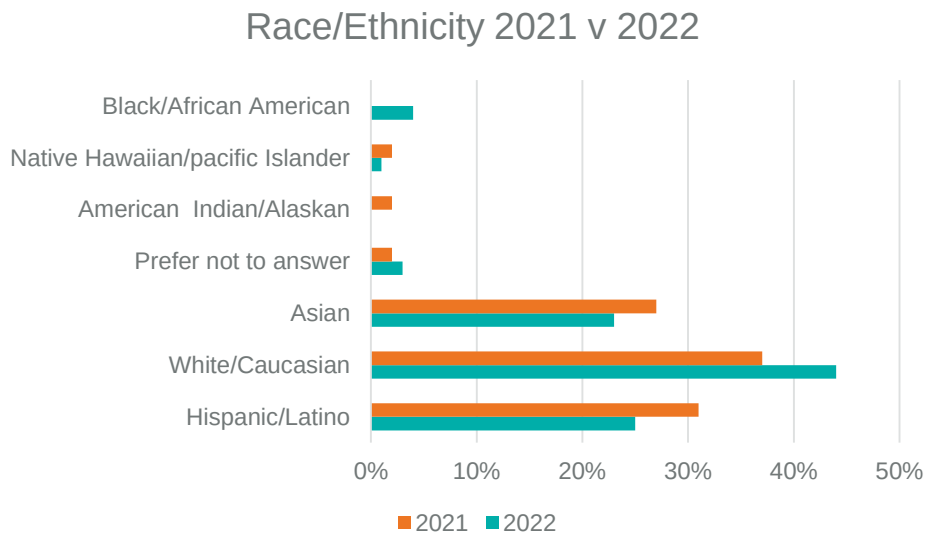
July 2022

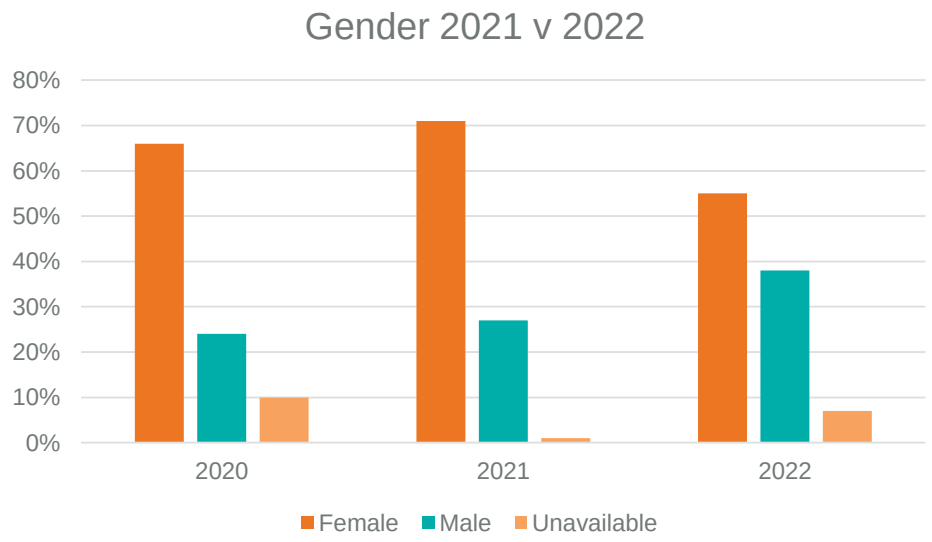
2022 Member Behavioral Health (BH) Experience Survey

- Annual telephonic survey conducted by the BH case management team
- **Survey purpose:** assess the members' perception of their access to care and quality of care
  - Survey language adapted from CAHPS supplemental questions, as suggested by NCQA
- **Methodology**:
  - 583 members received BH services in 2021
  - Random sample of 232 members (95% confidence interval and margin of error of 5)
  - BH Team conducted up to 2 calls per member between July 12, 2022 - July 22, 2022
  - Assessment responses logged in essette and provided to BH via Tableau report
- **Outcome**: 32% completion rate (compared to 23% in 2021)
  - # of Unable to Reach: increased from 46% to 78% of incompletions
  - # of Declined: decreased from 23% to 8% of incompletions

Demographics

- Age of members who completed surveys stayed the same from 2021 – 2022, with ages 55+ making up 80% of completed surveys



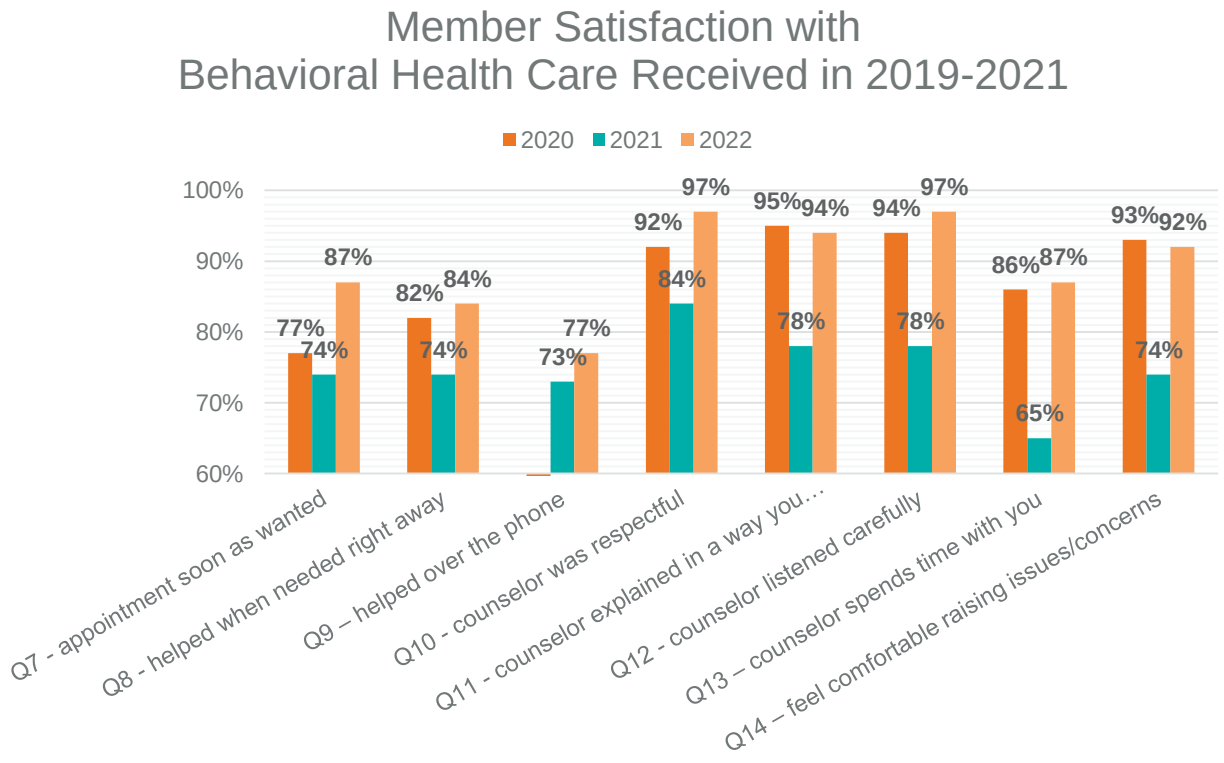


Survey Results

Survey Question	2020	2021	2022	Percentage Pt. Increase Yr/Yr	Goal = 85%
Q7 - appointment soon as wanted	0.77	0.74	0.87	13	Met
Q8 - helped when needed right away	**0.82**	**0.74**	**0.84**	**10**	**Not Met**
Q9 – helped over the phone	**NA**	**0.73**	**0.77**	**4**	**Not Met**
Q10 - counselor was respectful	0.92	0.84	0.97	13	Met
Q11 - counselor explained in a way you understood	0.95	0.78	0.94	16	Met
Q12 - counselor listened carefully	0.94	0.78	0.97	19	Met
Q13 – counselor spends time with you	0.86	0.65	0.87	22	Met
Q14 – feel comfortable raising issues/concerns	0.93	0.74	0.92	18	Met

Survey Results Observations

- 2022 survey responses suggest member satisfaction levels with their behavioral healthcare in 2021 are around the same level they were at in 2019.



Q15-Q20 Survey Results

- Other questions in the survey were meant to assess member progress and the impact of the behavioral health care on their lives:

- *Q15 – "Compared to 12 months ago, how would you rate your ability to deal with daily problems?"*
- *Q16 – "Compared to 12 months ago, how would you rate your ability to deal with crisis situations?"*
- *Q17 – "Compared to 12 months ago, how would you rate your ability to accomplish the things you wanted to do?"*
- *Q18 – "Compared to 12 months ago, how would you rate your ability to deal with social situations?"*
- *Q19 – "What effect has your counseling had on your symptoms and problems?"*
- *Q20 – "What effect has your counseling had on the quality of your life?"*

Q15-Q20 Survey Results

- 8-Percentage point decrease in members who felt that they were much or a little better at dealing with daily problems (**39%)** and, 5-percentage point decrease in members who reported that they were better at dealing with crisis situations (**43%)**
- 10-percentage point increase in respondents who believed they were more or a little better able to deal with social situations compared to 12 months ago **(40%)**
- 25 and 22-percentage point increase, respectively, in the number of members who responded that counseling has had a helpful impact on their quality of life **(65%)** as well as their symptoms/problems **(58%).**

Qualitative Analysis

- A cross-functional workgroup with representatives from QI, G&A, Health Services and Behavioral Health
- Workgroup noted the general increase in positive responses regarding behavioral healthcare experiences in 2021 and made the following observations:
  - Lightened COVID-19 restrictions in 2021 leading members to resume care
  - New contract with Array to provide mild-to-moderate BH telehealth services, increasing access to care
  - Behavioral Health Integration Incentive Program (BHIIP) kicked off in 2021, providing more behavioral health services for members at certain clinics as part of their primary care experience

Unmet Goals

- **Q8** – *"How often did you see someone as soon as you wanted when you needed help right away?"*
  - Responses improved by 10-percentage points but still did not meet 85% goal
  - Despite improvements, there are still limited available providers and long appointment wait times that may impact members' ability to access immediate care
  - Increase in behavioral health crisis and urgent need for care in 2021

- **Q9** – *"How often did you get the help or advice you needed over the phone?"*
  - Workgroup noticed ambiguity in this question and discussed the need to identify ***who*** the members are calling ***why***
  - Workgroup also noted the need for SCFHP and Santa Clara County Behavioral Health Services Department (SCCBHSD) to improve coordination to ensure a more seamless entry into the BH delivery system

Opportunities for Improvement

1. Improve coordination between SCCBHSD and SCFHP when members are calling in for BH referrals and/or screening
   - **Intervention(s)**:
     - SCFHP and SCCBHSD forming workgroup in 2022 to implement closed loop referrals of BH services and improved coordination between BH delivery systems

2. Educate members and providers on ways to access BH care when needed immediately due to crisis
   - **Intervention(s)**:
     - Promote new SCCBHSD 9-8-8 Crisis & Suicide Prevention 24-hr Lifeline among members & providers

3. Clarify survey language and process to allow for specific identification of opportunities for improvement
   - **Intervention(s):**
     - Improve information gathering of 2023 survey by providing BH team callers with information regarding the members' services received, and by clarifying the question verbiage to allow for more accurate root cause analyses

Santa Clara Family Health Plan™

Questions?

Contact Jamie Enke, BH Program Manager, jenke@scfhp.com

Annual Review of Quality Improvement Policies

August 9, 2022

Policy No.	Policy Title	Changes
QI.17 v3	Behavioral Health Care Coodination	Revised name; included information from QI.24 to address parity; included information from APL 22-005 and 22-006; No Wrong Door for Mental Health Services policy and Non Specialty Mental Health Services Coverage
QI.18 v2	Sensitive Services, Confidentiality, Rights of Adults and Minors	Removed reference to procedure that no longer exists; corrected departmental names in the Responsibilities section
QI.21 v2	Information Exchange Between SCFHP & Santa Clara County Behavioral Health Services Department (SCCBHSD)	Revised to be consistent with MOU; grammatical updates, spelling error updates; removed inappropriate language that was too specific and procedural for a policy
QI.25 v3	Palliative Care	Title change to Palliative Care; updated APL 18-020 which replaced APL 17-015; no major content change
QI.34 v1	Housing and Homelessness Incentive Program	N/A

POLICY

Policy Title:	Behavioral Health Care Coordination and Coverage	Policy No.:	QI.17
Replaces Policy Title (if applicable):	• Behavioral Health Care Coordination • Mental Health Parity	Replaces Policy No. (if applicable):	• QI.17 • QI.24
Issuing Department:	Health Services – Behavioral Health	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

The purpose of this policy is to outline the responsibilities of Santa Clara Family Health Plan (SCFHP) in ensuring members receive timely and consistent mental health services regardless of the initial delivery system from which they were referred. This policy also outlines SCFHP's responsibilities for the provision and/or arrangement of clinically appropriate and timely covered non-specialty mental health services (NSMHS) as well as the delineation of responsibilities for referring to and coordinating with Santa Clara County Behavioral Health Services Department (SCCBHSD) for the delivery of specialty mental health services (SMHS).

II. Policy

A. Medical Necessity

i. SCFHP is required to furnish all appropriate and medically necessary services that could be covered under California's Medicaid State Plan, as described in 42 USC Section 1396d(a).

ii. SCFHP defines medical necessity for NSMHS in accordance with California's Welfare and Institutions (W&I) Code sections 14059.5 and 14184.402. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.)

1. **Individuals under 21:** Medical necessity for individuals under 21 is established if the service is needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the California Medi-Cal state plan
    a. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and thus are medically necessary and covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
    b. In accordance with CMS federal guidelines, behavioral health services need not be curative or completely restorative to ameliorate a behavioral health condition.
2. **Individuals 21 and over**: A service is medically necessary when it is reasonable to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

POLICY

B. Eligible Populations

i. SCFHP provides and/or arranges the provision of NSMHS for the following populations:
   1. Members 21 and over with mild-to-moderate distress or impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders
   2. Members under 21 years of age, to the extent they are eligible for services under EPSDT, regardless of the level of distress or impairment, or the presence of a
   3. diagnosis; Members of any age with a potential undiagnosed mental health condition

C. Non-Specialty Mental Health Services (NSMHS)

i. SCFHP provides and/or arranges the provision of the following NSMHS:
   1. Mental health evaluation and treatment, including individual, group and family psychotherapy.
      a. SCFHP provides psychotherapy to members under 21 years of age with certain risk factors or mental health symptoms, in absence of a mental health disorder
      b. SCFHP covers up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when the therapy is delivered during the prenatal period, and/or delivered during the 12 months after childbirth.
   2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
   3. Outpatient services for purposes of monitoring drug therapy.
   4. Psychiatric consultation.
   5. Outpatient laboratory, drugs, supplies and supplement prescribed by SCFHP in-network providers.
      a. The above includes drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions.

D. Mental Health Parity and Mental Health Assessments

i. SCFHP provides access to outpatient mental health services for beneficiaries who do not meet the criteria for SMHS
ii. To ensure mental health parity with medical or surgical benefits, SCFHP members can request a mental health assessment from an in-network licensed mental health provider without a prior authorization. (Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)).
iii. 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.
iv. SCFHP does not require a prior authorization for an initial mental health assessment.
v. SCFHP also works with in-network PCPs to ensure mental health screenings are conducted as appropriate.
vi. If a member screens positive for a mental health condition, the PCP can treat the member within the scope of their practice or refer to an in-network mental health provider.

POLICY

E. Alcohol and Substance Use Disorder Screening, Referral, and Services

i. SCFHP provides for covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.

ii. Covered services include the provision of Medications for Addiction Treatment (MAT) provided in primary care, inpatient hospital, emergency departments and other contracted medical settings, as well as emergency services needed to stabilize the member.

iii. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug MediCal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by Santa Clara County, whether or not the member has a co-occurring mental health condition

F. Emergency Room Professional Services

i. As described in Section 53855 of Title 22 of the California Code of Regulations, SCFHP coverage includes:

1. facility and professional services and facility charges claimed by emergency departments,

2. all professional physical, mental, and substance use treatment services, screening examinations necessary to determine the presence or absence of an emergency medical condition and,

3. if an emergency medical condition exists, for all services medically necessary to stabilize the member

G. Coordination between Mental Health Delivery Systems

i. Clinically appropriate NSMHS are covered by SCFHP even when;

1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
    a. SCFHP will not deny reimbursement for NSMHS during the assessment period if the assessment determines that the member does not meet the criteria for NSMHS or SMHS.
2. Services are not included in an individual treatment plan, as long as services are clinically appropriate and covered;
3. The member has a co-occurring mental health condition and SUD; or,
4. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicative.
    a. For members receiving NSMHS and SMHS, SCFHP will coordinate with SCCBHSD to ensure member choice, facilitate care transitions, and to guide closed loop referrals between MSMHS and SMHS providers.

b. Members that have an established relationship with a provider for either NSMHS or SMHS will be able to continue to see this provider despite whether or not they are receiving simultaneous NSMHS and SMHS, provided the care is unduplicated and coordinated.

ii. SCFHP provides coverage and payment for medically necessary physical health care services rendered for a member receiving SMHS.

H. Care Coordination

i. 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, and contracted plan providers.

ii. 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.

III. Responsibilities

A. SCFHP Behavioral Health Department and SCCBHSD are responsible for coordinating to ensure timely, consistent, clinically appropriate and comprehensive NSMHS and SMHS are delivered to SCFHP members. Both parties are responsible for ensuring the loop is closed on any referrals made to another behavioral health delivery system.

B. SCFHP works with SCCBHSD to ensure the shared Memorandum of Understanding (MOU) memorializes relevant requirements set forth in this policy.

C. SCFHP Behavioral Health department partners with the Medical Management and Provider Contracting departments to ensure an adequate network of behavioral health providers necessary to provide NSMHS to its members.

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

E. For eligible members, SCFHP's Case Management department provides physical and mental health case management and care coordination for members receiving NSMHS or SMHS. This includes, but is not limited to, medication reconciliation and coordination of All medically necessary, contractually required Medi-CaL covered services, including mental health services, both within and outside of SCFHP's contracted provider network.

F. SCFHP is responsible for working with SCCBHSD to coordinate care for mutual members.

G. SCFHP informs members of coverage benefits set forth in this policy through member-facing communications, such as the Explanation of Coverage (EOC) handbook.

IV. References

A. California's Welfare and Institutions (W&I) Code sections 14059.5 and 14184.402

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006

C. CA Health and Safety Code 1367.01
D. DHCS APL 22-005
E. Mental Health Parity (Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR))
F. Medicaid Mental Health Parity Final Rule (CMS-2333-F)
G. Memorandum of Understanding (MOU) between Santa Clara Family Health Plan and Santa Clara County Behavioral Health Services Department
H. 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.

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
[Manager/Director Name] [Title] Date	[Compliance Name] [Title] Date	[Executive Name] [Title] Date

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

POLICY

Policy Title:	**Sensitive Services, Confidentiality, Rights of Adults and Minors**	**Policy No.:**	QI.18
Replaces Policy Title (if applicable):	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Replaces Policy No. (if applicable):**	C036_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ 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

III. Responsibilities

Health Services works with IT, Provider Network Operations, Customer Service, Providers and Community-Based Organizations 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

POLICY

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical 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	Quality Improvement	Approve; 8/9/2017	
v1	Reviewed	Quality Improvement	Approve; 6/6/2018	
v2				

POLICY

Policy Title:	Information Exchange Between Santa Clara Family Health Plan & Santa Clara County Behavioral Health Services Department	**Policy No.:**	QI.21
Replaces Policy Title (if applicable):	Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara County	**Replaces Policy No. (if applicable):**	HS.409
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

Santa Clara Family Health Plan (SCFHP) and Santa Clara County Behavioral Health Services Department (SCCBHSD) entered into a Memorandum of Understanding (MOU) effective January 1, 2014 to establish the responsibilities between the two entities regarding the provision of Medi-Cal Specialty Mental Health and/or drug Medi-Cal services as a managed care benefit under the Cal Medi-Connect (CMC) program. The purpose of this policy is to outline and expand upon the main roles, responsibilities, and requirements of SCCBHSD and SCFHP as stated in the MOU.

II. Policy

A. It is the policy of SCFHP to provide coordination of care for CMC members who are connected with SCCBHSD, their mental health clinics, and contractors. The SCFHP and the SCCBHSD 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 an attachment to the MOU. Medical necessity for Drug Medi-Cal Substance Abuse Services is as defined in Title 22, California Code of Regulations (CCR).

III. Responsibilities

A. Assessment Process

i. SCFHP and SCCBHSD maintain mutually agreed upon policies and procedures regarding screening and assessment processes that comply with all federal and state requirements, including the Care Coordination Standards and Behavioral Health Coordination Standards.

ii. 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 behavioral health and serious mental illness (SMI) indicators. The HRA, in conjunction with claims, pharmacy, and utilization data, may be used to develop an initial Individualized 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.

B. Referrals

SCFHP and SCCBHSD maintain mutually agreed upon policies and procedures regarding referral processes including:

i. SCCBHSD accepts referrals from SCFHP staff, providers, and members' self-referral for determination of medical necessity.

ii. SCFHP accepts referrals from SCCBHSD for services needed when the specific service is provided by SCFHP and not SCCBHSD, and the beneficiary does not meet Medi-Cal specialty mental health and/or Drug Medi-Cal medical necessity criteria.

C. Information Exchange

i. SCCBHSD and SCFHP will develop, agree on, and maintain information sharing policies and procedures that specify roles and responsibilities for sharing personal health information.

ii. Information sharing policies and procedures regarding the exchange of personal health information (PHI) for the purposes of medical and behavioral health care coordination are in alignment with Title 9, CCR, Section 1810.370(a)(3) and the Health Insurance Portability and Accountability Act, California Welfare and Institutions Code section 5328 (as applicable) and 42 CFR part 2.

iii. SCFHP will maintain a list of members who are receiving Medi-Cal specialty mental health services, and/or Drug Medi-Cal services for the purposes of tracking their care coordination and service delivery to the extent possible under state and federal privacy laws.

D. Care Coordination

i. 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.

ii. The policies and procedures include:

1. An identified point of contact from both SCCBHSD and SCFHP who will initiate and maintain ongoing care coordination.
2. SCCBHSD and their contractors will participate in ICT's for members receiving County services and identified as needing an ICT.
3. At the County's request, the SCFHP will assist SCCBHSD in developing behavioral health care plans.
4. 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.
5. SCFHP will have regular, quarterly meetings to review the care coordination process and effectiveness of the exchange of patient health information.
6. SCFHP will coordinate with the SCCBHSD to perform an annual review, analysis and 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

A. Memorandum of Understanding (MOU) between Santa Clara Family Health Plan and Santa Clara County Behavioral Health Services Department, including Amendments 1-6

B. Title 9, CCR, Section 1810.370(a)(3)

C. The Health Insurance Portability and Accountability Act
D. CFR part 2
E. California Code, Welfare and Institutions Code - WIC § 5328.1

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
[Manager/Director Name] [Title] Date	[Compliance Name] [Title] Date	[Executive Name] [Title] Date

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

POLICY

Policy Title:	**Palliative Care**	**Policy No.:**	QI.25
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:		**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

To promote access to appropriate and effective symptom management and palliative care in accordance with Final Draft All Plan Letter Palliative Care (APL) 18-020 and Senate Bill (SB) 1004, with the intent that members facing serious illness may achieve optimal quality of life.

II. Policy

A. The Palliative Care 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 Palliative Care program is organized to promote quality palliative care, client satisfaction and cost efficiency through the use of collaborative patient-centered palliative care services, evidence-based guidelines and protocols, and targeted goals and outcomes.
C. SCFHP defines the process of how the plan coordinates palliative care services for members with serious illness and helps them access needed resources and care.

III. Responsibilities

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

IV. References

California Welfare and Institutions Code (WIC) Section 14132.75
APL 18-020 Palliative Care, December 2018

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Angela Chen RN Director, Case Management & Behavioral Health Date	[Compliance Name] [Title] Date	Laurie Nakahira D.O. Chief Medical Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	8/2022	Quality Improvement Committee	08/09/2022	

POLICY

Policy Title:	**Housing and Homelessness Incentive Program**	**Policy No.:**	QI.34
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Long Term Services & Supports (LTSS)	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

To outline Santa Clara Family Health Plan's (SCFHP) process to follow All Plan Letter (APL) 22-007: California Housing and Homelessness Inventive Program (HHIP) in order to earn incentive payments linked to the HHIP implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal (MC) Home and Community-Based Services (HCBS) Spending Plan.

II. Policy

A. SCFHP acknowledges the incentive program intends to support delivery and coordination of health and housing services for MC members. DHCS:
   1. Rewards SCFHP for developing the necessary capacity and partnerships to connect their members to needed housing services; and
   2. Incentivizes SCFHP to take an active role in reducing and preventing homelessness

B. SCFHP acknowledges that by way of voluntary participation in this incentive program, the HHIP includes all MC members who are at risk of, have recently been, or are currently experiencing homelessness.

C. SCFHP expects the incentive program period to be effective from January 1, 2022 to December 31, 2023. The program period is split between two distinct Program Years (PY) with three distinct measurement periods:

MCP Submission	Measurement Period	MCP Submission Date	Program Year
MCP Local Homelessness Plan (LHP) Submission	January 1, 2022 to April 30, 2022	June 30, 2022	1
MCP Submission 1	May 1, 2022 to December 31, 2022	February 2023[2]	1
MCP Submission 2	January 1, 2023 to October 31, 2023	December 2023[3]	2

SCFHP complies with the following requirements to earn incentive payments for respective program years:

1. For Payment 1, DHCS evaluates SCFHP based on the quality of the LHP components submitted, including the Landscape Analysis, Funding Availability Assessment, and Managed Care Plan (MCP) Strategies, as well as on the program measures. Each program measure will either be earned in full or not earned.

a. SCFHP collaborates with other participating MCPs operating in Santa Clara County to submit a single Local Homelessness Plan (LHP);
b. SCFHP along with other participating MCPs completes the LHP Template in full, as outlines in the LHP;
c. SCFHP electronically submits to DHCSHHIP@dhcs.ca.gov by June 30, 2022

2. For Payment 2, SCFHP reports a set of quantitative and narrative measures, as outlines in the MCP Submission 1 Template, describing SCFHP's performance in Program Year 1 in February 2023.
3. For Payment 3, SCFHP reports a set of quantitative and narrative measures, as outlined in the MCP Submission 2 Template, describing SCFHP's performance in Program Year 2 in December 2023.

D. SCFHP defines individuals experiencing homelessness and/or are at risk of homelessness, as provided in Section 91.5 of Title 24 of the Code of Federal Regulations (CFR), include;
1. An individual or family who lacks adequate nighttime residence;
2. An individual or family with a primary residence that is a public or private place not designed or ordinarily used for habitation;
3. An individual or family living in a shelter;
4. An individual exiting an institution into homelessness;
5. An individual or family who will imminently lose housing in the next 30 days;
6. Unaccompanied youth and homeless families and children and defines as homeless under other federal statutes;
7. Individuals fleeing domestic violence.

E. SCFHP's efforts to meeting the program's goals and report measures include working closely with all applicable local partners, including but not limited to: local Continuums of Care (CoCs), counties, public health agencies, organizations that deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion) including Enhanced Care Management (EMC) and Community Supports, county mental health plans (MHPs), and Drug MC Organized Delivery System (DMC-ODS). SCFHP will maximize HHIP investment with these local partners leading housing and homelessness-related efforts and directly supporting and assisting this vulnerable population.

III. Responsibilities

A. Long Term Services and Supports (LTSS)
1. Manager, Social Determinants of Health, leads the HHIP and is responsible for ensuring collaboration with other participating MCPs in the county, the tracking and monitoring of DHCS metrics, stakeholder facilitation and communication, and DHCS submissions for the HHIP.
2. Community Supports and ECM program staff coordinates efforts to achieve related DHCS metrics.
3. LTSS provides recommendations for investment funding opportunities and monitors metrics related to investment.

B. Finance
1. Finance tracks and ensures payment for implementation of the HHIP for the health plan.

2. Finance provides payments to recipient during agreed upon timeframes.

C. Provider Network Operations (PNO)
   1. Contracting coordinates contractual agreements relation to achieving metrics and payment for community investments from the HHIP.
   2. PNO ensures subcontractors and network providers comply with all applicable state and federal laws.
   3. PNO facilitates communication with subcontractors and network providers on screening members for homelessness and referrals to ECM Homelessness Population of Focus and Community Supports programs related to housing.

IV. References

All Plan Letter (APL) 22-007: California Housing and Homelessness Incentive Program

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Lori Andersen, Director, LTSS [Manager/Director Name] [Title] **07/26/2022** Date	[Compliance Name] [Title] Date	[Executive Name] [Title] Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement Committee	08/09/2022	

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: 06/01/2022

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

DIRECT NETWORK		
Initial Credentialing		
Number initial practitioners credentialed	3	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	11	
Number practitioners recredentialed within 36-month timeline	11	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 05/31/2022	688	

DELEGATED NETWORS							
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**	**NEMS**
Total # of Suspension	0	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	1	0	0
Total # of Resignations	0	0	0	0	0	0	0
Total # of practitioners	1368	904	889	803	1218	499	1035

Total counts for some Networks have increased due to Provider Adds for Full Delegate Network Reporting.

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, August 10, 2022, 12:15 – 1:45 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

Members Present
Thad Padua, MD, Chair
Clara Adams, LCSW
Dolly Goel, MD
Michael Griffis, MD
Jimmy Lin, MD
Peter L. Nguyen, DO
Sherri Sager
Meg Tabaka, MD

Members Absent
Pedro Alvarez, MD
Ghislaine Guez, MD
Bridget Harrison, MD
Jack Pollack, MD
Hien Truong, MD

Staff Present
Christine Tomcala, Chief Executive Officer
Laurie Nakahira, DO, Chief Medical Officer
Ngoc Bui-Tong, Ms. Bui-Tong, VP, Strategies and Analytics
Angela Chen, Director, Case Management & Behavioral Health
Janet Gambatese, Director, Provider Network Operations
Dang Huynh, PharmD, Director, Pharmacy & Utilization Management
Brandon Engelbert, Manager, Provider Network Operations
Karen Fadley, Manager, Provider Data, Credentialing and Reporting
Amy O'Brien, Administrative Assistant
Robyn Esparza, Administrative Assistant

1. **Roll Call/Establish Quorum**
   Thad Padua, MD, Chair, called the meeting to order at 12:17 pm. Roll call was taken and a quorum was established.
2. **Public Comment**
   There was no public comment.
3. **Meeting Minutes**
   The minutes of the May 11, Provider Advisory Council (PAC) meeting were reviewed.

   It was moved, seconded, and the May 11, 2022, Provider Advisory Council (PAC) minutes were **unanimously approved.**

   Motion: Dr. Jimmy Lin
   Second: Dr. Peter Nguyen
   Ayes: Ms. Adams, Dr. Goel, Dr. Griffis, Dr. Lin, Dr. Nguyen, Dr. Padua, Ms. Sager, Dr. Tabaka

4. **Chief Executive Officer Update**

Christine Tomcala, CEO, presented the August 2022 Enrollment Summary and noted a total enrollment of 315,281, with 10,414 members in Cal MediConnect (CMC) and 304,867 members in Medi-Cal.

Ms. Tomcala noted the Plan is currently focused on routine audits, as well as new initiatives and expectations from the State regarding Medi-Cal reform.

5. **Pharmacy Updates**

   a. **Review and Discuss the Current Drug Reports**

   Dr. Huynh, Director, Pharmacy & Utilization Management, presented the 2022 Q2 Top 10 Drugs by Total Cost and Prior Authorization (PA) Volume for 04/01/22 – 06/30/22. Regarding the Top 10 Drugs by Total Cost report, Dr. Huynh noted that there is a similar mix of drugs from the previous quarter's top ten. The only noteworthy thing is the increase of approximately 200,000 from the previous quarter. For the CMC PAs by Volume report, Dr. Huynh noted there was not much of a change in top drugs other than an increase of Januvia and Abilify. The PA volume increased roughly by 100 PAs from the previous quarter.

   b. **Pharmacy Updates**

   Medi-Cal Rx

   Dr. Huynh noted as of July 1, 2022, blood pressure monitors are now a Medi-Cal Rx benefit. Members can now get blood pressure monitors and cuffs through the pharmacy. As of July 22, 2022, Medi-Cal Rx reinstated their Drug Utilization Review (DUR) Rejection Code 88. This DUR code stops claims such as early refill, late refill, and drug interaction. The DUR code can be overridden by a Pharmacist with a point-of-sale code stating that the prescriber or beneficiary has been counseled.

   DSNP Pharmacy

   Dr. Huynh noted as the Plan transitions from CMC to a Dual Special Needs (DSNP) Plan in 2023, the pharmacy benefit will be slightly different. The Plan will still manage the Medicare Part D benefit thru its PBM. The MC drugs, which are currently Tier 3 and Tier 4 drugs, will no longer be managed by the Plan. MC drugs will be under Medi-Cal Rx. Brand and generic Part D drugs will be under one tier at the cost of a zero-dollar co-pay thru a VBID (Value-Based Insurance Design) Program. We expect the same drugs to be covered from this and we will be working on transition plans for any members that may potentially impacted with the change.

6. **Utilization Management (UM) Updates**

   a. **CBAS Emergency Remote Services (ERS)**

   Dr. Huynh noted that as mentioned at the last meeting, the Temporary Access for Remote Services (TAS) will be ending on September 30th. It is expected that there will be some potential dis-enrollment from CBAS centers with members that are unable to go back to the centers for concerns of COVID-19. The plan has voiced some of our concerns to the Department of Aging and DHCS, however, Emergency Remote Services (ERS) is expected to be implemented on October 1st. ERS will allow remote services of CBAS when there is a national or personal emergency.

   b. **Biomarker Testing for Cancer (SB. 535)**

   Dr. Huynh noted there is a senate bill and an APL that requires MCPs in California to cover biomarker testing without prior authorization for FDA-associated treatment for Stage 3 and Stage 4 metastatic or advanced cancer. The plan removed PA requirements for any biomarker testing that is associated with FDA treatment. These would test for mutations in various types of cancer such as breast or lung cancer. The claims systems have been updated to meet this requirement.

   c. **Medi-Cal Intermediate Care Facilities Carve-In**

   Dr. Huynh noted long-term care is being carved into all the managed care plans, however, the Plan has already provided long-term care services as a benefit. Intermediate care facilities is part of that transition also carved into managed care plans. Starting January 1, 2023, the plan will be financially responsible for intermediate care facilities. SCFHP is working on contracting, identifying those members, and working on a transition and communication plan.

   d. **Low Acuity and Non-Emergent (LANE) Clinical Efficiency Handout**

   Ms. Ngoc Bui-Tong, VP, Strategies and Analytics, provided a presentation on Low Acuity and Non-Emergent (LANE) Clinical Efficiency. She reminded council she last presented in 2021 on this clinical efficiency that the State is looking into and is here to give an update on the matter to refresh the council on

what the program is about. She explained that the State, through its rate development process, looks at how the Plan's utilization is being reported to them and that they apply a certain efficiency, which basically means that we should be doing better UM patient education around Low Acuity and Non-Emergent (LANE) Clinical Efficiency. The presentation outlined the following: (1) The Definition of LANE Efficiency; (2) Which ED Visits Are Considered LANE; (3) SCFHP Top 15 Grouped LANE Diagnosis Codes, CY19 (used for CY22 rates); (4) Statewide Top 15 Grouped LANE Diagnosis Codes, CY19 (used for CY22 rates); (5) LANE Visits per Thousand by Network, Category of Aid (COA), and Race/Ethnicities; and (6) Strategies to Reduce LANE Visits.

Dr. Dolly Goel, VHP, inquired as to the success of MDLive and what the Plan was doing by way of education. Dr. Laurie Nakahira, CMO, noted some of the strategies related to tele-health education have included information in the health plan newsletter, as well as the website, and bringing it to the JOCs so that the providers can take back and educate their members. She also noted there are reports available that she can bring back to council that outlines the nurse advise line and how the flow goes from the nurse advise line and elevates to MDLive if needed, as well as providing the member utilization numbers. She noted that the Plan may not have yet compared to see if there is higher use of MD Live and the nurse advise line against our ED rates. She noted it may be hard to do due to COVID over the last two years and people avoiding the ED the first year of COVID. Per the data, there was a significant drop in ED usage.

**Action Item: Dr. Goel requested data regarding the success of MD Live and how MD Live reduces the number of ED visits, with discussion on further strategies to prevent overuse of ED.*

e. SCFHP Contracted Urgent Care Facilities

Ms. Bui-Tong noted in the LANE presentation strategies to reduce LANE visits and that the Plan has been working hard to increase our urgent care contracts since the State does not consider these visits in an urgent care setting as avoidable.

7. Quality

HEDIS & Health Disparity Follow-up

Dr. Laurie Nakahira, COO, provided an in-depth overview of the CY21 HEDIS Measure Analysis. She gave an FY '21-'22 Plan Objective Success Measure; Medi-Cal Managed Care Accountability Set (MCAS) Performance Trend; Medi-Cal HEDIS Measure Percentiles by Network & Ethnicity; Department of Health Care Services (DHCS) BOLD Goals 50x2025; CMC HEDIS/Stars Rate Overview.

Regarding the Medi-Cal MCAS Measures for CY 2021, council members inquired why there were deficiencies for Well-Child Visits. Dr. Nakahira explained the main reason was getting all six visits in before age 15 months and that was very difficult during COVID times. She noted the data is being looked at and work plans are being developed to try and get the children in earlier and that it really has to do with access and spacing out the immunizations.

Action Item: Dr. Goel requests further information on whether or not the Plan accepts TeleHealth visits as counting towards the postpartum visits metric. Dr. Nakahira will provide it at the next PAC meeting.

8. Provider Network Operations

a. Present Network Adequacy for DSNP

Item was heard out of order following agenda item #4, CEO Update. Ms. Karen Fadley, Manager, Provider Data, Credentialing and Reporting, Provider Network Operations (PNO), provided a detailed presentation on DSNP – CMS Network Adequacy. Ms. Fadley explained that CMS holds the plan accountable to a network of providers that meet member address to provider address – miles and minutes, along with a provider ratio for the county. The membership file that is used to evaluate SCFHP DSNP by CMS is a census file. We have to meet the 90% metric. Ms. Fadley noted that Podiatry, Outpatient or ASC Facility Surgical Services, and Facility Occupational Therapy are outliers not meeting access of the CMS sample membership with 89%, 86.5%, and 86.7% adequacy, respectively. Ongoing contracting efforts are still in play with our DSNP providers. Contracting efforts continue with PAMF and solo or group practitioners in North County; Contracting efforts also continue for Facility Surgical Services or ASC with PAMF and independent Ambulatory Surgery Centers in North and South County. Facility Occupational Therapy contract efforts continue with Good Samaritan and Regional.

b. Provider Satisfaction Survey Update

Ms. Janet Gambatese, Director, Provider Network Operations (PNO**)** informed the council that one of SCFHP's Plan Objectives for FY 2021-2022 was Provider Satisfaction and wanting to conduct an enhanced provider satisfaction survey with our providers and delegates to get a deeper dive into where we are doing good and where there is an opportunity for improvement. This involved working with a vendor to conduct an online survey and then conducting focus groups and individual interviews. Data is still being gathered and still have a few focus groups to conduct this month.

A presentation on Initial Findings of the Provider Satisfaction Survey was reviewed. There were a total of 61 respondents, who responded to the 23-item survey launched at the end of April 2022. Provider demographics included 60% working in primary care practices and 40% working in specialty practices. The majority of respondents were very familiar with SCFHP, with 42% reporting that their organization has worked with The Plan for 16 years or more. The longevity with The Plan is helpful in providing comparative data.

Most promising of the survey is the finding regarding overall satisfaction rates. Fifty-eight percent (58%) respondents report that The Plan is either "*somewhat above average*" or "*well above average*" when compared to other contracted health plans. Respondents identified the following Plan services as most effective: (1) Provider Relations; (2) Access to Non-Emergency Healthcare Services; and (3) Utilization Management. The respondents identified The Plan strengths as: (1) Patient access to care, including the ability to see patients without turning anyone way, access to lab services, CME courses, and gaps in care lists; (2) Communication with providers, including summaries of new APL and guidelines; and (3) Care & commitment shown to community, responsiveness of SCFHP staff to their practice, and the care and commitment shown to the community at large.

Review of the survey data revealed challenges faced by respondents including: (1) Timeliness in processing authorization requests; (2) Call system issues (reaching Plan staff); (3) Authorization mistakes & denials; (4) Delays in member reassignment; and (5) Difficulty utilizing translation services. Survey and focus group respondents report the need for additional network specialists including: (1) Mental health practitioners (adult and child); (2) Pediatric specialists; (3) Physical therapists; (4) Dermatology; and (5) Gastroenterologists

The next steps are to finish conducting the focus groups and individual interviews this month, identify trends, opportunities and interventions based off the survey results, and then implement them. Finally, we are going to develop a year round provider engagement strategy to keep a pulse on provider satisfaction with this year being the baseline and then conduct other surveys to get a pulse if we are improving with satisfaction.

9. Case Management / Behavioral Health

a. Crisis & Suicide Prevention Line - 988

Ms. Angela Chen, Director, Case Management & Behavioral Health, provided a presentation on the County of Santa Clara Crisis & Suicide Prevention Lifeline – 988. She noted that as of last month, members and their loved ones can now dial 988 to reach the Crisis & Suicide Prevention Line, where they can speak to a trained crisis counselor for help if they are experiencing thoughts of suicide or having a mental health, substance abuse crisis or any other type of emotional distress. The lifeline is anonymous, confidential and free to use 24/7, and available in over 200 languages. Ms. Chen advised that the Mental Health and Gateway Call Centers have merged. Instead of having two different phone numbers for individuals to call for mental health or substance abuse treatment services, individuals can now call just the one number at 800-704-0900 for any non-crisis support. The calls continue to be answered by Health Services representatives and transferred to licensed clinicians as appropriate. She encouraged council members to print the provided 988 Crisis Suicide Prevention Lifelines flyers and post around their offices for patients to access. She noted the flyers are also available on the county website as well. Council member inquired about what happens after the call, asking what happens members make the call and if they get follow-up with psychiatrist and/or counselor because there is a lack of providers. Ms. Chen noted BH Services has initiated multiple steering committees and workgroups with County Mental Health Department to talk about the ways to expedite the access to care. A brief review of 2022 Member Behavioral Health Experience Survey was provided.

10. Old Business

There was no old business discussed.

11. New Business

a. Save the Date: CME on M2M Behavioral Health

Dr. Nakahira, CMO, informed the council of the Continuing Medical Education (CME) scheduled for November 8, 2022, at Fiorillo's Banquet Facility. A virtual session is also scheduled for November 15th. The topic of education is Mild to Moderate Behavioral Health. Details to follow as the event draws closer.

12. Discussion / Recommendations

There were no further discussions and/or recommendations.

13. Adjournment

The meeting adjourned at 1:45 p.m. The next meeting is scheduled for Wednesday, November 9, 2022.

_____ _____

Thad Padua, Chair Date

Regular Meeting of the

Santa Clara County Health Authority

Consumer Advisory Committee

Tuesday, September 6, 2022, 6:00 PM – 7:00 PM
Santa Clara Family Health Plan – Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Sherri Sager, Chair
Rebecca Everett
Blanca Ezquerro
Rachel Hart
Ishendra Sinha
Hoang Truong
Tran Vu

Members Absent
Barifara (Bebe) Barife
Vishnu Karnataki
Ajit Raina
Maria Cristela Trejo Ramirez

Guests
Jadelynn Pettyplace
Timothy Pollard
Sandra Schaad

Staff Present
Chris Turner, Chief Operating Officer
Laurie Nakahira, DO, Chief Medical Officer
Chelsea Byom, Vice President, Marketing, Communications and Outreach
Lori Andersen, Operations Director, Long-Term Services and Supports
Mai Chang, Director, Quality and Process Improvement
Mike Gonzalez, Director, Community Engagement
Carole Ruvalcaba, Director, Marketing and Communications
Lucille Baxter, Manager, Quality and Health Education
Jocelyn Ma, Manager, Community Outreach
Jenny Arellano, Marketing Project Manager
Zara Hernandez, Health Educator
Amy O'Brien, Administrative Assistant

1. **Roll Call/Introduction of Members and SCFHP Staff**

   Sherri Sager, Chair, called the meeting to order at 6:02 p.m. Roll call was taken and a quorum was established. Consumer Advisory Committee members and SCFHP staff introduced themselves to Ms. Sager.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The minutes of the June 7, 2022 Consumer Advisory Committee meeting were reviewed.

   It was moved, seconded, and the minutes of the June 7, 2022 Consumer Advisory Committee meeting were **unanimously approved.**

Motion:	Mr. Sinha
Second:	Ms. Ezquerro
Ayes:	Ms. Everett, Ms. Ezquerro, Ms. Hart, Ms. Sager, Mr. Sinha, Mr. Truong, Mr. Vu
Absent:	Ms. Barife, Mr. Karnataki, Mr. Raina, Ms. Ramirez

4. Health Plan Update

Chris Turner, Chief Operating Officer, gave the Health Plan Update on behalf of Ms. Tomcala. The Plan's total membership includes 315,281 members as of August 1, 2022, and this is a 10.4% increase since August 2021. The Plan's Medi-Cal (MC) membership includes 304,867 members, and this is a 10.8% increase since August 2021.

Ms. Turner continued with a summary of various Plan updates that are of interest to the committee. The COVID-19 public health emergency is likely to extend through mid-January 2023. As a result, Board and committee meetings may remain virtual. Ms. Turner discussed the MC redeterminations "pause" which remains in effect until at least January 2023. Adults ages 26-49 will remain on "pause" until after January 2024. Ms. Turner gave a brief overview of the MC redeterminations process.

Ms. Turner discussed the expansion of MC eligibility offered to adults ages 50 or over regardless of their immigration status. Ms. Turner also shared that the results of the State's Medi-Cal re-procurement bid were announced, and the Department of Health Care Services (DHCS) will renew its contract with Anthem Blue Cross Partnership Health Plan, as the commercial Medi-Cal health insurance provider in Santa Clara County. The contract takes effect in 2024.

Ms. Turner continued with a summary of the Fiscal Year 2022-2023 Plan Objectives. She concluded her update with an overview of the Plan's activities and events that will be held in celebration of SCFHP's 25th anniversary.

At this time, guest, Sandra Schaad, joined the meeting with questions and concerns regarding the medical transportation benefit, and the customer service and grievance and appeals processes. Ms. Turner responded that new guidelines have very recently been issued by the state that set new standards for transportation to medical appointments. Once SCFHP has reviewed these guidelines and established a process for their implementation, members of this committee will be notified.

5. Population Needs Assessment (PNA) Report Medi-Cal

Zara Hernandez, Health Educator, presented the results of the Population Needs Assessment. Ms. Hernandez explained the purpose of the PNA. She gave a summary of the data sources that are used for the assessment. She also gave an overview of the Plan's 2021 membership profile, with a breakdown by ethnicity and languages spoken. Ms. Hernandez summarized the key findings of the PNA. She explained that, as part of the report, a program gap analysis is performed in the areas of health education, cultural and linguistics, and quality improvement in order to identify opportunities for improvement. Ms. Hernandez highlighted specific quality improvement interventions.

Ms. Hernandez concluded her presentation with the 2021 and 2022 action plans, and the interventions that were implemented throughout 2022 and for 2023. Due to limited time, Ms. Sager asked committee members to type any feedback into the chat box. There was neither feedback nor comments from members.

6. Medi-Cal Community Supports (CS)

Lori Andersen, Operations Director, Long-Term Services and Supports, presented an overview of the Medi Cal CS program. Ms. Andersen explained that the CS program is part of the new California Advancing and Innovating Medi-Cal (CalAIM) initiative. The goal of these CS programs is to provide a variety of social supports services to individuals to help them avoid institutionalization, or to assist them with their transitions out of institutions and back into their communities.

Ms. Andersen highlighted the various CS services available to eligible members as of January 1, 2022, and the upcoming services that will be available on January 1, 2023. Ms. Andersen summarized the various CS services, such as housing services, medically supportive home-delivered meal options, and Sobering Centers, which are just a few of the many programs available under CS. Ms. Andersen concluded her update

with an explanation on eligibility requirements and enrollment instructions. Members can refer to the complete Consumer Advisory Committee agenda packet for the slides that outline these services in detail.

7. Blanca Alvarado Community Resource Center

Mike Gonzalez, Director, Community Engagement, presented highlights of the recent activities at the Center. Mr. Gonzalez introduced 2 new Customer Service Representatives who work at the Center, Elizabeth Gonzales-Alvarez and Teresa Nguyen. He also highlighted the date, time, and address of SCFHP's 25th anniversary event, the staff members that will be available, and some of the activities that are planned for this event. Mr. Gonzalez encouraged the committee members to mark their calendars and plan to attend. For information on the specific programs, services, events, and resources offered at the Center, committee members can refer to the complete Consumer Advisory Committee agenda packet.

8. SCFHP Member Communications

Chelsea Byom, Vice President, Marketing, Communications, and Outreach highlighted the member communications completed since the June 2022 meeting. The summer newsletter has been mailed out to all Plan members. The Plan is in the process of mailing out the Wellness Rewards Outreach letters. There is also a new Behavioral Health Services webpage that provides members with information on how to access behavioral health services. Her presentation highlighted the SCFHP website which is updated with materials such as the Formulary, the Provider directory, and our quarterly newsletters. Ms. Byom concluded with a list of the events the Plan participated in since our June 2022 meeting.

9. Future Agenda Items

Ms. Sager announced that the next meeting is on Tuesday, December 6, 2022 at 6:00 p.m. SCFHP staff will add a discussion on the transportation benefit and the G&A process to the December agenda. At this time, it is expected this meeting will be conducted via Zoom. If this changes, members will be notified.

10. Adjournment

The meeting adjourned at 7:02 p.m.

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Sherri Sager, Chair
Consumer Advisory Committee

Santa Clara County Health Authority
Updates to Pay Schedule
September 22, 2022

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Chief Health Equity and Strategy Officer	Annually	227,539	295,801	364,062
Director, Infrastructure and System Support	Annually	158,013	205,417	252,821
Director, Vendor Management	Annually	158,013	205,417	252,821
Manager, Payroll	Annually	99,315	126,626	153,938
Supervisor, Enrollment and Eligibility	Annually	76,598	95,747	114,897
Vice President, Health Services	Annually	227,539	295,801	364,062

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
September 22, 2022

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Vice President, Strategies and Analytics	Annually	227,539	295,801	364,062

Santa Clara Family Health Plan™

Encounter Submission Services

Dual-Eligible Special Needs Plan (DSNP)

D-SNP Requirements

Submit encounter for each item and service provided to a Medicare Advantage Organization (MAO), including D-SNP, enrollee.

- Plans are required to
  - Submit data necessary to characterize the context and purposes of each item and service provided to Medicare enrollee by a provider, supplier, physician, or other practitioner;
  - Submit data that conform to CMS' requirements and to all relevant national standards;
  - Submit data at least once a month for Plans with less than 50,000 members;
  - Process encounter response files and make necessary corrections; and
  - Certify to the accuracy, completeness, and truthfulness of their encounter data (based on best knowledge, information and belief).
- Encounter data serve as basis for calculating Risk Adjustment Factor (RAF) which impacts capitation.

Vendor Recommendation and Possible Action

Vendor Selection

- Six vendors submitted proposals that included Encounter Data Processing System (EDPS) functionality.
  - Three vendors required the purchase of another product.
  - The current vendor Edifecs did not submit a proposal.
- The pricing for the remaining vendors ranged from $115K-450K per year.
- Currently, Edifecs' annual cost is $63.5K for maintenance but is not a hosted solution. Therefore, the support of the application requires additional SCFHP FTEs and additional costs for version upgrades.
- Optum was selected for functionality, pricing, and reference feedback.
  - This is a hosted solution, therefore, upgrade costs are included as well as less staff time involved in maintenance.

Possible Action

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with Optum, not to exceed $350,000 over three years.

Santa Clara Family Health Plan™

Vendor Selection for Customer Service Support Dual-Eligible Special Needs Plan (D-SNP)

September 15, 2022

D-SNP Customer Service Support Requirements

Ensure timely handling of member calls in accordance with CMS required hours of operation and telephone service standards

- Effective 10/1/2022, SCFHP must provide live customer service support (vs. use of alternative technology) 8am – 8pm, 7 days a week, including holidays*
- Call volumes during the evening hours are relatively low, but are high enough to impact our ability to achieve CMS call standards, and CMS conducts test calls to ensure coverage during these “off” hours
- CMS Telephone Service Levels:
  - 80% of calls answered within 30 seconds
  - Abandonment rate not to exceed 5%
  - Average hold time not to exceed 2 minutes

*Including New Years Day and other company holidays not recognized by the federal government

Current Status

SCFHP staff support CMC call center Mon-Fri 8am – 8pm

Staffing:

- Team of 3 people support the 5-8pm hours
- Rotating supervisory/management resource

Challenges:

- Hard on existing supervisory/management resources
- Expanding the requirements to include weekends/holidays will tax resources, reduce employee satisfaction, cause burnout and increase turnover

Call Volumes

Call volumes during the evening hours are relatively low, but are high enough to effect our ability to achieve CMS call standards, and CMS conducts test calls to ensure coverage during these “off” hours

Call Volumes:

- CMC Member total call volumes average = 3150/month
- Average talk time average = 9 minutes
- SCFHP Member Call volumes between 5-8pm range between 180-220 calls/month which equates to 6-7% of total calls/month during the M-F 5-8pm shift
    - If 6-7% of calls do not achieve CMS service levels, organizationally we will struggle to achieve overall compliance so this small volume is important to achieve/maintain compliance, and we need enough dedicated staff to meet CMS standards.

Recommended Solution

- Recommend outsourcing Customer Service staffing to cover hours including:
  - 5pm – 8pm Monday thru Friday
  - 8am – 8pm Saturday and Sunday
  - 8am – 8pm Holidays
  - Other times as needed for business purposes
- Recommended Vendor is Harte Hanks:
  - Proven track record working with Medicare Advantage plans
  - Excellent references
  - Utilize SCFHP computer systems to access Customer Service resources and document call tracking
  - Support business requirements in terms of flexibility and timeliness of execution
  - Cost is not dissimilar from staffing internally, and provides the additional support required to recruit, hire, train and manage a team

Budget

- SCFHP FY 22/23 Budget allocated $250k for one year to cover 3 Customer Service Representatives salary, overhead, holiday pay
- Harte-Hanks proposal includes customer service representatives, plus the necessary human resource, managerial and training resources required to hire and support this team

D-SNP Customer Service Solution

Possible Action

Authorize Chief Executive Officer to negotiate, execute, and amend a contract with Harte-Hanks for outsourcing of customer service staffing up to $320,000 annually for an initial one-year term, with the ability to renew for subsequent terms.

Santa Clara Family Health Plan.

2023

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Governing Board 12:00pm – 2:30pm	Quality Improvement Committee 6:00pm – 7:30pm
March 23	January 10
June 22	February 14
September 28	March 14
December 14	April 11
Executive/Finance Committee 10:30am – 12:30pm	May 9
	June 13
January 26	July 11
February 23	August 8
April 27	September 12
May 25	October 10
July 27	November 14
August 24	Utilization Management Committee 6:00pm – 8:00pm
October 26	
November 16	
Compliance Committee 1:30pm – 2:30pm	January 18
	April 19
	July 19
February 23	October 18
May 25	Credentialing Committee 12:15pm – 1:30pm
August 24	
November 16	
Provider Advisory Council 12:15pm – 1:45pm	February 1
	April 5
	June 7
February 8	August 2
May 10	October 4
August 9	December 6
November 8	Pharmacy & Therapeutics Committee 6:00pm – 8:00pm
Consumer Advisory Committee (Medi-Cal) 6:00pm – 7:00pm	March 16
March 7	June 15
June 6	September 21
September 5	December 14
December 5	Consumer Advisory Board (CAB) 11:30am – 1:00pm
	March 2
	June 1
	September 7
	December 7

MEMORANDUM

Date: September 15, 2022

From: Tyler Haskell, Interim Compliance Officer

To: SCFHP Executive/Finance Committee

Re. AB 361 compliance

Background

Because the Governor's executive order suspending certain Brown Act requirements expired at the end of September 2021, the Legislature passed, and the Governor signed, AB 361. AB 361 amended Government Code §54953 to permit teleconferencing by local agencies during a declared state of emergency without providing public access to each individual teleconference location. In order to do so, a local agency must make the following findings by majority vote every 30 days:

- The local agency has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

The Executive/Finance Committee met and made the above findings in August and the Governing Board needs to do so again in order for the Governing Board and committees to continue meeting remotely during the ongoing declared state of emergency.

Recommended Action

Make the following findings and approve continued use of teleconferencing without providing public access to each teleconference location:

- Santa Clara Family Health Plan has reconsidered the circumstances of the state of emergency.
- Any of the following circumstances exist:
    - The state of emergency continues to directly impact the ability of the members to meet safely in person.
    - State or local officials continue to impose or recommend measures to promote social distancing.

Santa Clara Family Health Plan™

Unaudited Financial Statements

For The Month Ended July 31, 2022

Agenda

Santa Clara Family Health Plan

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Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$114.3 M		$114.3 M	
Medical Expense (MLR)	$104.6 M	91.5%	$104.6 M	91.5%
Administrative Expense (% Rev)	$6.0 M	5.3%	$6.0 M	5.3%
Other Income/(Expense)	$614K		$614K	
Net Surplus (Net Loss)	**$4.3 M**		**$4.3 M**	
Cash and Investments			$496 M	
Receivables			$556 M	
Total Current Assets			$1.06 B	
Current Liabilities			$801 M	
Current Ratio			1.33	
Tangible Net Equity			$289 M	
% of DMHC Requirement			841.0%	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Net Loss)	Month: Surplus of $4.3M is $3.5M or 434.8% favorable to budget of $799K surplus. YTD: Surplus of $4.3M is $3.5M or 434.8% favorable to budget of $799K surplus.
Enrollment	Month: Membership was 313,729 (8,054 or 2.6% higher than budget of 305,675). YTD: Member Months YTD was 313,729 (8,054 or 2.6% higher than budget of 305,675).
Revenue	Month: $114.3M ($2.2M or 2.0% favorable to budget of $112.1M). YTD: $114.3M ($2.2M or 2.0% favorable to budget of $112.1M).
Medical Expenses	Month: $104.6M ($157K or 0.2% unfavorable to budget of $104.5M). YTD: $104.6M ($157K or 0.2% unfavorable to budget of $104.5M).
Administrative Expenses	Month: $6.0M ($946K or 13.5% favorable to budget of $7.0M). YTD: $6.0M ($946K or 13.5% favorable to budget of $7.0M).
Tangible Net Equity	TNE was $289.4M (represents approximately three months of total expenses).
Capital Expenditures	YTD Capital Investments of $108K vs. $6.2M annual budget, primarily hardware.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment of 313,729 members is 8,054 or 2.6% higher than budget. Since the beginning of the fiscal year, total enrollment has increased by 7,347 members or 2.4%, which largely represents newly-eligible MCAL undocumented adults.
- Medi-Cal & CMC enrollment have been increasing since March 2020 largely due to COVID. Beginning in March 2020, annual eligibility redeterminations were suspended and, as a result, enrollment continues to increase.
- Since the beginning of the fiscal year, Medi-Cal Non-Dual enrollment has increased 2.7%, Medi-Cal Dual enrollment has increased 0.6%, and CMC enrollment has grown 0.2%.

	For the Month July 2022				For One Month Ending July 31, 2022					
	Actual	Budget	Variance	Variance (%)	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY23 vs. FY22
Medi-Cal	303,375	295,291	8,084	2.7%	303,375	295,291	8,084	2.7%	274,030	10.7%
Cal Medi-Connect	10,354	10,384	(30)	(0.3%)	10,354	10,384	(30)	(0.3%)	10,148	2.0%
Total	**313,729**	**305,675**	**8,054**	**2.6%**	**313,729**	**305,675**	**8,054**	**2.6%**	**284,178**	**10.4%**

Santa Clara Family Health Plan Enrollment By Network
July 2022

Network	Medi-Cal		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	41,872	14%	10,354	100%	52,226	17%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	152,547	50%	-	0%	152,547	49%
North East Medical Services	3,422	1%	-	0%	3,422	1%
Palo Alto Medical Foundation	7,427	2%	-	0%	7,427	2%
Physicians Medical Group	45,486	15%	-	0%	45,486	14%
Premier Care	16,415	5%	-	0%	16,415	5%
Kaiser	36,206	12%	-	0%	36,206	12%
Total	**303,375**	**100%**	**10,354**	**100%**	**313,729**	**100%**
Enrollment at June 30, 2022	296,050		10,332		306,382	
Net Δ from Beginning of FY22	2.5%		0.2%		2.4%	

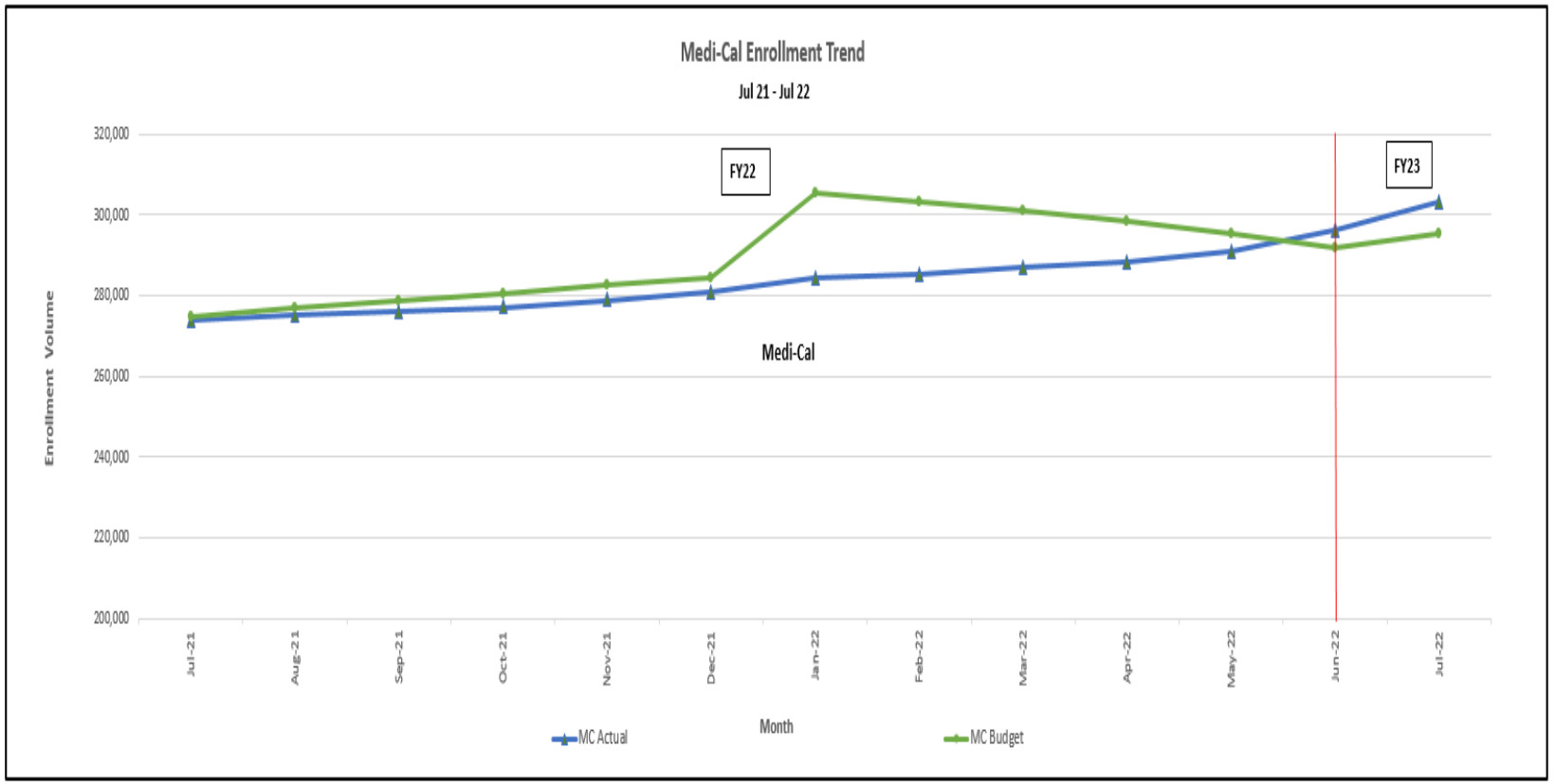
[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD JULY - 2022

		2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	FYTD var	%
NON DUAL	Adult (over 19)	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	39,310	1,449	3.8%
	Child (under 19)	101,010	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	103,866	245	0.2%
	SPD	22,363	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	25,130	930	3.8%
	Adult Expansion	90,711	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	106,715	4,517	4.4%
	Long Term Care	414	408	401	391	385	392	391	403	395	393	397	398	412	14	3.5%
	Total Non-Duals	**247,493**	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**275,433**	**7,155**	**2.7%**
DUAL	Adult (over 21)	367	376	375	396	398	408	410	403	407	412	431	423	424	1	0.2%
	SPD	23,980	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	24,491	107	0.4%
	Long Term Care	1,127	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	1,159	11	1.0%
	SPD OE	1,063	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	1,868	51	2.8%
	Total Duals	**26,537**	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**27,942**	**170**	**0.6%**
	Total Medi-Cal	**274,030**	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**303,375**	**7,325**	**2.5%**
CMC	CMC Non-Long Term Care	9,939	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	10,146	19	0.2%
	CMC - Long Term Care	209	208	203	208	204	210	202	213	215	206	206	205	208	3	1.5%
	Total CMC	**10,148**	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**10,354**	**22**	**0.2%**
	Total Enrollment	**284,178**	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**313,729**	**7,347**	**2.4%**

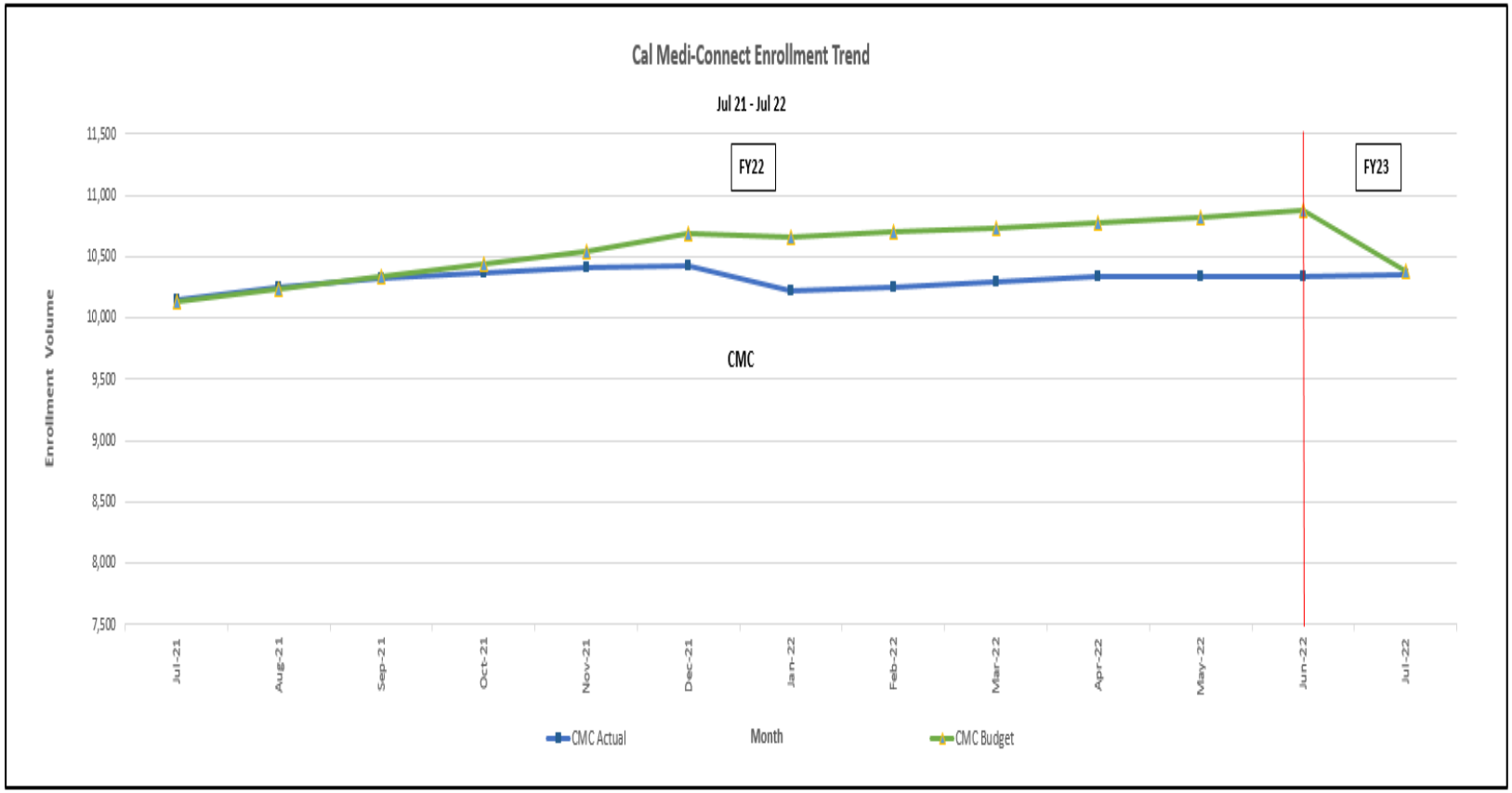
Medi-Cal Enrollment Trend



- Actual enrollment, represented by the blue line, showed a continued COVID enrollment growth through FY22 primarily due to public health emergency (PHE). Newly undocumented members starting July 23.

- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY22 but continues to increase due to sustained public health emergency. The FY22 budget included a higher projection of new mandatory Medi-Cal population having Other Health Coverage (OHC) starting Jan 2022. The FY23 budget assumed (1) the PHE continued through October & (2) lower estimated Undocumented Adult enrollment.

Cal Medi-Connect Enrollment Trend

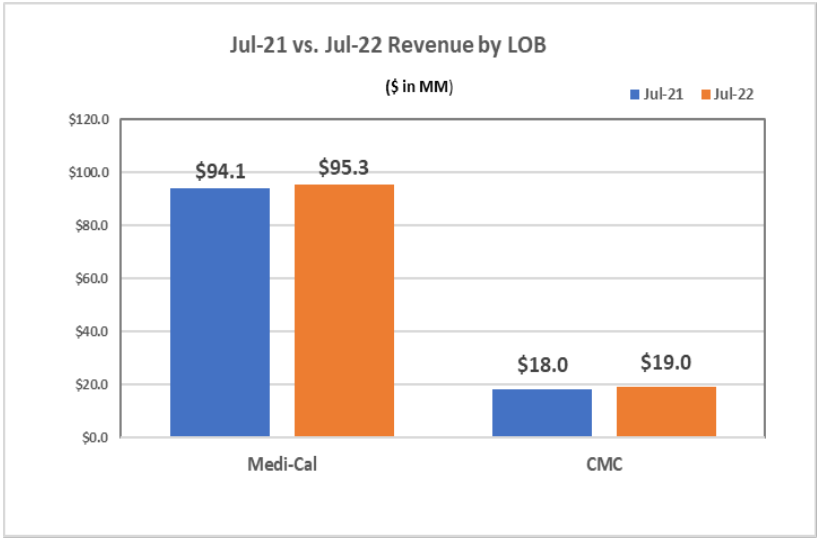


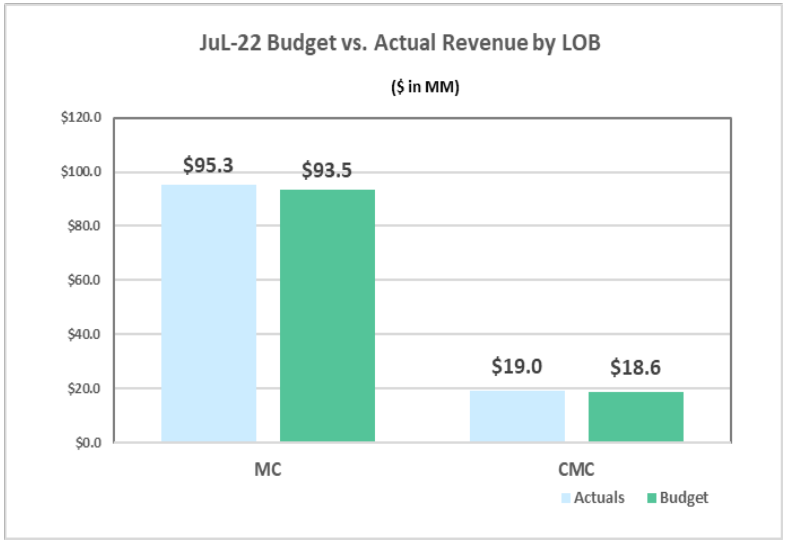
- Actual enrollment, represented by the blue line, showed a continued COVID enrollment growth through FY22 primarily due to public health emergency (PHE). Eligibility reinstates at January 1.
- Budgeted enrollment, represented by the green line, was presumed to plateau in late FY22 but continues to increase due to the sustained public health emergency. Beginning Jan 23, projections for D-SNP program are included.

Current Month Revenue

Current month revenue of $114.3M was $2.2M or 2.0% favorable to budget of $112.1M. The current month variance was primarily due to the following:

- Medi-Cal revenue was $1.9M favorable to budget due primarily to (1) higher enrollment ($4.5M favorable, (2) supplemental revenue ($1.4M favorable) due to increased BHT utilization and higher maternity deliveries, (3) COVID incentive program ($824K favorable), offset by (4) unfunded DHCS incentive programs (HHIIP, ECM and SBHIP) ($3.4M unfavorable), (5) revised LTC counts versus budget ($839K unfavorable), and (6) the Prop 56 Value Based Payment program was discontinued on June 30 ($605K unfavorable). The unfavorable revenue variances and favorable medical expense variances pertaining to incentive payments offset, due to timing of receipt.
- CMC revenue was $366K favorable to budget due to (1) higher Part C rate, (2) favorable mix corridor estimate, offset by (3) lower enrollment versus budget.

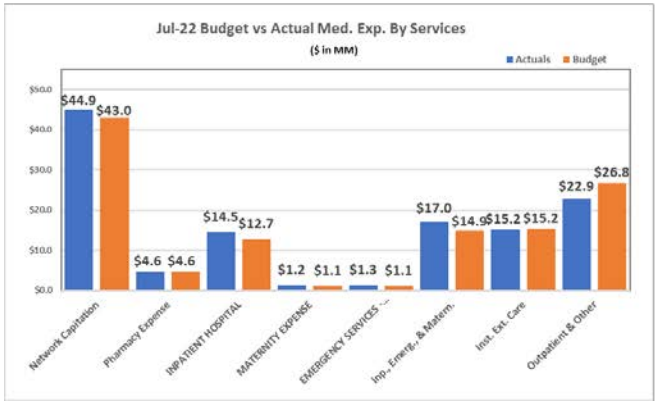


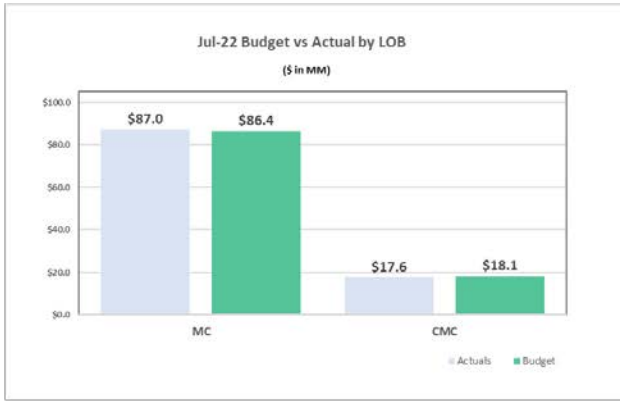


Current Month Medical Expense

Current month medical expense of $104.6M was $157K or 0.2% unfavorable to budget of $104.5M. The current month variance was due largely to:

- Fee-For-Service expense was $3.1M or 6.4% unfavorable to budget due to (1) increased unit cost versus budget for Inpatient, LTC, Transportation, Outpatient, and Physician Specialty services ($4.4M unfavorable) and (2) increased supplemental Behavioral Health Therapy utilization ($1.7M unfavorable) (offset with favorable revenue variance), offset by (3) lower utilization in PCP, Other Medical services, ECM, and Community Support services ($3.0M favorable).
- Capitation expense was $706K or 1.6% unfavorable to budget due to (1) higher capitated enrollment than expected ($811K unfavorable volume variance), offset by (2) lower blended CY22 rate which is based on actual member mix ($105K favorable rate variance).
- Reinsurance & Other expenses were $3.7M or 54.3% favorable to budget due to unspent (1) Housing & Homelessness Incentive Program ($1.8M favorable), (2) ECM Provider Incentive Program ($957K favorable), (3) Prop 56 Value Based Payment program was discontinued on June 30 ($579K favorable), (4) School of Behavioral Incentive Program ($375K favorable), (5) increased claim recoveries ($44K favorable). The unfavorable revenue variances and favorable medical expense variances pertaining to incentive payments offset, due to timing of receipt.

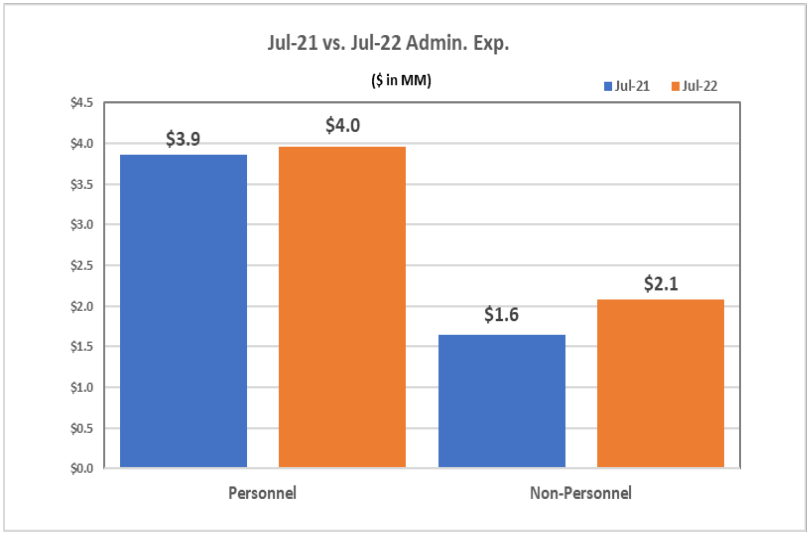


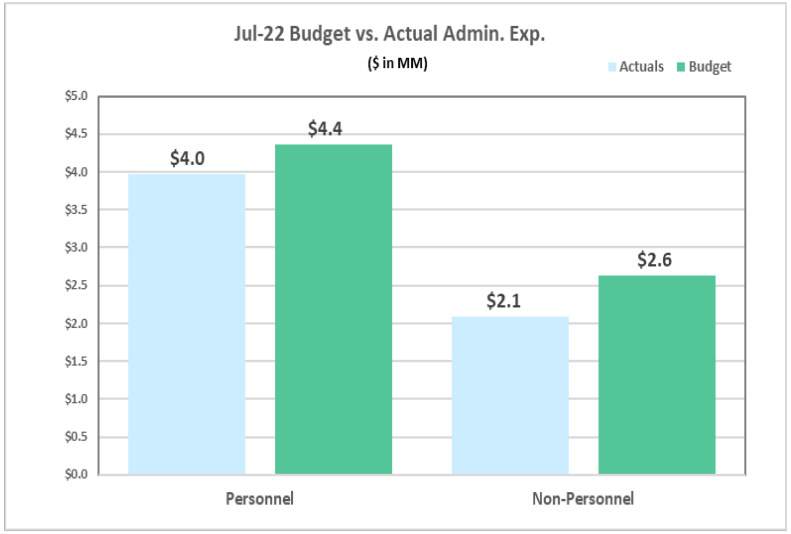


Current Month Administrative Expense

Current month expense of $6.0M was $946K or 13.5% favorable to budget of $7.0M. The current month variances were primarily due to the following:

- Personnel expenses were $393K or 9.0% favorable to budget due to lower headcount than budget which included payroll tax, benefit savings and CalPERS reconciliations.
- Non-Personnel expenses were $553K or 21.0% favorable to budget due to the timing of spending in certain expense categories.





Balance Sheet

- Current assets totaled $1.06B compared to current liabilities of $800.8M, yielding a current ratio (Current Assets/Current Liabilities) of 1.33:1 vs. the DMHC minimum requirement of 1.0:1.
- On a YTD basis, the overall cash balance decreased by $54.8M compared to the cash balance as of year-end June 30, 2022 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
Short-Term Investments				
County of Santa Clara Comingled Pool	$183,653,817	1.25%	$100,000	$100,000
Wells Fargo Investments	($20)	0.00%	$0	$0
City National Bank Investments	$269,965,289	1.51%	$471,128	$471,128
	$453,619,086		$571,128	$571,128
Cash & Equivalents				
City National Bank Accounts	$37,701,145	0.01%	$536	$536
Wells Fargo Bank Accounts	$4,745,735	1.76%	$5,594	$5,594
	$42,446,880		$6,130	$6,130
Assets Pledged to DMHC				
Restricted Cash	$325,000	0.01%	$3	$3
Petty Cash	$500	0.00%	$0	$0
Month-End Balance	**$496,391,466**		**$577,260**	**$577,260**

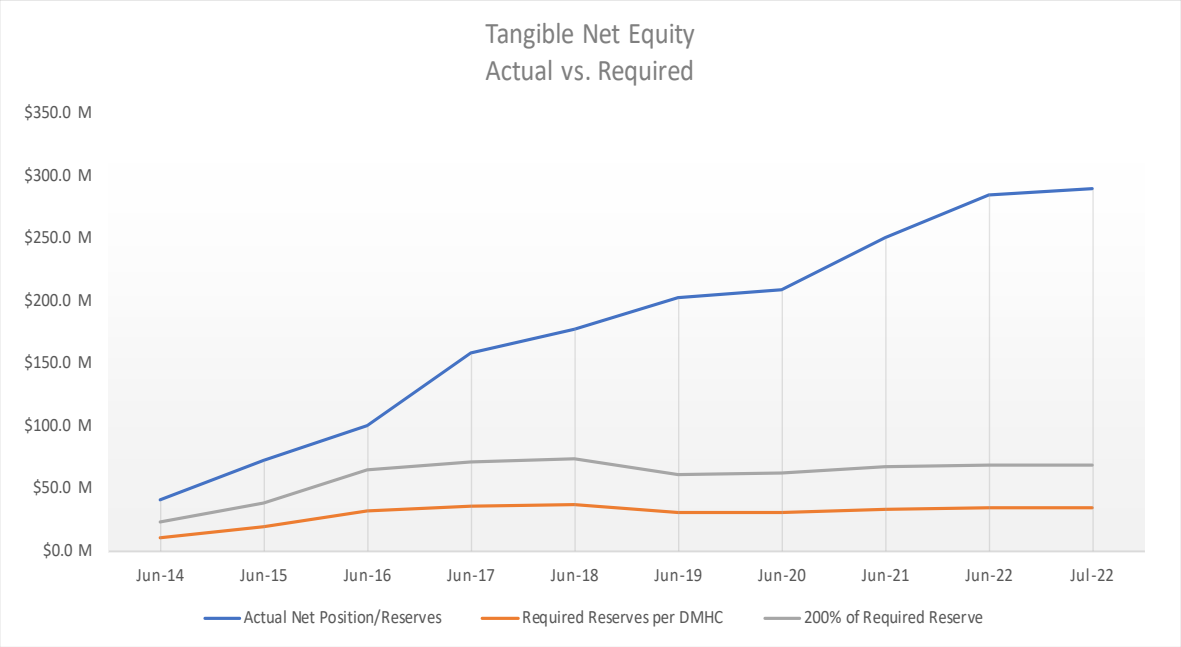
- Cash balances include balances payable to the State of CA for certain items.
- County of Santa Clara Comingled Pool funds have longer-term investments with a higher yield.
- Overall cash and investment yield is significantly higher than budget (1.30% actual vs. 0.3% budgeted).

Tangible Net Equity

- TNE was $289.4M - representing approximately three months of the Plan's total expenses.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of July 31, 2022

	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21	Jun-22	Jul-22
Actual Net Position/Reserves	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$202.1 M	$208.6 M	$250.4 M	$285.1 M	$289.4 M
Required Reserves per DMHC	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$30.9 M	$31.3 M	$33.9 M	$34.7 M	$34.4 M
200% of Required Reserve	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$61.8 M	$62.5 M	$67.8 M	$69.5 M	$68.8 M
Actual as % Required	357.5%	376.9%	309.8%	441.2%	483.4%	654.4%	667.2%	739.1%	821.0%	841.0%



Reserves Analysis

Santa Clara Family Health Plan

SCFHP RESERVES ANALYSIS JULY 2022

Financial Reserve Target #1: Tangible Net Equity	Board Funds Committed	Approved Projects	Funds Expended	Balance
Unrestricted Net Assets				**$249,656,434** *
Board Designated Funds (Note 1):				
Special Project Funding for CBOs	$4,000,000	$774,995	$494,995	$3,505,005
Innovation & COVID-19 Fund	$16,000,000	$7,944,043	$4,042,591	$11,957,410
Subtotal	$20,000,000	$8,719,038	$4,537,585	$15,462,415
Net Book Value of Fixed Assets				$23,976,239
Restricted Under Knox-Keene Agreement				$325,000
Total Tangible Net Equity (TNE)				$289,420,088
Current Required TNE				$34,414,852
TNE %				841.0%
SCFHP Target TNE Range:				
350% of Required TNE (Low)				$120,451,984
500% of Required TNE (High)				$172,074,262
Total TNE Above/(Below) SCFHP Low Target				**$168,968,104**
Total TNE Above/(Below) High Target				**$117,345,825**
Financial Reserve Target #2: Liquidity				
Cash & Investments				$496,391,466
Less Pass-Through Liabilities:				
Hospital Directed Payments				(357,214)
MCO Tax Payable to State of CA				(15,754,630)
Prop 56 / Whole Person Care				(1,672,180)
Other Pass-Through Liabilities (Note 2)				(119,799,014)
Total Pass-Through Liabilities				**(137,583,038)**
Net Cash Available to SCFHP				358,808,428
SCFHP Target Liquidity (Note 3)				
45 Days of Total Operating Expense				(167,169,144)
60 Days of Total Operating Expense				(222,892,192)
Liquidity Above/(Below) SCFHP Low Target				**191,639,284**
Liquidity Above/(Below) High Target				**135,916,236**

- **Unrestricted Net Assets represents approximately 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 & COVID-19 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

- YTD Capital investments of $108K, largely due to hardware, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Community Resource Center	$0	$94,400
Hardware	$90,366	$2,205,000
Software	$17,500	$3,806,437
Building Improvements	$0	$30,650
Furniture & Equipment	$339	$36,000
TOTAL	**$108,205**	**$6,172,487**

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
INCOME STATEMENT
For One Month Ending July 31, 2022

	Jul-2022 Actuals	% of Rev	Jul-2022 Budget	% of Rev	Current Month Variance $	Current Month Variance %	YTD Jul-2022 Actuals	% of Rev	YTD Jul-2022 Budget	% of Rev	YTD Variance $	YTD Variance %
REVENUES												
MEDI-CAL	$ 95,336,206	83.4%	$ 93,478,688	83.4%	$ 1,857,518	2.0%	$ 95,336,206	83.4%	$ 93,478,688	83.4%	$ 1,857,518	2.0%
CMC MEDI-CAL	3,865,351	3.4%	3,771,482	3.4%	93,869	2.5%	3,865,351	3.4%	3,771,482	3.4%	93,869	2.5%
CMC MEDICARE	15,114,063	13.2%	14,841,540	13.2%	272,523	1.8%	15,114,063	13.2%	14,841,540	13.2%	272,523	1.8%
TOTAL CMC	18,979,414	16.6%	18,613,022	16.6%	366,392	2.0%	18,979,414	16.6%	18,613,022	16.6%	366,392	2.0%
TOTAL REVENUE	**$ 114,315,620**	**100.0%**	**$ 112,091,710**	**100.0%**	**$ 2,223,910**	**2.0%**	**$ 114,315,620**	**100.0%**	**$ 112,091,710**	**100.0%**	**$ 2,223,910**	**2.0%**
MEDICAL EXPENSES												
MEDI-CAL	$ 87,020,800	76.1%	$ 86,354,697	77.0%	$ (666,103)	(0.8%)	$ 87,020,800	76.1%	$ 86,354,697	77.0%	$ (666,103)	(0.8%)
CMC MEDI-CAL	3,167,976	2.8%	3,644,174	3.3%	476,198	13.1%	3,167,976	2.8%	3,644,174	3.3%	476,198	13.1%
CMC MEDICARE	14,418,777	12.6%	14,451,763	12.9%	32,986	0.2%	14,418,777	12.6%	14,451,763	12.9%	32,986	0.2%
TOTAL CMC	17,586,753	15.4%	18,095,937	16.1%	509,185	2.8%	17,586,753	15.4%	18,095,937	16.1%	509,185	2.8%
TOTAL MEDICAL EXPENSES	**$ 104,607,553**	**91.5%**	**$ 104,450,634**	**93.2%**	**$ (156,919)**	**(0.2%)**	**$ 104,607,553**	**91.5%**	**$ 104,450,634**	**93.2%**	**$ (156,919)**	**(0.2%)**
GROSS MARGIN	**$ 9,708,067**	**8.5%**	**$ 7,641,076**	**6.8%**	**$ 2,066,992**	**27.1%**	**$ 9,708,067**	**8.5%**	**$ 7,641,076**	**6.8%**	**$ 2,066,992**	**27.1%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 3,966,196	3.5%	$ 4,359,048	3.9%	$ 392,852	9.0%	$ 3,966,196	3.5%	$ 4,359,048	3.9%	$ 392,852	9.0%
RENTS AND UTILITIES	54,529	0.0%	39,803	0.0%	(14,725)	(37.0%)	54,529	0.0%	39,803	0.0%	(14,725)	(37.0%)
PRINTING AND ADVERTISING	59,129	0.1%	88,975	0.1%	29,846	33.5%	59,129	0.1%	88,975	0.1%	29,846	33.5%
INFORMATION SYSTEMS	353,297	0.3%	461,429	0.4%	108,133	23.4%	353,297	0.3%	461,429	0.4%	108,133	23.4%
PROF FEES/CONSULTING/TEMP STAFFING	955,865	0.8%	1,202,683	1.1%	246,818	20.5%	955,865	0.8%	1,202,683	1.1%	246,818	20.5%
DEPRECIATION/INSURANCE/EQUIPMENT	311,096	0.3%	449,516	0.4%	138,420	30.8%	311,096	0.3%	449,516	0.4%	138,420	30.8%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	56,642	0.0%	65,161	0.1%	8,519	13.1%	56,642	0.0%	65,161	0.1%	8,519	13.1%
MEETINGS/TRAVEL/DUES	112,717	0.1%	189,013	0.2%	76,296	40.4%	112,717	0.1%	189,013	0.2%	76,296	40.4%
OTHER	179,956	0.2%	139,833	0.1%	(40,123)	(28.7%)	179,956	0.2%	139,833	0.1%	(40,123)	(28.7%)
TOTAL ADMINISTRATIVE EXPENSES	**$ 6,049,428**	**5.3%**	**$ 6,995,462**	**6.2%**	**$ 946,034**	**13.5%**	**$ 6,049,428**	**5.3%**	**$ 6,995,462**	**6.2%**	**$ 946,034**	**13.5%**
OPERATING SURPLUS/(LOSS)	**$ 3,658,640**	**3.2%**	**$ 645,614**	**0.6%**	**$ 3,013,026**	**466.7%**	**$ 3,658,640**	**3.2%**	**$ 645,614**	**0.6%**	**$ 3,013,026**	**466.7%**
INTEREST & INVESTMENT INCOME	$ 577,260	0.5%	$ 118,000	0.1%	$ 459,260	389.2%	$ 577,260	0.5%	$ 118,000	0.1%	$ 459,260	389.2%
OTHER INCOME	36,287	0.0%	35,284	0.0%	1,003	2.8%	36,287	0.0%	35,284	0.0%	1,003	2.8%
NON-OPERATING INCOME	**$ 613,547**	**0.5%**	**$ 153,284**	**0.1%**	**$ 460,263**	**300.3%**	**$ 613,547**	**0.5%**	**$ 153,284**	**0.1%**	**$ 460,263**	**300.3%**
NET SURPLUS (LOSS)	**$ 4,272,187**	**3.7%**	**$ 798,898**	**0.7%**	**$ 3,473,289**	**434.8%**	**$ 4,272,187**	**3.7%**	**$ 798,898**	**0.7%**	**$ 3,473,289**	**434.8%**

Balance Sheet

Santa Clara Family Health Plan

SANTA CLARA COUNTY HEALTH AUTHORITY
As of July 31, 2022

	Jul-2022	Jun-2022	May-2022	Jul-2021
Assets				
Current Assets				
Cash and Investments	$ 496,391,466	$ 551,230,175	$ 530,957,859	$ 398,162,794
Receivables	555,607,005	548,791,748	546,977,941	516,784,910
Prepaid Expenses and Other Current Assets	9,665,098	6,854,698	7,304,447	9,307,620
Total Current Assets	**$ 1,061,663,568**	**$ 1,106,876,622**	**$ 1,085,240,247**	**$ 924,255,325**
Long Term Assets				
Property and Equipment	$ 52,806,959	$ 52,698,754	$ 52,661,309	$ 51,843,223
Accumulated Depreciation	(28,830,720)	(28,593,844)	(28,247,165)	(24,811,725)
Total Long Term Assets	23,976,239	24,104,910	24,414,144	27,031,498
Total Assets	**$ 1,085,639,807**	**$ 1,130,981,532**	**$ 1,109,654,390**	**$ 951,286,823**
Deferred Outflow of Resources	**$ 5,156,729**	**$ 5,156,729**	**$ 5,379,606**	**$ 7,413,357**
Total Assets & Deferred Outflows	**$ 1,090,796,536**	**$ 1,136,138,261**	**$ 1,115,033,997**	**$ 958,700,180**
Liabilities and Net Assets:				
Current Liabilities				
Trade Payables	$ 15,109,231	$ 12,915,439	$ 11,108,109	$ 5,681,993
Deferred Rent	43,003	43,785	44,567	48,033
Employee Benefits	4,771,651	4,559,004	4,270,614	3,212,807
Retirement Obligation per GASB 75	2,499,662	2,499,662	2,459,537	1,817,537
Whole Person Care	1,672,180	1,678,180	1,684,180	1,879,180
Prop 56 Pass-Throughs	56,013,654	53,418,561	63,768,752	45,153,608
HQAF Payable to Hospitals	4,715	4,715	4,751	103,819
Hospital Directed Payment Payable	352,499	352,499	352,688	472,944
Pass-Throughs Payable	28,838,527	24,557,190	20,485,300	181
Due to Santa Clara County Valley Health Plan and Kaiser	45,401,893	83,721,764	77,175,627	22,173,902
MCO Tax Payable - State Board of Equalization	15,754,630	35,019,123	24,890,650	14,757,661
Due to DHCS	90,960,487	90,267,754	88,077,172	59,213,361
Liability for In Home Support Services (IHSS)	419,990,933	419,990,933	419,990,933	419,990,933
Current Premium Deficiency Reserve (PDR)	8,294,025	8,294,025	8,294,025	8,294,025
DHCS Incentive Programs	7,889,389	7,718,646	7,718,646	0
Medical Cost Reserves	103,240,652	105,409,762	103,332,724	101,984,270
Total Current Liabilities	**$ 800,837,131**	**$ 850,451,043**	**$ 833,658,276**	**$ 697,801,789**
Non-Current Liabilities				
Net Pension Liability GASB 68	(0)	(0)	(0)	(124,085)
Total Non-Current Liabilities	**$ (0)**	**$ (0)**	**$ (0)**	**$ (124,085)**
Total Liabilities	**$ 800,837,131**	**$ 850,451,042**	**$ 833,658,275**	**$ 697,677,704**
Deferred Inflow of Resources	**$ 539,318**	**$ 539,318**	**$ 539,318**	**$ 539,318**
Net Assets				
Board Designated Fund: Special Project Funding for CBOs	$ 3,505,005	$ 3,505,005	$ 3,505,005	$ 3,337,274
Board Designated Fund: Innovation & COVID-19 Fund	11,957,410	12,082,410	12,082,410	13,730,001
Invested in Capital Assets (NBV)	23,976,239	24,104,910	24,414,144	27,031,498
Restricted under Knox-Keene agreement	325,000	325,000	325,000	325,000
Unrestricted Net Equity	245,384,247	214,833,276	214,524,042	210,426,828
Current YTD Income (Loss)	4,272,187	30,297,300	25,985,802	5,632,558
Total Net Assets / Reserves	**$ 289,420,088**	**$ 285,147,901**	**$ 280,836,403**	**$ 260,483,159**
Total Liabilities, Deferred Inflows and Net Assets	**$ 1,090,796,536**	**$ 1,136,138,261**	**$ 1,115,033,997**	**$ 958,700,180**

Cash Flow Statement

Santa Clara Family Health Plan

	Jul-2022
Cash Flows from Operating Activities	
Premiums Received	$ 88,928,604
Medical Expenses Paid	(145,096,534)
Adminstrative Expenses Paid	823,878
Net Cash from Operating Activities	**$ (55,344,052)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	$ (108,205)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	613,547
Net Increase/(Decrease) in Cash & Cash Equivalents	**$ (54,838,710)**
Cash & Investments (Beginning)	551,230,175
Cash & Investments (Ending)	**$ 496,391,466**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Surplus/(Loss)	$ 3,658,640
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	236,877
Changes in Operating Assets/Liabilities	
Premiums Receivable	(6,815,256)
Prepaids & Other Assets	(2,810,400)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	9,276,086
State Payable	(18,571,760)
IGT, HQAF & Other Provider Payables	(38,319,871)
DHCS Incentive Programs	170,743
Medical Cost Reserves & PDR	(2,169,110)
Total Adjustments	**$ (59,002,692)**
Net Cash from Operating Activities	**$ (55,344,052)**

Statement of Operations by Line of Business - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For One Month Ending July 31, 2022

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Grand Total
P&L (ALLOCATED BASIS)					
REVENUE	$95,336,206	$3,865,351	$15,114,063	$18,979,414	**$114,315,620**
MEDICAL EXPENSE	$87,020,800	$3,167,976	$14,418,777	$17,586,753	**$104,607,553**
(MLR)	91.3%	82.0%	95.4%	92.7%	91.5%
GROSS MARGIN	$8,315,406	$697,375	$695,286	$1,392,661	**$9,708,067**
ADMINISTRATIVE EXPENSE	$5,045,063	$204,549	$799,816	$1,004,365	**$6,049,428**
(% of Revenue Allocation)					
OPERATING SURPLUS/(LOSS)	$3,270,343	$492,826	($104,530)	$388,296	**$3,658,640**
(% of Revenue Allocation)					
OTHER INCOME/(EXPENSE)	$511,682	$20,746	$81,119	$101,865	**$613,547**
(% of Revenue Allocation)					
NET SURPLUS/(LOSS)	$3,782,025	$513,572	($23,411)	$490,161	**$4,272,187**
PMPM (ALLOCATED BASIS)					
REVENUE	$314.25	$373.32	$1,459.73	$1,833.05	**$364.38**
MEDICAL EXPENSES	$286.84	$305.97	$1,392.58	$1,698.55	**$333.43**
GROSS MARGIN	$27.41	$67.35	$67.15	$134.50	**$30.94**
ADMINISTRATIVE EXPENSES	$16.63	$19.76	$77.25	$97.00	**$19.28**
OPERATING INCOME/(LOSS)	$10.78	$47.60	($10.10)	$37.50	**$11.66**
OTHER INCOME/(EXPENSE)	$1.69	$2.00	$7.83	$9.84	**$1.96**
NET INCOME/(LOSS)	$12.47	$49.60	($2.26)	$47.34	**$13.62**
ALLOCATION BASIS:					
MEMBER MONTHS - YTD	303,375	10,354	10,354	10,354	313,729
REVENUE BY LOB	83.4%	3.4%	13.2%	16.6%	100.0%

Santa Clara Family Health Plan™

Appendix

Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD AUGUST - 2022

		2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	FYTD var	%
NON DUAL	Adult (over 19)	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	37,861	39,310	39,644	334	0.8%
	Child (under 19)	101,085	101,093	101,125	101,411	101,722	102,516	102,519	102,740	103,211	103,765	103,621	103,866	103,987	121	0.1%
	SPD	22,276	22,331	22,381	22,463	22,537	22,740	22,731	22,749	22,751	22,836	24,200	25,130	25,189	59	0.2%
	Adult Expansion	91,392	91,960	92,393	93,186	94,092	95,819	96,366	97,386	98,130	99,249	102,198	106,715	107,599	884	0.8%
	Long Term Care	408	401	391	385	392	391	403	395	393	397	398	412	432	20	4.9%
	Total Non-Duals	**248,442**	**249,331**	**250,099**	**251,690**	**253,396**	**257,118**	**257,780**	**259,374**	**261,014**	**263,280**	**268,278**	**275,433**	**276,851**	**1,418**	**0.5%**
DUAL	Adult (over 21)	376	375	396	398	408	410	403	407	412	431	423	424	422	-2	(0.5%)
	SPD	24,159	24,206	24,244	24,307	24,320	24,330	24,350	24,378	24,282	24,352	24,384	24,491	24,518	27	0.1%
	Long Term Care	1,115	1,092	1,083	1,106	1,111	1,085	1,107	1,102	1,111	1,126	1,148	1,159	1,153	-6	(0.5%)
	SPD OE	1,135	1,223	1,308	1,372	1,431	1,496	1,531	1,612	1,666	1,739	1,817	1,868	1,923	55	2.9%
	Total Duals	**26,785**	**26,896**	**27,031**	**27,183**	**27,270**	**27,321**	**27,391**	**27,499**	**27,471**	**27,648**	**27,772**	**27,942**	**28,016**	**74**	**0.3%**
	Total Medi-Cal	**275,227**	**276,227**	**277,130**	**278,873**	**280,666**	**284,439**	**285,171**	**286,873**	**288,485**	**290,928**	**296,050**	**303,375**	**304,867**	**1,492**	**0.5%**
CMC	CMC Non-Long Term Care	10,037	10,122	10,160	10,211	10,221	10,017	10,038	10,084	10,127	10,128	10,127	10,146	10,200	54	0.5%
	CMC - Long Term Care	208	203	208	204	210	202	213	215	206	206	205	208	214	6	2.9%
	Total CMC	**10,245**	**10,325**	**10,368**	**10,415**	**10,431**	**10,219**	**10,251**	**10,299**	**10,333**	**10,334**	**10,332**	**10,354**	**10,414**	**60**	**0.6%**
	Total Enrollment	**285,472**	**286,552**	**287,498**	**289,288**	**291,097**	**294,658**	**295,422**	**297,172**	**298,818**	**301,262**	**306,382**	**313,729**	**315,281**	**1,552**	**0.5%**

Santa Clara Family Health Plan™

Fiscal Year 2021-2022 Team Incentive Compensation

September 23, 2021

Performance Level	Payout *(% of salary/ wages)*	Medi-Cal Quality HEDIS *(average performance score)*	CMC Quality HEDIS *(average performance score)*	Compliance Metrics *(% of dashboard metrics in compliance)*	Reduce COVID Vaccination Disparities *(% of members ≥ age 12 who received ≥1 dose)*	D-SNP Network Contracting
weighting		*25%*	*25%*	*25%*	*10%*	*15%*
Max	10%	≥ 2.30	≥ 2.21	98% - 100%	≥ 78.0%	Mid + PCPs serving 95% of members contracted by June 1, 2022
Mid	7%	2.15 - 2.29	1.98 - 2.20	95% - 97.9%	73.0% - 77.9%	Min + 100% network adequacy by June 1, 2022
Min	5%	2.00 - 2.14	1.75 - 1.97	93% - 94.9%	68.0% - 72.9%	90% network adequacy by February 1, 2022
Outcome	***3.2%***	*2.47*	*1.47*	*90.2*	*76.5%*	

Calculation:

- 0.25 (Medi-Cal HEDIS Payout %) + 0.25 (CMC HEDIS Payout %) + 0.25 (Compliance Metrics Payout %) + 0.10 (COVID Vaccine Payout %) + 0.15 (Contracting Payout %) = **Overall Percent Payout**

- All staff are eligible to receive the Overall Percent Payout multiplied by the salary/wages they were paid as a regular employee from July 2021 through June 2022. (Does not include PTO cash out.)

Process:

- Santa Clara Family Health Plan must achieve a **Net Operating Surplus** as a gate to any incentive award consideration.

- Incentive compensation will be determined upon receipt of the audited financial statements for the fiscal 2021-22 performance year.

- **HEDIS average performance scores** are based on the following scale:

Point Value	National Percentile
4	≥ 90th
3	75th
2	50th
1	25th
0	< 25th

- **Medi-Cal HEDIS** will be calculated as the average point value of all measures (15) held to the minimum performance level (MPL) in measurement/calendar year 2021, based on the four-point scale.

- **CMC HEDIS** will be calculated as the average point value of all quality measures (47) with NCQA benchmarks in measurement/calendar year 2021, based on the four-point scale.

- **Compliance Metrics** will be calculated as the percent of compliance dashboard measures that meet or exceed regulatory requirements (July 2021 – June 2022).

- **COVID Vaccinations** will be calculated as the percent of members age 12 and up in June 2022, who have received at least one COVID vaccine dose.

- **D-SNP Contracting** will be based on the CMS HSD Table network adequacy standards.

- To be eligible to receive a payout, an employee must be employed by Santa Clara Family Health Plan in a regular position at the time of distribution. Employees who score less than Meets Expectations (< 3.00) on their 2022 annual performance appraisal will be eligible to receive half of the Overall Percent Payout.

Fiscal Year 2022-2023 Team Incentive Compensation

September 22, 2022

Performance Level	Payout *(% of salary/ wages)*	Medi-Cal Quality HEDIS *(average performance score)*	CMC Quality HEDIS *(average performance score)*	Compliance Metrics *(% of dashboard metrics in compliance)*	Reduce Health Disparities *(% of African American/Black members receiving post-partum care)*	CalAIM *(Key components of DHCS Population Health Management [PHM] program guide implemented)*
weighting		*25%*	*25%*	*20%*	*15%*	*15%*
Max	10%	≥ 2.14	≥ 1.68	95.5% - 100%	≥ 75%	4 requirements
Mid	7%	2.07 - 2.13	1.60 - 1.67	94% - 95.9%	72% - 74.9%	3 requirements
Min	5%	2.00 - 2.06	1.52 - 1.59	92% - 93.9%	69% - 71.9%	2 requirements

Calculation:

- 0.25 (Medi-Cal HEDIS Payout %) + 0.25 (CMC HEDIS Payout %) + 0.20 (Compliance Metrics Payout %) + 0.15 (Health Disparity Payout %) + 0.15 (CalAIM Payout %) = **Overall Percent Payout**

- All staff are eligible to receive the Overall Percent Payout multiplied by the salary/wages they were paid as a regular employee from July 2022 through June 2023. (Does not include PTO cash out.)

Process:

- Santa Clara Family Health Plan must achieve a **Net Operating Surplus** as a gate to any incentive award consideration.

- Incentive compensation will be determined upon receipt of the audited financial statements for the fiscal 2022-23 performance year.

- **HEDIS average performance scores** are based on the following scale:

Point Value	National Percentile
4	≥ 90th
3	75th
2	50th
1	25th
0	< 25th

- **Medi-Cal HEDIS** will be calculated as the average point value of all measures (15) held to the minimum performance level (MPL) in measurement/calendar year 2022, based on the four-point scale.

- **CMC HEDIS** will be calculated as the average point value of all quality measures (45) with NCQA benchmarks in measurement/calendar year 2022, based on the four-point scale.

- **Compliance Metrics** will be calculated as the percent of compliance dashboard measures that meet or exceed regulatory requirements (July 2022 – June 2023).

- **Reduce Health Disparities** will be calculated as the percent of African American/Black members who receive post-partum care following delivery (July 2022 – June 2023).

- **CalAIM** will be based on the number of the following DHCS PHM program guide components that are implemented by the noted date:

    1. Integrate behavioral and dental health into Risk Stratification and Segmentation (RSS) by January 2023.
    2. Develop and implement a data strategy that establishes a foundation to ensure health for all, reducing biases, by March 2023.
    3. Establish Admission/Discharge/Transfer (ADT) data feed with all contracted hospitals and share data with PCPs by June 2023.
    4. Establish ADT data feed/share with the top 5 Medi-Cal census Skilled Nursing Facilities by June 2023.
    5. Establish agreements with at least 3 organizations listed in the PHM Guide to facilitate care coordination and exchange of information by June 2023.

- To be eligible to receive a payout, an employee must be employed by Santa Clara Family Health Plan in a regular position at the time of distribution. Employees who score less than Meets Expectations (< 3.00) on their 2023 annual performance appraisal will be eligible to receive half of the Overall Percent Payout.

Santa Clara County Health Authority
Board Designated Innovation Fund Request Summary

Organization Name:	Santa Clara Family Health Plan (SCFHP)
Project Name:	25th Anniversary Scholarship Program
Contact Name and Title:	Chelsea Byom, Vice President, Marketing, Communications & Outreach cbyom@scfhp.com 408.680.3175
Requested Amount:	$500,000
Time Period for Project Expenditures:	10/1/2022 – 10/1/2027
Proposal Submitted to:	Governing Board, 09/22/2022
Date Proposal Submitted to SCFHP for Review:	N/A

Summary of Proposal:

In honor of Santa Clara Family Health Plan's 25th anniversary, SCFHP proposes designation of $500,000 from the Innovation Fund to establish a health care career scholarship program. The scholarship program will provide financial support to empower the next generation of healthcare professionals in Santa Clara County who reflect the diversity of SCFHP members and community, in support of our 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. Through this scholarship program, SCFHP seeks to reduce the barriers to higher education by covering the tuition and/or non-tuition costs associated with completing a degree or certificate program.

Summary of Projected Outcome/Impact:

Scholarships will be awarded to members of Santa Clara Family Health Plan who are attending colleges and universities within Santa Clara County. By streamlining eligibility criteria, SCFHP will minimize the administrative burden on applicants to ensure scholarships are attainable by our members. SCFHP staff will manage and disburse the scholarships, not to exceed $5,000 per person per year, and not to exceed $100,000 in total disbursements per year.

Evaluation Relative to SCFHP Innovation Fund Criteria and Considerations:

Criteria	Met/Not Met
1. Demonstrate focus on identified gaps in serving our members, potential members, and providers to better meet health needs, consistent with SCFHP's mission.	Met
2. Demonstrate that the initiative will enable SCFHP to address evolving state and federal health care policy and regulatory expectations.	Met
3. Demonstrate ability to work in collaboration with organizations in the community, as appropriate for the initiative.	Met
4. Demonstrate alignment with SCFHP Strategic Plan.	Met
a. Demonstrate the project addresses health equity and/or reduces health disparities for SCFHP members.	✓
b. Demonstrate the project addresses Social Determinants of Health (SDOH).	✓
c. Demonstrate that the project promotes quality of care and/or cost efficiency.	✓
d. Demonstrate that the project promotes service excellence and/or administrative efficiency.	✓
5. Indicate if funding is being sought from other potential sources.	N/A

SCFHP's 25th Anniversary Event

Celebrating 25 years of service to Santa Clara County and Health for All

Activities will include:
Health screenings
Resource fair
Entertainment & music
And more!

Date: Saturday, October 22, 2022

Location: SCFHP Blanca Alvarado Community Resource Center
408 N. Capitol Ave. San Jose, CA 95133

Time: 10 am – 3 pm

25 YEARS
Health for All

AB 2449

Public Meeting Teleconferencing

- Permitted without normal requirements under certain circumstances
  - Personal or family emergency—requires approval of the body
  - Just cause—no approval required, but limited to twice per calendar year
    - Caring for a family member
    - Contagious illness
    - Physical or mental disability
    - Official business travel on behalf of the body/agency
  - Disclose presence and relationship with anyone under 18 in the room
  - Must participate using audio **and** visual technology
  - Quorum must participate physically at the noticed location

Santa Clara Family Health Plan™

Cal MediConnect Transition to Duals Special Needs Plan

September 22, 2022

Transition from CMC to D-SNP

Overview

- Individuals dually eligible for Medicare and Medi-Cal (duals) are among the highest need populations.
- Lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care.
- California has made significant progress in building integrated systems through the implementation of the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC) in seven counties.
- As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs across California.
- This includes mandatory enrollment for duals into Managed Care Plans (MCPs) for their Medi-Cal benefit and increasing the availability of aligned D-SNPs.
- This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their Medi-Cal MCP.

Dual Eligible Special Needs Plans

- D-SNPs are Medicare Advantage (MA) health plans which provide specialized care for dual eligible beneficiaries that must have a State Medicaid Agency Contract (SMAC) with the Department of Health Care Services (DHCS).
- D-SNPs serve dual eligible beneficiaries who are individuals eligible for both Medicare and Medi-Cal.
- Under CalAIM, DHCS is moving toward aligned enrollment in D-SNPs; having beneficiaries enroll in an MCP and D-SNP operated by the same parent company allows for greater integration and coordination of care.
- Aligned enrollment for Santa Clara County begins in 2023.

D-SNP vs. Cal MediConnect

What's the difference?

- CMC is a demonstration project that is part of the Coordinated Care Initiative (CCI) that combined both Medicare and Medi-Cal benefits and services into a single benefit package for individuals who are fully eligible for Medicare and Medicaid.
- CMC plans coordinate dual eligible members Medicare and Medi-Cal benefits under a single health plan.
- The CMC program has only been available in 7 CCI counties including Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara. These counties are the first to transition to the D-SNP effective January 1, 2023.
- Other counties statewide will launch their D-SNP programs in 2024 and 2025 to meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

From the Member's Perspective

- D-SNPs offer an integrated approach to care and care coordination like CMC.
- SCFHP will deliver all covered benefits to members.
- Members will receive integrated member materials such as one integrated ID card.
- Members will begin to receive notices regarding the transition in October 2022.
- Members will be "lifted and shifted" from CMC to the D-SNP. No action is necessary for them to be enrolled.
- Beneficiaries enrolled in a D-SNP product prior to January 1, 2023 will be able to remain in those plans. Alternatively, they may enroll in FFS Medicare, or other MA products.
- MA D-SNP "Look alike" plans that offer the same cost-sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal will not have their contracts renewed if they project 80% or more of their enrollment will be entitled to Medicaid.

From the Provider's Perspective

- SCFHP offered new contracts to all providers who were contracted under the Cal MediConnect program.
- Providers are still directly contracted with the plan – not through a delegated relationship.
- Like CMC, only credentialing is a delegated activity.
- Contract rates are lower than the rates offered under the CMC program due to what we could afford to pay based on the CMS bid process, which was not utilized under CMC.
- Referrals and prior authorizations and claim payment rules will be similar to CMC with broader access to Medi-Cal covered services such as Community Supports, which are not covered by CMC.

From the Plan Perspective

- ✓ Integrated member materials
- ✓ Consumer Advisory Board
- ✓ DHCS, CMS, SCFHP quarterly joint contract management team meetings.
- ✓ DHCS/CMS coordination of audit timing.
- ✓ Coordination of LTSS benefits.
- New systems for handling enrollment transactions and financial reconciliations from CMS (vs. CMC process where we receive a file from the state).
- Bid submissions including the actuarial analysis that is required to be submitted with the bid.
- Use of brokers to extend reach during Annual Election Period (AEP) and throughout the year.

Santa Clara Family Health Plan™

MANAGED CARE TERMS AND ACRONYMS

834 File	Eligibility File	An electronic data interchange file that is the standard for benefit enrollment and maintenance data.
ABD	Adverse Benefit Determination	Any of the following actions taken by Contractor: A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; B. The reduction, suspension, or termination of a previously authorized Covered Service; C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition Clean Claim is not an Adverse Benefit Determination; D. The failure to provide Covered Services in a timely manner; E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals; F. The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan; or G. The denial of a Member's request to dispute financial liability.
ACA	Affordable Care Act	The Affordable Care Act (ACA) is a U.S. federal statute signed into law in 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Also known as "Obamacare."
ACAP	Association for Community Affiliated Plan	The national trade association for the 29 Medi-Cal and Medicare local initiative health plans. Pronounced "a-cap."

ADHC	Adult Day Health Care	An organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.
ADL	Activities of Daily Living	A person's ability to eat, dress, bathe, shop, etc. without assistance; used in the context of disabled or elderly persons.
ADWDL	All County Welfare Directors Letter	Letter from the Department of Health Care Services (DHCS) regarding new or changed policies and/or procedures used in determining eligibility for Medi-Cal benefits.
AEVS	Automated Eligibility Verification System	Allows authorized parties to check Medi-Cal eligibility status. Pronounced "aves" (rhymes with "saves").
AHCD	Advanced Health Care Directive	A legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.
AHIP	America's Health Insurance Plans	The National trade association for commercial, non-profit and public agency health plans. Pronounced "a-hip."
AMA	American Medical Association	The national trade association for physicians.
AMSC	Alcohol Misuse Screening and Counseling	A comprehensive and integrated approach to the early delivery of intervention and treatment services through universal screening for Members experiencing alcohol and substance use disorders and for Members at risk.
APL	All Plan Letters	Sub-regulatory guidance issued by state regulatory agencies that have the force of law.

AQHP	Appropriately Qualified Health Professional	For purposes of determining who can give a second opinion. Refers to a PCP or Plan Specialist who has a clinical background related to the particular illness, disease or condition for which one is seeking a second opinion.
BAA	Business Associate Agreement	An agreement governing the use of restricted information by entities performing certain functions on behalf of a health plan.
BAFO	Best and Final Offer	A bid containing final pricing and deliverables submitted by bidding contractors based on the outcome of the negotiations conducted during the initial bid stage.
Basic PHM	Basic Population Health Management	An approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.
BCCTP	Breast and Cervical Cancer Treatment Program	The program provides cancer treatment benefits to eligible low-income California residents diagnosed with breast and/or cervical cancer.
BH	Behavioral Health	Umbrella term for services for the treatment mental health and substance use disorder conditions.
BHT	Behavioral Health Treatment	Services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.
BIC	Beneficiary Identification Card	A plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Brown Act	Ralph M. Brown Act	An act of the California State Legislature that guaranteed the public's right to attend and participate in meetings of local legislative bodies.
CAC	Consumer Advisory Committee	An SCFHP advisory committee for Medi-Cal members, caregivers, advocates and stakeholders.
CAHP	California Association of Health Plans	A trade association representing the majority of license health care services plans in California.
CAHPS	Consumer Assessment of Health Providers and Systems	Consumer satisfaction survey done annually for Medicare subscribers and every three years for Medi-Cal subscribers. A CMS term for their surveys which ask consumers to evaluate the interpersonal aspects of health care. Pronounced "caps."
CalAIM	California Advancing and Innovating Medi-Cal	A far-reaching, multiyear plan to transform California's Medi-Cal program and to make it integrate more seamlessly with other social services. Led by California's Department of Health Care Services, the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs.
CBAS	Community-Based Adult Services	Outpatient, facility based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services
CBAS Individual Plan of Care	CBAS Individual Plan of Care	A written plan of care developed by a CBAS center's multidisciplinary team, as specified in the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9 Special Terms and Conditions, amended December 29, 2020, or as specified in any subsequent Demonstration amendment or renewal, or successive Demonstration, waiver, or other Medicaid authority governing the provision of CBAS.
CBO	Community-Based Organization	A local entity not operated by the government or any commercial enterprise.

CCI	Coordinated Care Initiative	http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiatiave.aspx
CCM	Complex Care Management	An approach to care management that meets differing needs of high and rising-risk Members, including both chronic care coordination and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all NCQA CCM requirements.
CCS	California Children's Services	A DHCS program for children with certain physical limitations and chronic health conditions or diseases.
CDC	Centers for Disease Control	The CDC is the national public health institute of the U.S., and is a federal agency under the DHHS.
CDL	Contract Drugs List	See formulary.
CFR	Code of Federal Regulations	The codification of the general and permanent regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.
CHDP	Child Health & Disability Prevention	A public health program that reimburses public and private health care providers for early health assessments to detect or prevent disease and disabilities in children and youth.
CHI	Children's Health Initiative	Grassroots collaborative established to provide access to health insurance to the uninsured children. No longer active.
CHR	Clinical High Risk	Level of clinical risk associated with an Enhanced Care Management population of focus.

CHW	Community Health Worker	CHWs, sometimes called promotores, are frontline public health workers who are trusted members of and/or have a close understanding of the community served. CHWs serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. Some CHW services may be covered Medi-Cal benefits.
CIN	Client Identification Number	The Medi-Cal identification number on a benefits identification card.
CITED	Capacity and Infrastructure Transition, Expansion and Development	The CalAIM Providing Access and Transforming Health Initiative will provide direct funding to support the delivery of Enhanced Care Management and Community Supports services. Entities, such as providers, CBOs, county agencies, public hospitals, tribes, and other, that are contracted or plan to contract with a managed care plan can apply to receive funding for specific capacity needs to support the transition, expansion, and development of these specific services.
CLAS	Culturally and Linguistically Appropriate Services	A set of standards established by the Office of Minority Health of DHCS, directed at health care organizations to encourage them to make their services more accessible to diverse groups.
CLIA	Clinical Laboratory Improvement Act	
CLPPB	Childhood Lead Poisoning Prevention Branch	Branch of the Department of Public Health committed to preventing childhood lead poisoning.
CMA	California Medical Association	The statewide trade association for physicians.

CMC	Cal MediConnect	The Cal MediConnect demonstration program, part of California's Coordinated Care Initiative, aims to improve care coordination for beneficiaries dually eligible for Medicare and Medi-Cal.
CME	Continuing Medical Education	Education designed for clinicians to meet requirements for maintaining licensure.
CMP	Care Management Plan	A written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for clinical and non-clinical service needs.
CMS	Centers for Medicare and Medicaid Services	A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program and health insurance portability standards.
CNM	Certified Nurse Midwife	A registered Nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.
CNP	Certified Nurse Practitioner	
COB	Coordination of Benefits	Process of determining financial responsibility for health care services rendered when a patient is covered by more than one insurance program or health plan.
COBA	Coordination of Benefits Agreement	Agreement with Medicare.

COE	Center of Excellence	A designation assigned to a transplant program by DHCS' upon confirmation that the transplant program meets DHCS' criteria.
COHS	County Organized Health Systems	One of three Medi-Cal Managed Care Models in California. Everyone in a COHS county is in the same Managed Care Health Plan. Pronounced "coes."
CPSP	Comprehensive Perinatal Services Program	California Department of Public Health program for pregnant and postpartum Medi-Cal beneficiaries.
CPT	Current Procedure Terminology	Current Procedural Terminology (CPT codes) are numbers assigned to every task and service a medical healthcare provider may provide to a patient including medical, surgical, and diagnostic services.
CS	Community Supports	Medically appropriate and cost-effective alternatives to services covered under Medi-Cal.
CSHCN	Children with Special Health Care Needs	
CSS-Eligible Condition	California Children's Services (CCS)-Eligible	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 *et seq*.
CSR	Customer Service Representative	A health plan employee who serves as the contact person for members who have questions about access, quality, billing or others.
DD	Developmental Disabilities	
DDS	California Department of Developmental Services	Works to ensure Californians with developmental disabilities have the opportunity to make choices and lead independent, productive lives as members of their communities in the least restrictive setting possible.

DF	Disclosure Form	See Evidence of Coverage.
DHCS	Department of Health Care Services	The DHCS is department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal. It was formerly known as the California Department of Health Services, which was reorganized into the DHCS and the California Department of Public Health.
DHHS	Department of Health and Human Services	U.S. cabinet-level department responsible for health care and social services.
DMC	Drug Medi-Cal	The State system wherein Members receive Covered Services from DMC-certified SUD treatment Providers.
DMC-ODS	Drug Medi-Cal Organized Delivery System	A continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care.
DME	Durable Medical Equipment	Personal items such as oxygen tanks, wheelchairs, canes, etc. that are prescribed by a physician based on a patient's medical and physical condition.
DMFEA	Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse	

DMHC	Department of Managed Health Care	An HMO consumer rights organization to help California consumers resolve problems with their health plans and to provide a stable and financially solvent managed care system.
DOB	Date of Birth	
DOD	Department of Defense	
DOT	Direct Observed Theory	
DOFR	Division of Financial Responsibility	Term used in any business or contract to delineate which parties are bound legally to cover the cost of which services. Pronounced “dofer.”
DSM V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition	Published by the American Psychiatric Association, the DSM V offers a common language and standard criteria for the classification of mental disorders.
D-SNP	Dual Eligible Special Needs Plan	Health plan for people with Medicare and Medicaid.
DTRR	Daily Transaction Response Reply	File distributed through CMS enrollment broker that summarizes enrollments and cancellations.
DUR	Drug Use Review	A federally required program to improve the quality and cost effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.
DVBE	Disabled Veteran Business Enterprises	
EAS	External Accountability Set	

ECM	Enhanced Care Management	A whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered.
EHR	Electronic Health Record	An EHR is a systematic collection of electronic health information about an individual patient or population. It is a record in digital format that is capable of being shared across different health care settings. EHRs may include a range of data, including medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics like age and weight, and billing information.
EMT	Emergency Medical Transportation	Transportation services for an Emergency Medical Condition, and includes emergency air transportation.
EOB	Explanation of Benefits	Accounting sent to patient by health plan indicating services billed by a provider, amounts paid/denied, and amounts for which the patient is financially responsible.
EOC	Evidence of Coverage	Documentation provided to a member, noting the member's eligibility date and providing a detailed description of benefits and services.
EOC/DF	Evidence of Coverage/Disclosure Form	See Evidence of Coverage.
ePHI	Electronic Protected Health Information	
EPO	Established Patients Only	Provider not willing to see new patients.
EPO	Exclusive Provider Organization	Like a PPO except that non-emergency and out-of-network services are the responsibility of the member.

EPSDT	Early Periodic Screening, Diagnosis and Treatment Supplemental Services	A Medicaid program designed to improve the health of low-income children.
EQR	External Quality Review	The analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.
EQRO	External Quality Review Organization	An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
ESRD	End Stage Renal Disease	The fifth stage of Chronic kidney disease (CKD), also known as chronic renal disease (CRD), and is a progressive loss in renal function over a period of months or years.
F2F	Face-to-Face	
FAME	Fiscal Intermediary Access to Medi-Cal Eligibility	A state system into which data are uploaded and from which reports are downloaded regarding SCFHP's Medi-Cal enrollment. Pronounced "fame."
FBC	Freestanding Birthing Centers	
FBDE	Full Benefit Dual Eligible	Individuals entitled to Medicare Part A and/or Part B and eligible for some form of Medicaid benefit. Also known as "Medi/Medi's."
FDA	U.S. Food and Drug Administration	

FedRAMP	Federal Risk and Authorization Management Program	
FFP	Federal Financial Participation	Federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.
FFS	Fee for Services	Some services, which are not provided through a Medi-Cal managed health or dental plan, are contracted directly with health care providers to deliver covered Medi-Cal services. In these cases, you may choose a doctor, dentist, or other provider, who accepts Medi-Cal payments for each service he/she provides at the Medi-Cal payment rate.
FFS/MC	Fee-For-Service Medi-Cal Mental Health Services	
FI	Fiscal Intermediary	
FIDE-SNP	Fully Integrated Dual Eligible Special Needs Plan	
FIPS	Federal Information Processing Standards	
FMAP	Federal Medical Assistance Percentage	Percentage of Medi-Cal funding provided by the federal government.
Formulary		List of medications that are approved to be prescribed under a particular insurance policy.
FPL	Federal Poverty Level	

FQHC	Federally Qualified Health Center	Designation granted by the U.S. Health Resources and Services Administration to community clinics which may then be compensated for treating Medicaid and Medicare patients.
FQHMO	Federally Qualified Health Maintenance Organization	A prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.
FRADS	Federally Required Adult Dental Services	
FSR	Facility Site Review	An assessment of a facility's physical site including the building, accessibility, equipment, and policies/procedures for all contracted sites at the time of initial contracting and up to every three years thereafter. This assessment is conducted by a registered nurse, who is a DHCS-certified site reviewer. The site review tool is used to determine compliance with the standards set by the DHCS.
FY	Fiscal Year	Any 12-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30; the federal Fiscal Year is October 1 through September 30.
GAAP	Generally Accepted Accounting Principles	
GC	California Government Code	
GHPP	Genetically Handicapped Persons Program	A DHCS program to provide coverage for adults with specific diseases such as cystic fibrosis or hemophilia or with neurologic or metabolic disorders.

GMC	Geographic Managed Care	One of three Medi-Cal Managed Care Models. Sacramento and San Diego counties are under this model.
H&S	California Health and Safety Code	
HCBA	Home and Community Based Alternatives	Programs that offer Medi-Cal services to a limited number of people with disabilities to help them live at home instead of in a nursing facility or other Medi-Cal funded institution.
HCBS	Home and Community Based Services	Home and community based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.
HCO	Health Care Options	A hotline and website that provides health care services through networks of organized systems of care. Networks include providers such as doctors and hospitals. HCO's role is to assure access to health care through an enrollment broker contractor. The contractor gives information to Medi-Cal beneficiaries about managed care plans.
HEAT	Health Care Fraud Prevention and Enforcement Action Team	In 2009, the DHHS and Department of Justice (DOJ) created HEAT. With its creation, the fight against Medicare fraud became a Cabinet-level priority.
HEDIS	Healthcare Effectiveness Data and Information Set	An assessment system established by NCQA for quality measurement and used by health plans to assist in reporting to government agencies. Pronounced "he-diss."
HICAP	Health Insurance Counseling & Advocacy Program	http://www.cahealthadvocates.org/HICAP/index.html

HIE	Health Information Exchange	
HIPAA	Health Insurance Portability and Accountability Act	Federal legislation passed in 1996 to limit the use and transmittal of patient's medical information. Pronounced "hippa."
HITECH	Health Information Technology for Economic and Clinical Health Act	The HITECH Act, was enacted under the American Recovery and Reinvestment Act of 2009 to promote and expand the adoption of health information technology. At the time it was enacted, it was considered the "foundation for health care reform."
HIV	Human Immunodeficiency Virus	
HK	Healthy Kids	Offered benefits and providers similar to Medi-Cal and accepts children from birth to age 19, regardless of their immigration status. The Healthy Kids program transitioned to Medi-Cal in 2019.
HMIS	Homeless Management Information System	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.
HPA	Health Plan Accreditation	
HPMS	Health Plan Management System	The Centers for Medicare & Medicaid Services' (CMS) Health Plan Management System (HPMS) is a web-enabled information system that serves a critical role in the ongoing operations of the Medicare Advantage (MA) and Part D programs. It monitors quality, benefits packages, finances and compliance.

HRA	Health Risk Assessment	A process by which a managed care plan uses information about a member's health status, personal and family health history, and health-related behaviors to predict the member's likelihood of experiencing specific illnesses or injuries. Also known as health risk appraisal. Cal MediConnect members receive this assessment within 45 days of enrollment.
ICD-10	International Classification of Diseases, Tenth Revision	A medical classification list published by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
ICE	Industry Collaboration Effort	A California-based, non-profit organization working to improve health care regulatory compliance through education of the public.
ICF	Intermediate Care Facility	A residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at SNFs, and meets the standards specified in 22 CCR section 51212.
ICP	Individual Care Plan	An integrated, individualized, person-centered care plan jointly created and managed by the beneficiary, his or her selected support system, his or her health plan care management team, and his or her interdisciplinary team of care providers. The plan incorporates a holistic, preventative, and recovery focus and is based on a comprehensive assessment of clinical and non-clinical needs and addresses identified gaps in care and barriers to care.
ICT	Interdisciplinary Care Team	
IEP	Individualized Education Plan	
IFSP	Individualized Family Service Plan	

IGT	Intergovernmental Transfers	A transfer of funds from another government entity (e.g., county, city or another state agency) to the state Medicaid agency.
IHA	Initial Health Assessment	A report on a person's health status and health related behaviors.
IHS	Indian Health Service	
IHSP	Individualized Health and Support Plan	
IHSS	In-Home Supportive Services	In-Home Supportive Services (IHSS) is a program that provides in-home assistance as an alternative to out-of-home care. IHSS services may include but not be limited to: Housecleaning, meal preparation, laundry, grocery shopping, personal care, accompaniment to medical appointments and other services.
ILOS	In Lieu of Services	Acronym no longer in use. See Community Supports.
IMD	Institution for Mental Diseases	Any hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.
IMR	Independent Medical Review	An IMR is the process used by DMHC to make final coverage determinations for enrollees who appeal the denial of a service by a health plan. Physicians not affiliated with the health plan review and determine whether the requested services is medically necessary.
IPA	Independent Practice Association	An association of physicians from individual or small-group practices who unite primarily for the purpose of contracting with managed care entities.
IPC	Individual Plan of Care	
IRA	Individual Risk Assessment	
IRS	Internal Revenue Service	

ISO	International Organization for Standardization	
IT	Information Technology	
JC	Joint Commission	The organization that provides health care accreditation and related services that support performance improvement in health care organization, and is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.
JOC	Joint Operating Committee	A committee responsible for the operation of a business or program and whose members are from more than one organization.
Knox-Keene	Knox-Keene Health Care Service Plan Act	A law enacted in 1975 that instituted financial and quality standards for HMOs, set a basic minimum benefit package, required plans to ensure continuity of patient care, and protected the physician-patient relationship in health care decisions.
LAS	Language assistance services	Oral interpretation and written translation and the provision of free auxiliary aids and services for people with disabilities.
LEP	Limited English Proficient	Adjective for a person with limited proficiency in English.
LGA	Local Government Agency	A local governmental entity including, but not limited to, a county child welfare agency, county probation department, county behavioral health department, county social services department, county public health department, school district, or county office of education.
LHD	Local Health Department	
LHPC	Local Health Plans of California	The trade association for the state's local initiative Medi-Cal managed care plans.

LIS	Low Income Subsidy	An additional amount of money paid out by an agency or program on behalf of a person whose income is low relative to federal poverty guidelines.
LM	Licensed Midwife	
LTC	Long-Term Care	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
LTSS	Long Term Services and Supports	Long-term services and supports are services that help improve a long-term medical condition, often in home and community-based settings.
MA	Medicare Advantage	Managed care program for Medicare recipients.
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)	
MCE	Managed Care Expansion	See “Affordable Care Act”
MMCE	Mandatory Managed Care Enrollment	In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, the Department of Health Care Services (DHCS) is standardizing managed care and FFS enrollment statewide, and will require certain Medi-Cal beneficiaries to mandatorily enroll in a managed care plan.
MCH	Maternal Child Health	Generic term for programs or issues relating to the health of women of child-bearing age and their children.
MCO	Managed Care Organization	Often referring to the MCO tax.
MECP	Member Emergency Care Plan	
MFTP	Money Follows the Person	
MH	Mental Health	

MHP	County Medical Health Plan	
MIA	Medically Indigent Adult	An industry term for a person without health insurance and not eligible for government programs such as Medicare or Medicaid.
MIS	Management and Information Services	
MLR	Medical Loss Ratio	(aka Medical Cost Ratio) Actual amount we spend on a member.
MLTSS	Managed Long-Term Services and Supports	Refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
MMCD	Medi-Cal Managed Care Division	A division of DHCS which contracts with health plans to set up managed care networks for Medi-Cal recipients.
MMP	Medicare Medicaid Plan	An MMP is an alignment initiative in which Medicare and Medicaid benefits are offered as a single plan in a three-way contract between CMS, the state Medicaid agency (SMA), and the health plan.
MOC	Model of Care	A Contractor's framework for providing ECM and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.
MOU	Memorandum of Understanding	A brief document executed in advance of a contract so that the parties can begin interacting even though all details have not been worked out.
MPL	Minimum Performance Level	A Contractor's minimum performance requirements for select Quality Performance Measures.

MSSP	Multipurpose Senior Services Program	The Multipurpose Senior Services Program (MSSP) Waiver provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement.
NABD	Notice of Adverse Benefit Determination	A formal letter from a managed care plan informing a member of an adverse benefit determination.
NAR	Notice of Appeal Resolution	A formal letter from a managed care plan informing a member of the outcome of the appeal of an adverse benefit determination.
NCQA	National Commission for Quality Assurance	A non-profit organization which develops standards and programs for measuring quality of care.
NDN	Nondiscrimination Notice	Managed care plans must comply with all of the nondiscrimination requirements set forth under federal and state law and DHCS guidance, including the posting and distribution of the nondiscrimination notice.
NOA	Notice of Action	Legal term for formal written notification by some authority for an action initiated against a person or entity.
NOD	Notice of Dispute	Term for a formal challenge questioning the legality of actions taken by another party.
NPI	National Provider Identifier	A unique identification number for Providers. Contractor must use the NPIs in the administrative and financial transactions adopted under HIPAA.
NPP	Notice of Privacy Practices	http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html
NQTL	Non-Quantitative Treatment Limitation	

NSMHS	Non-Specialty Mental Health Service	All of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice: A. Mental health evaluation and treatment, including individual, group and family psychotherapy; B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; C. Outpatient services for the purposes of monitoring drug therapy; D. Psychiatric consultation; and E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.
OB-GYN	Obstetrician-Gynecologist	
OHC	Other Health Coverage	Refers to private health insurance. Federal and state laws require Medi-Cal beneficiaries to report OHC to ensure Medi-Cal is the payer of last resort.
OIG	Office of Inspector General	
P4P	Pay for Performance	Pay for Performance in healthcare (P4P), also known as value-based payment, comprises payment models that attach financial incentives/disincentives to provider performance.
PA	Prior Authorization	A formal process requiring a health care provider to get approval to provide specific services or procedures from the health plan or delegate.
PAC	Provider Advisory Council	An advisory body to assist SCFHP in achieving the highest quality of care for members of the health plan.

PACE	Program of All Inclusive Care for the Elderly	Program of All-Inclusive Care for the Elderly (PACE) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. Pronounced “pace.”
PAMF	Palo Alto Medical Foundation	A provider group with a contract with SCFHP.
PATH	Providing Access and Transforming Health	A new waiver initiative in California that would access federal funds to support capacity building, including payments for infrastructure, interventions, and services to complement and ensure access to the array of services and benefits that are part of successful implementation of Enhanced Care Management (ECM) and In Lieu of Services (ILOS), as well as a number of intersecting CalAIM initiatives designed to ensure continuity of health care coverage and care for individuals leaving prisons and county jails and re-entering the community
PBM	Pharmacy Benefits Manager	A third-party administrator of a prescription drug program that is primarily responsible for processing and paying prescription drug claims.
PBP	Planned Benefits Package	Specifications of what your benefits are for a Medicaid product.
PCC	California Public Contract Code	
PCP	Primary Care Physician	An industry term for a gatekeeper physician who provides primary care and refers patients to specialists as needed.
PHE	Public Health Emergency	A PHE can be declared by the Secretary of the Department of Health and Human Services and to grant certain authorities to the Secretary to protect the health of the public.

PHI	Protected Health Information	Record of a person's medical care or status, the privacy of which is a concern with regard to HIPAA.
PHM	Population Health Management	
PHMS	Population Health Management Strategy	A comprehensive plan of action for addressing member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. Contractor is required to include, at a minimum, a description of how it will: A. Keep all members healthy by focusing on wellness and prevention services; B. Identify and manage members with high and rising-risk; C. Include a separate section on Members less than 21 years of age; D. Ensure effective transition planning, across delivery systems or settings, through care coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and E. Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance health equity.
PHM Service	Population Health Management Service	A service that collects and integrates Medi-Cal recipient information from disparate sources in order to perform Risk Stratification and Segmentation (RSS) and Risk Tiering functions, analytics and reporting, identify gaps in care, pre-populate Medi-Cal recipient assessments, perform other population health function, and allow for multi-party data access and use in accordance with State and federal laws, regulations, and policies.
PHP	Prepaid Health Plan	System in which members pay and providers are paid at the beginning of the month for services that might be rendered/received, versus billing/paying as services are provided.
PI	Personal Information	

PIA	Prison Industry Authority	
PIP	Performance Improvement Project	
PIR	Privacy Incident Reporting	
PIU	Program Integrity Unit	
PL	Policy Letter	Provide instruction to contractors about changes in Federal or State law and Regulation that affect the way in which they operate, or deliver services to Medi-Cal beneficiaries.
PMG	Physicians Medical Group	A provider group with a contract with SCFHP.
PMPM	Per Member Per Month	Reference to the basis upon which a health plan may be paid by the government for managing care and/or physicians paid for providing care, versus paying on the basis of actual services provided or resources utilized.
PNA	Population Needs Assessment	A process for: A. Identifying Member health needs and Health Disparities; B. Evaluating health education, Cultural & Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and C. Implementing targeted strategies for health education, C&L, and QI programs and services.
POC	Provider Organization Certification	
POD	Privacy Officer Database	

POS	Point-of-Service	A type of health plan in which the member is assigned a PCP but may seek specialty care outside of the network, albeit at a higher out-of-pocket cost.
PPACA	Patient Protection and Affordable Care Act	See “Affordable Care Act.”
PPC	Provider-Preventable Condition	
PPO	Preferred Provider Organization	A type of health plan which allows members to see any contracted primary care or specialist physician, without having to be assigned or receive prior authorization.
PPR	Post Payment Recovery	Contractor’s efforts to recover the cost of the services from other third party payors responsible for the payment of a Member’s health care services.
PSCI	Personal, Sensitive, and/or Confidential Information	
PTC	Pharmacy and Therapeutics Committee	Also referred to as P&T. Provides input to the development and maintenance of a formulary.
QAS Paraprofessionals	Qualified Autism Services Professionals	An individual who is employed and supervised by a QAS Provider to provide Medically Necessary BHT services to Members.
QAS Professionals	Qualified Autism Services Professionals	An individual who is employed and supervised by a QAS Provider to provide Medically Necessary BHT services to Members.
QAS Provider	Qualified Autism Services Provider	A licensed practitioner or Board Certified Behavior Analyst (BCBA) who designs, supervises, or provides Medically Necessary BHT services to Members.

QI	Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
QIHEC	Quality Improvement and Health Equity Committee	A committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.
QIHETP	Quality Improvement and Health Equity Transformation Program	The systematic and continuous activities to monitor, evaluate and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and this Contract.
QSO	Qualified Service Organization	
QTL	Quantitative Treatment Limitation	A limit on the scope or duration of a Covered Service that is expressed numerically.
RAF	Referral Authorization Form	Processed so that a patient may see a specialist or receive services (treatment, procedure) beyond the primary care level.
RC	Regional Center	A non-profit, community-based entity that is contracted by DDS and that develops, purchases and manages services for Members with developmental disabilities and their families.
RFI	Request for Information	
RHC	Rural Health Clinic	An entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.
RPD	Restrictive Provider Database	A non-profit, community-based entity that is contracted by DDS and that develops, purchases and manages services for Members with developmental disabilities and their families.

RSS	Risk Stratification Segmentation	The process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS must result in the categorization of Members with care needs at all levels and intensities.
SABIRT	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment	SABIRT is a comprehensive health promotion approach for delivering early intervention and treatment services to people with, or at risk of developing, alcohol and drug use disorders.
SBC	Summary of Benefits and Coverage	An easy-to-understand summary about a health plan's benefits and coverage.
SBIRT Services	Screening, Brief Intervention, and Referral to Treatment	A comprehensive, integrated delivery of early intervention and treatment services for Members with SUDs, as well as those who are at risk of developing SUDs.
SCCIPA	Santa Clara County IPA	An independent practice association of over 800 physicians throughout the county. Pronounced "skippa."
SCO	State Controller's Office	
SDOH	Social Drivers of Health	Also called Social Determinants of Health.
SED	Serious Emotional Disturbance	The presence of a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
SFTP	Secure File Transfer Protocol	
SFY	State Fiscal Year	

SH	State Hearing	A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services.
SHA	Stay Healthy Assessment	The Staying Healthy Assessment (SHA) is the Department of Health Care Services' (DHCS's) Individual Health Education Behavior Assessment (IHEBA).
SMAC	State Medicaid Agency Contract	A contract between a managed care plan and the Department of Health Care Services that meets a number of requirements, including federal Medicare-Medicaid integration requirements.
SMH	Specialty Mental Health	
SMHS	Specialty Mental Health Services	Specialty Mental Health Services (SMHS) is a program carved out to county mental health plans (MHPs) that serves the needs and treatment goals of beneficiaries that meet medical necessity for severe impairment.
SMI	Serious Mental Illness	Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Definition applies to people over the age of 18 years old.
SNF	Skilled Nursing Facility	A licensed long-term care hospital. Commonly referred to as a nursing home. Pronounced "sniff."
SOC	Share of Cost	The amount of money an individual is responsible to pay towards their medical related services, supplies, or equipment before Medi-Cal will begin to pay.
SPD	Seniors and People with Disabilities	An aid code for Medi-Cal enrollees who are eligible because of age and/or disability.
SSI	Supplemental Security Income	

STC	Special Terms and Conditions	
STD	Sexually Transmitted Disease	
SUD	Substance Use Disorder	A mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.
SVILC	Silicon Valley Independent Living Center	http://svilc.org/
TA	Technical Assistance	
TAR	Treatment Authorization Request	Medi-Cal process for referring a patient for services beyond primary care. Pronounced “tar.”
TB	Tuberculosis	
TBD	To Be Determined	
TCM	Targeted Case Management	Services which assist Members within specified target groups to gain access to needed medical, social, educational and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.
TDD	Telecommunication Devices for the Deaf	
TNE	Tangible Net Equity	A health plan’s total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of normal course of business.

TPL	Third Party Liability	
TPTL	Third Party Tort Liability	The contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.
TTY	Text Telephone	(aka TDD) A telecommunication device for people who are deaf or hard of hearing.
Two-Plan		One of three Medi-Cal Managed Care Models. Santa Clara County has this model. Members choose between a commercial plan or a Local Initiative (such as SCFHP).
UM	Utilization Management	An industry term for reviewing and authorizing medical services beyond the primary care level.
U.S. DHHS	United States Department of Health and Human Services	The federal agency that oversees the Centers for Medicare and Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
U.S. DOJ	United States Department of Justice	
USC	United States Code	
USPSTF	United State Preventive Services Task Force	
VFC Program	Vaccines for Children Program	The evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.
VHP	Valley Health Plan	A provider group with a contract with SCFHP.

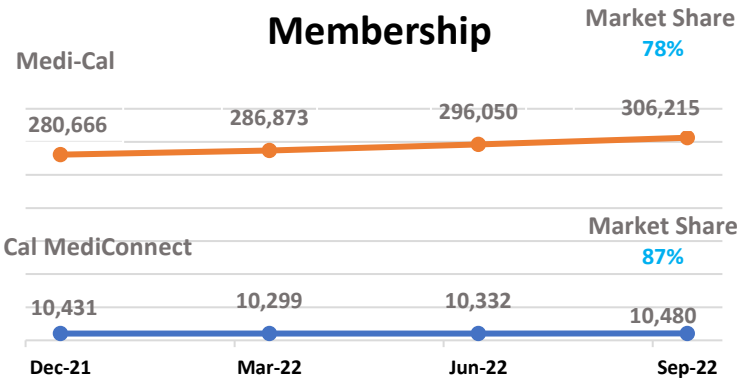
VMC	Santa Clara Valley Medical Center	Hospital owned and operated by the County of Santa Clara. Referred to as “Valley Med.”
W&I	California Welfare and Institutions	
WCM	Whole Child Model	A program that incorporates California Children’s Services (CCS) program covered services for Medi-Cal eligible CCS children and youth into a Medi-Cal managed care plan (MCP) contract.
WIC	Women, Infants, and Children Supplemental Nutrition Program	A program that helps families by providing nutrition education, breastfeeding support, healthy foods, and referrals to health care and other community services. WIC serves infants and children up to age 5 and people who are pregnant or have given birth or experienced pregnancy loss.
WPC	Whole Person Care	A pilot program from DHCS that gives a county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes.

Board Dashboard

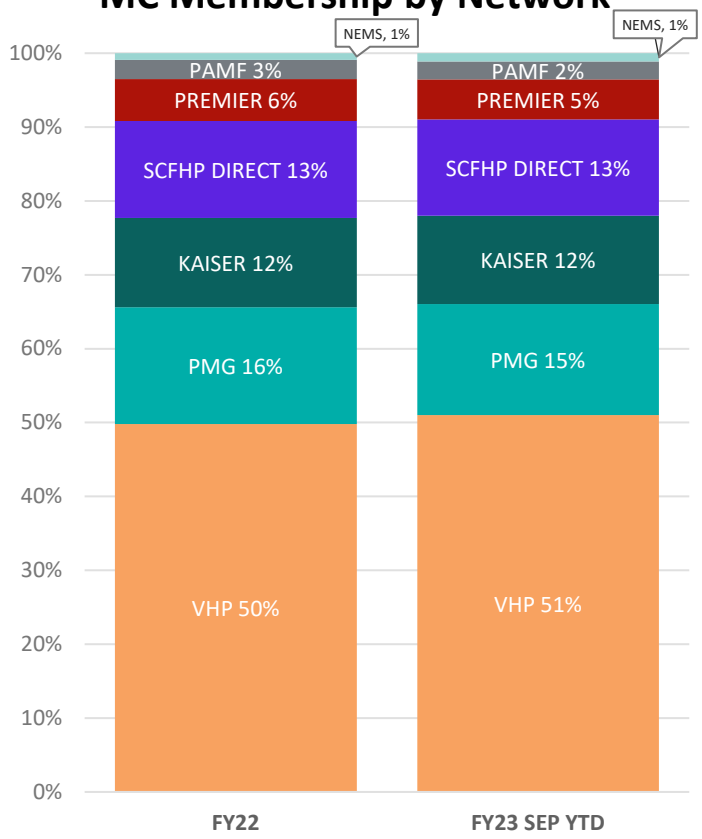
September 2022

Santa Clara Family Health Plan™

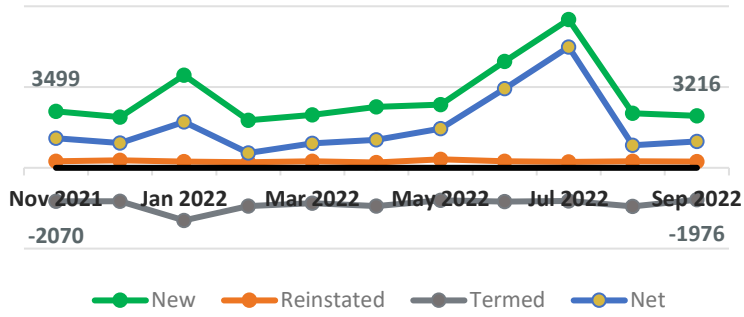
Membership



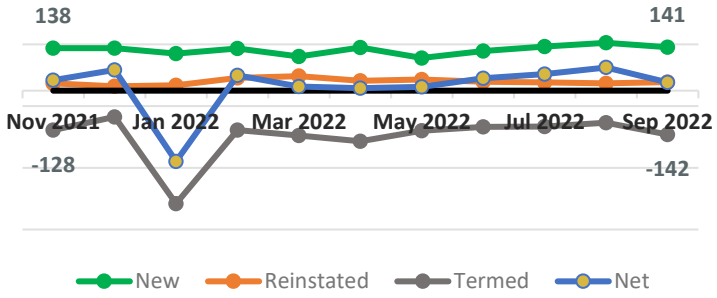
MC Membership by Network



Medi-Cal Membership Gain/Loss



Cal MediConnect Membership Gain/Loss



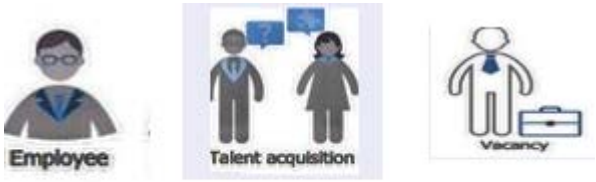
Financial Highlights

	JUL-22	YTD
Revenue	$114.3 M	$114.3 M
Medical Expense (MLR)	91.5%	91.5%
Administrative Expense	5.3%	5.3%
Net Surplus (Loss)	$4.3 M	$4.3 M

favorable variance

unfavorable variance

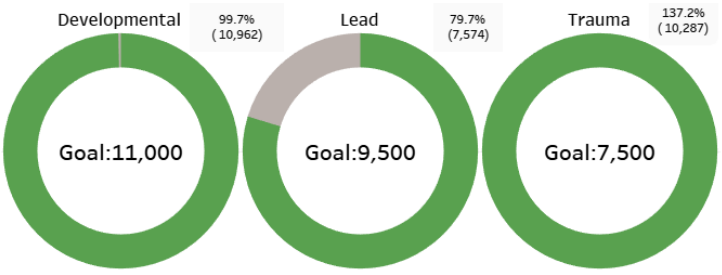
Human Resource Statistics



357 17 35

FY23 SEP YTD

Health Screenings FY22



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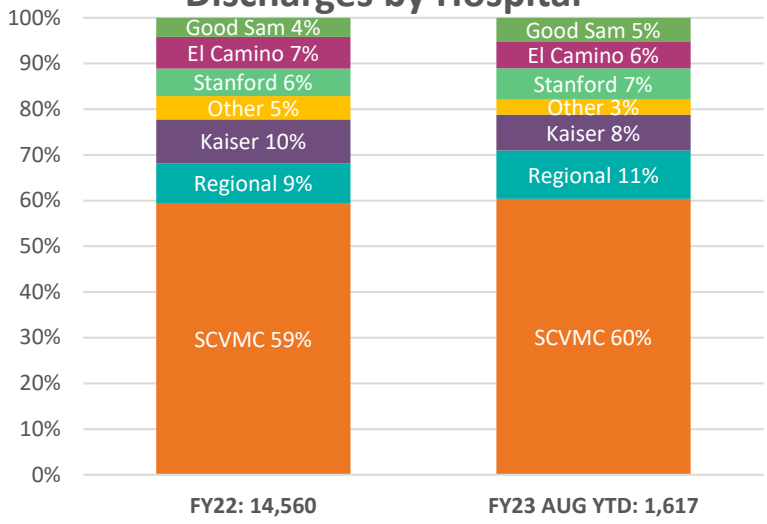
September 2022

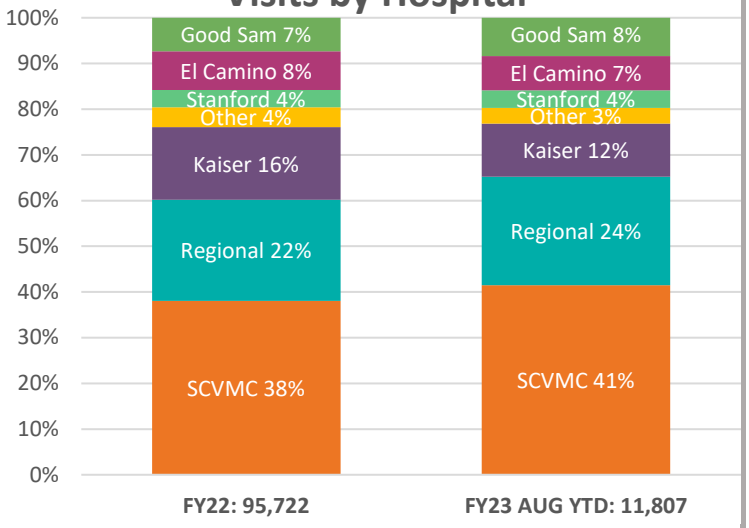
Santa Clara Family Health Plan™

Medi-Cal Inpatient Discharges by Hospital



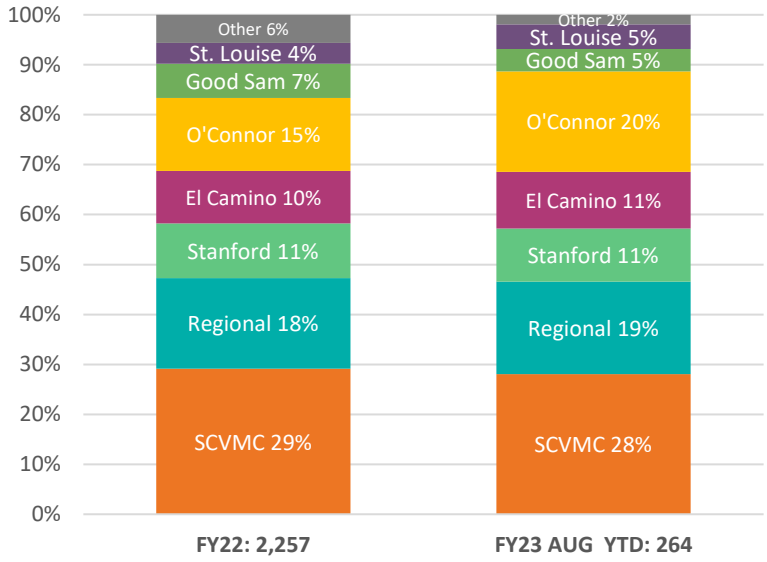
SCVMC= VMC, OCH, STL

Medi-Cal Emergency Visits by Hospital

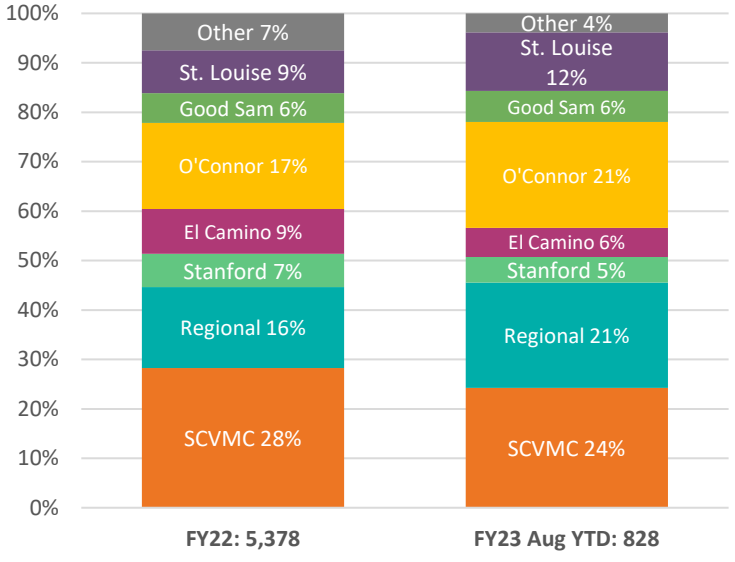


SCVMC= VMC. OCH. STL

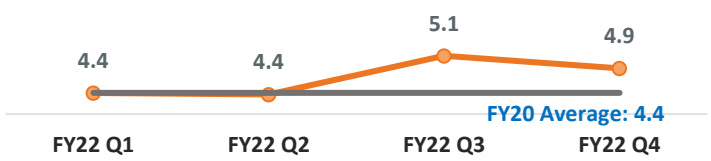
Cal MediConnect Inpatient Discharges by Hospital



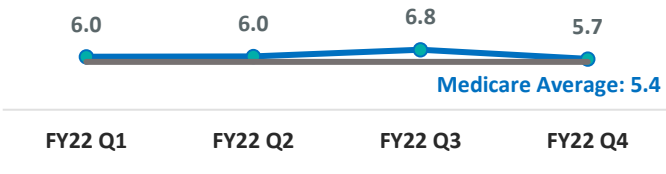
Cal MediConnect Emergency Visits by Hospital



Medi-Cal Inpatient Average Length of Stay (ALOS)



Cal MediConnect Inpatient Average Length of Stay (ALOS)



Board Dashboard

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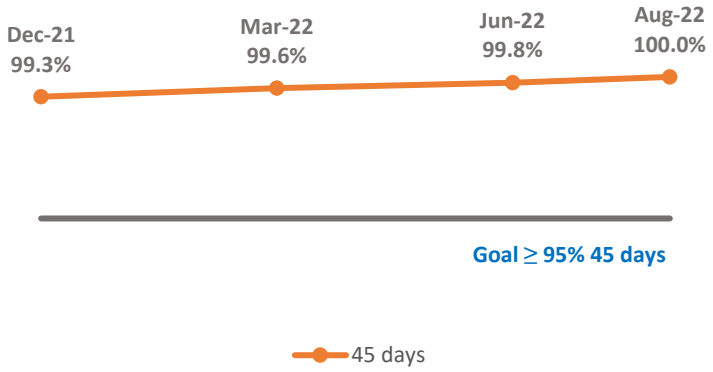
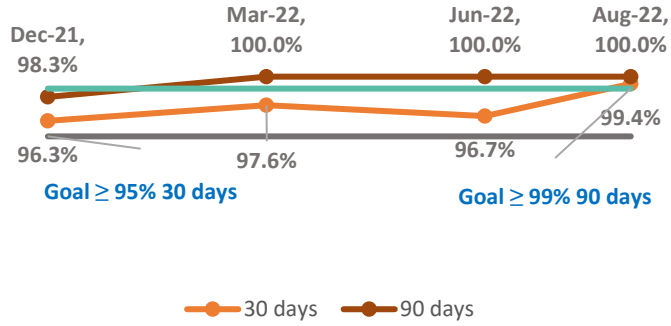
Santa Clara Family Health Plan™

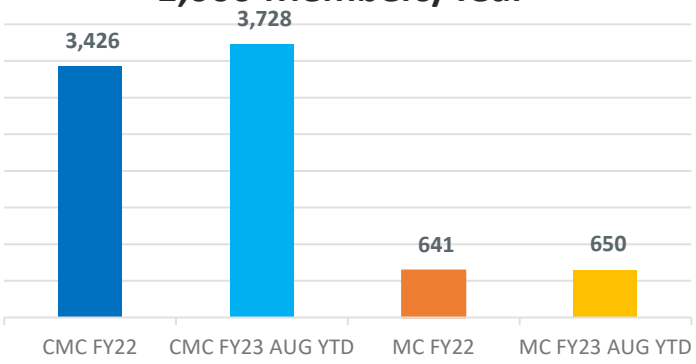
Medi-Cal Claims Processing



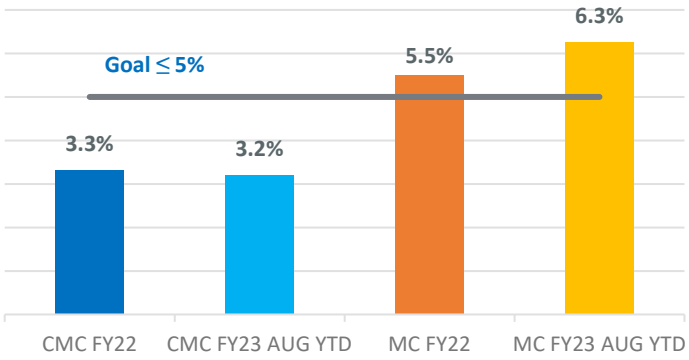
Cal MediConnect Claims Processing



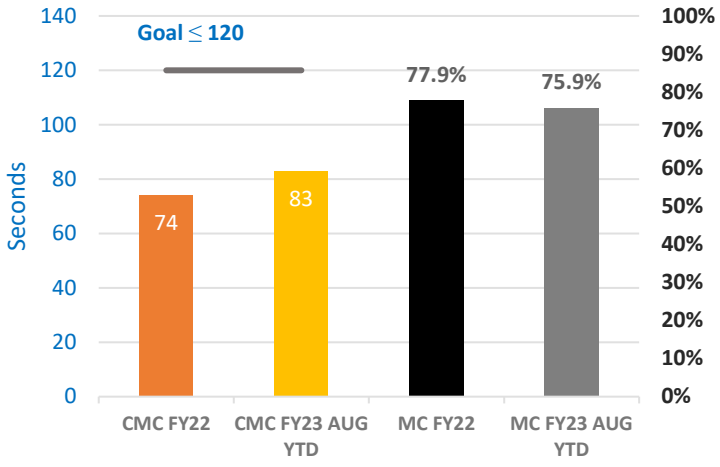
Member Calls Handled per 1,000 Members/Year



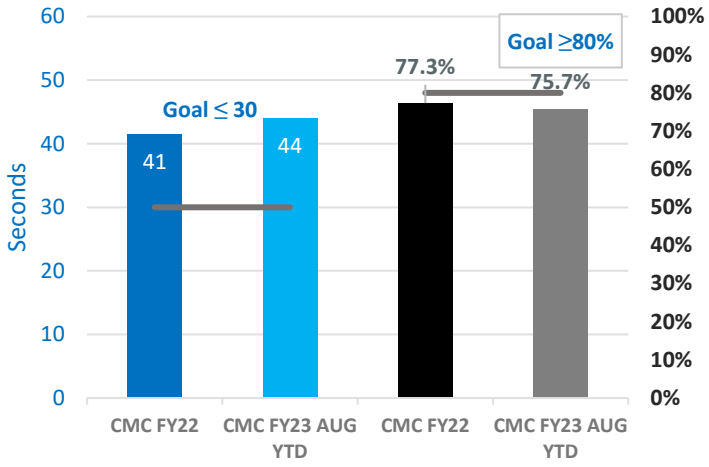
Abandoned Call Data



Medi-Cal Member Call Data



Cal MediConnect Member Call Data



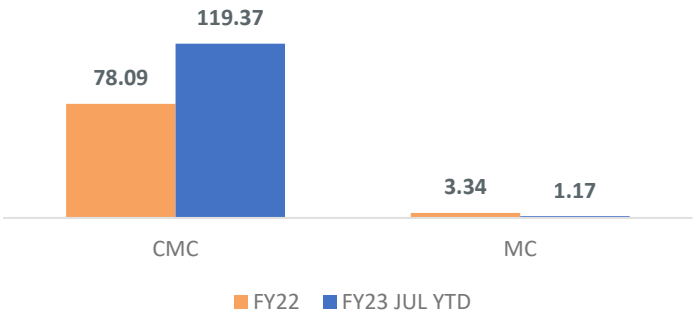
Board Dashboard

September 2022

Santa Clara Family Health Plan™

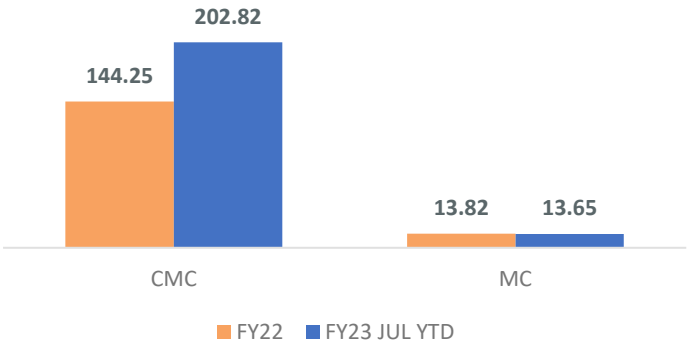
Appeals per 1,000 Members/Year

Appeal: request to change SCFHP coverage decision

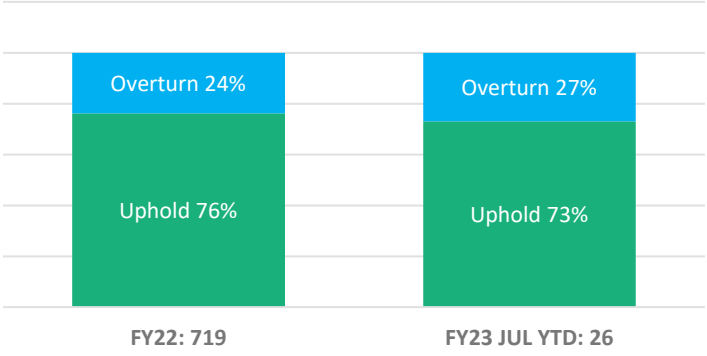


Grievances per 1,000 Members/Year

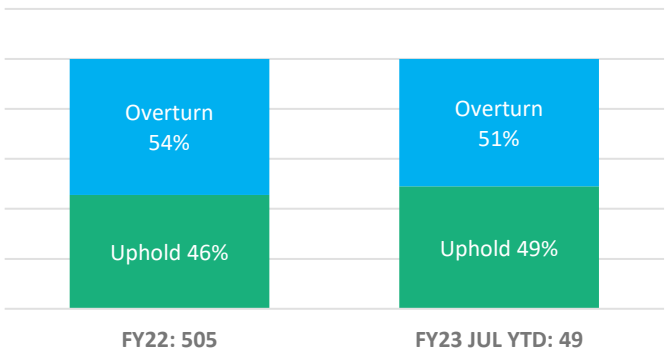
Grievance: member dissatisfaction with a service



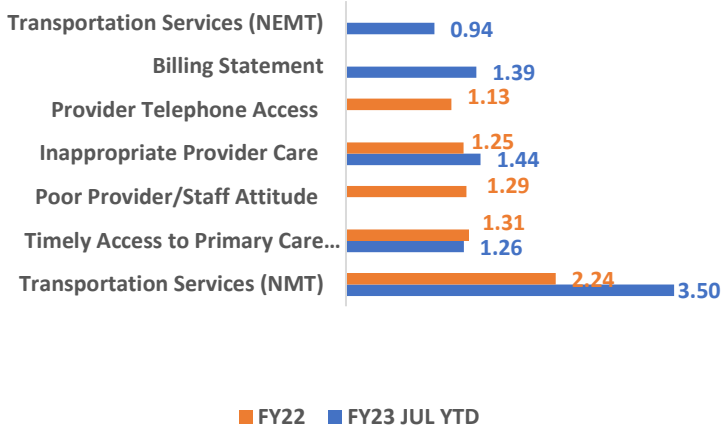
Medi-Cal Appeals by Outcome



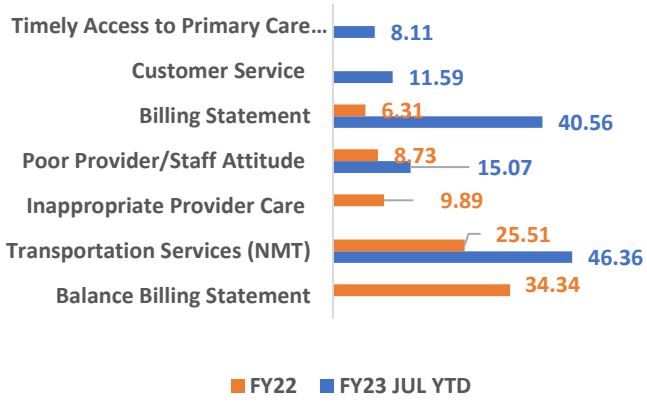
Cal MediConnect Appeals by Outcome



Medi-Cal Top Grievances per 1,000 Members/Year



Cal MediConnect Top Grievances per 1,000 Members/ Year



Compliance Activity Report

September 22, 2022

- **Department of Managed Health Care (DMHC) Routine Audit**
  In October, the Plan will undergo a routine DMHC survey covering the overall performance of the Plan against State health plan licensing regulations. Compliance has been leading the preparation and document response in advance of the audit.

- **DMHC Financial Audit**
  DMHC recently completed its routine financial audit. This audit, which occurs every three years, examines the financial health and sustainability of the health plan, including cash, investments, liabilities, billing processes, claims processing, and provider disputes. On August 24, DMHC advised that it has concluded its examination with no deficiencies. A final report is expected soon.

- **Department of Health Care Services (DHCS) Audit Update**
  The Plan underwent its annual DHCS audit in March, and has not yet received a written preliminary report.

- **2024 Department of Health Care Services (DHCS) Contract Operational Readiness**
  DHCS recently initiated a process to ensure Medi-Cal managed care plans' operational readiness for the requirements of the new 2024 contract. This is a comprehensive contract revision that will coincide with the implementation of the Medi-Cal managed care reprocurement. Between August 2022 and July 2023, plans will be required to submit documents demonstrating our readiness to implement the revised contract. Compliance has worked with internal business units to prepare our deliverable submissions for the first set of deadlines.

- **CMS Notice of Noncompliance**
  The Plan recently received a Notice of Noncompliance from CMS related to a required protected class drug that was missing from the Plan's July 2022 formulary submission. The Plan's pharmacy benefit manager, MedImpact, removed Trizivir from the formulary based on the deletion of its generic version from CMS's formulary reference file and the continued presence of its individual components on the formulary. CMS disagreed with MedImpact's interpretation of the formulary requirement and denied the formulary submission. MedImpact added Trizivir back to the formulary in the next submission window, six days after the previous submission was denied.

- **Medicare Data Validation Audit**
  The Plan recently completed its annual Medicare data validation audit, with final results indicating 100% validation. SCFHP engaged Advent Advisory Group to complete a validation of various reports to CMS for calendar year 2021 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 in April to review our reporting process and submitted the final results to CMS in July.

- **Compliance Program Effectiveness (CPE) Audit**
  CMS requires Medicare plans to have an independent review of the effectiveness of its compliance program each year. In collaboration with Health Plan Alliance, SCFHP partnered with Health Alliance Plan of Michigan to conduct a peer-review audit of our compliance program to meet CMS's CPE requirement for 2022. The audit process is based on the Part C and D Program Audit Protocols CMS uses for Medicare program audits. The audit occurred in August and the Plan recently received a preliminary report in early September. The report includes one finding related to the lack of documentation demonstrating the Plan had provided required annual compliance training to a consultant doing work related to our Medicare line of business. The report also includes four observations related to improving the consistency and clarity of internal documents and reducing audit completion times.

Santa Clara Family Health Plan™

Government Relations Update

September 22, 2022

Federal Issues

CMS

- Public charge rule
- Streamlining Medicaid eligibility and enrollment

Congress

- Inflation Reduction Act
- Improving Seniors' Timely Access to Care Act
- Advancing Telehealth Beyond COVID-19 Act
- Statutory PAYGO sequester
- COVID-19 and Monkeypox funding request

State Issues

DHCS/Medi-Cal

- Reprocurement RFP results

Legislation

- SB 1473 – COVID testing coverage
- SB 987 – complex cancer cases
- SB 858 – health plan penalties
- SB 966 – FQHC PHE flexibilities
- AB 2697 – CHW services