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

6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference Only
(408) 638-0968
Meeting ID: 884 8545 5248
Passcode: ExFin2022!
https://us06web.zoom.us/j/88485455248

AGENDA

1.	**Roll Call** Welcome new Board Secretary, Sarita Kohli.	Ms. Murphy	10:30	5 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Executive/Finance Committee reserves the right to limit the duration of the public comment period to 30 minutes.	Ms. Murphy	10:35	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. Murphy	10:40	5 min

a. Approve May 26, 2022 **Executive/Finance Committee** minutes
b. Approve **Governance Policy** GO.01 v2 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

4.	**May 2022 Financial Statements** Review May 2022 Financial Statements. **Possible Action:** Approve the May 2022 Financial Statements	Mr. Jarecki	10:45	10 min
5.	**Innovation Fund Expenditure Request** Consider funding request from the YMCA to further develop the Diabetes Prevention Program. **Possible Action:** Approve expenditure from the Board Designated Innovation Fund for the YMCA Diabetes Prevention Program	Ms. Bui-Tong	10:55	10 min
6.	**Special Project Fund for CBOs Expenditure Request** Consider funding request from South County Compassion Center in support of the Rental Assistance Program. **Possible Action:** Approve expenditure from the Board Designated Special Project Fund for CBOs for the South County Compassion Center Rental Assistance Program	Ms. Bui-Tong	11:05	10 min
7.	**CY'21 HEDIS Measure Analysis** Discuss HEDIS performance trends and reduction of outcome disparities.	Dr. Nakahira	11:15	20 min
8.	**Housing & Homelessness Incentive Program (HHIP) Overview** Discuss HHIP summary and support for HumanGood Morgan Hill Senior Housing Development.	Ms. Andersen Ms. Amirthavasar	11:35	10 min
9.	**Government Relations Update** Discuss local, state, and federal legislative and policy issues impacting the Plan and its members.	Mr. Haskell	11:45	10 min
10.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	11:55	5 min

Announcement Prior to Recessing into Closed Session
Announcement that the Executive/Finance Committee will recess into Closed Session to discuss Item No. 11 below.

11. Adjourn to Closed Session 12:00

a. Existing 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 litigation initiated by a vendor. Case name unspecified: disclosure of case name may jeopardize existing settlement negotiations.

b. Contract Rates (Welfare and Institutions Code Section 14087.38(n)):
It is the intention of the Executive/Finance Committee to meet in Closed Session to discuss Plan partner rates.

12. Report from Closed Session Ms. Murphy 12:25 5 min

13. Adjournment 12:30

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 Rita Zambrano 48 hours prior to the meeting at (408) 874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at (408) 874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, May 26, 2022, 10:30 AM – 12:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Sue Murphy, Chair
Bob Brownstein
Alma Burrell
Dave Cameron
Michele Lew

Staff Present
Christine Tomcala, Chief Executive Officer
Neal Jarecki, Chief Financial Officer
Laurie Nakahira, DO, Chief Medical Officer
Jonathan Tamayo, Chef Information Officer
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, VP, Strategies & Analytics
Chelsea Byom, VP, Marketing, Communications & Outreach
Teresa Chapman. VP, Human Resources
Laura Watkins, VP, Marketing & Enrollment
Barbara Granieri, Controller
Mike Gonzales, Director, Community Engagement
Tyler Haskell, Director, Government Relations
Khanh Pham, Director, Financial Reporting & Budgeting
Lloyd Alaban, Copy Writer and Content Strategist
Rita Zambrano, Executive Assistant
Robyn Esparza, Administrative Assistant

Others Present
John Domingue, Rossi Domingue LLP
Darcy Muilenburg, DSR Health Law

1. Roll Call

Sue Murphy, Chair, called the meeting to order at 10:32 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

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

a. Approve April 28, 2022 **Executive/Finance Committee** minutes
b. Accept **Network Detection and Prevention Update**
c. Approve **Finance Policy**
- FA.14 Board Committee Stipends

d. Approve **Dynamic Module** for D-SNP revenue reconciliation
e. Approve **Healthcare Fraud Shield** software solution

f. 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. Lew
Second: Mr. Cameron
Ayes: Ms. Burrell, Mr. Cameron, Ms. Lew, Ms. Murphy
Absent: Mr. Brownstein

4. March 2022 Financial Statements

Mr. Jarecki presented the unaudited financial statements for March 2022, which reflected a current month net surplus of $2.8 million ($2.9 million favorable to budget) and a year-to-date net surplus of $16.4 million ($8.0 million favorable to budget).

Enrollment increased by 1,750 members from the prior month to 297,172 members (14,503 members or 4.7% 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 disenrollment's have been suspended. YTD member months trailed budget by 69,973 member months or 2.6%.

Revenue reflected an unfavorable current month variance of $10.6 million (8.7%) largely due to the inclusion of Medi-Cal pharmacy throughout FY22 in the budget. Pharmacy was carved-out of managed care effective January 1, 2022, which reduced revenue by $12.1 million (with a corresponding reduction to medical expense). Additionally, revenue was $3.7 million lower than budget due to lower enrollment due to fewer OHC members (with a corresponding reduction to medical expense) and $1.1 million lower due to additional medical loss ratio accruals payable to DHCS. Offsetting these items, revenue reflected favorable calendar year 2022 Medi-Cal CCI rates versus budget ($2.9 million), enhanced Prop 56 revenue ($1.5 million) and unbudgeted COVID vaccine program revenue ($1.3 million).

Medical Expense reflected a favorable current month variance of $12.8 million (11.2%) largely due to offsets of key revenue items above (pharmacy carve-out and OHC enrollment totaling $12.4 million). Additionally, certain fee-for-service expense categories reflected favorable variances due to reduced enrollment and lower utilization than budgeted ($2.8M). Increased Prop 56 revenue exceeded budget by $2.4 million.

Administrative Expense was $1 million (14.2%) favorable to budget for the month largely due to lower headcount than budgeted and 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 1.29:1 versus the DMHC minimum current ratio requirement of 1.00:1.

Tangible Net Equity of $271.2 million, which represented approximately three months of the Plan's total expenses, included unrestricted net assets of $230.0 million.

Capital Investments of $923 thousand were made year-to-date, predominately computer software licenses, versus the annual capital budget of $3.3 million.

It was moved, seconded, and the March 2022 unaudited financial statements were **unanimously approved.**

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

5. CEO Update

Christine Tomcala, Chief Executive Officer, presented the updated COVID vaccination graphs, including data by age group, ethnicity, and booster status. Ms. Tomcala shared that there is currently a 16% gap between eligible SCFHP members (74%) and overall Santa Clara County residents (90%) who have received at least one COVID vaccine dose. She noted that the age band with the highest number of unvaccinated members is the 5-11 year-old group, with more than 20,000 unvaccinated children.

Ms. Tomcala shared that 63% of the Plan's Black/African Ancestry population and 66% of Hispanic/Latino members have received at least one vaccine, both of which remain below the Plan average. Ms. Tomcala noted that the comparably larger percentage of children in the Hispanic/Latino membership contributes to the lower rate of vaccinated individuals in that ethnic group.

Ms. Tomcala noted that of all Medi-Cal health plans, only San Francisco Health Plan has a higher vaccination rate than SCFHP.

Ms. Tomcala provided an update on the ongoing efforts at the Blanca Alvarado Community Resource Center (CRC). She noted that SCFHP continues to offer COVID-19 vaccine clinics, with a $50 incentive for any individual receiving a shot at the CRC. Over 2,000 vaccines have been administered from January through May, with eight more clinics scheduled through August. Ms. Tomcala noted we continue to partner with Bay Area Community Health, County of Santa Clara Mobile Vaccine Unit, COVID-19 Black, and Roots Community Health Center.

Ms. Tomcala announced that SCFHP now serves greater than 300,000 members, which is approximately 15% of the residents of Santa Clara County.

6. Government Relations Update

Tyler Haskell, Director of Government Relations, provided updates on recent government activity affecting the health plan. He discussed the likelihood of another 90-day extension of the federal Public Health Emergency and a recent request from the federal Department of Health and Human Services that the Federal Communications Commission clarify whether health plans are permitted to call and text their members to assist with coordination of Medicaid redeterminations. Mr. Haskell also discussed Congressional action related to COVID funding, out-of-pocket insulin costs, and the possibility of health care legislation that would carry various proposals related to services and coverage for low-income Americans. He gave an overview of new proposals included in the revised State budget, and discussed three bills affecting health plan operations that are pending in the State Legislature.

Mr. Brownstein arrived at 11:10 am.

7. Adjourn to Closed Session

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

b. <u>Pending Litigation</u>
The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding pending litigation.

c. <u>Contract Rates</u>
The Executive/Finance Committee met in Closed Session to discuss Plan partner rates.

Ms. Burrell left the meeting at 12:00 pm.

8. Report from Closed Session

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

9. Adjournment

The meeting was adjourned at 12:06 pm.

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Michele Lew, 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
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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:

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

2. Validates and confirms that all outbound misdirected claims files are successfully transmitted.

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

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

2. Monitors that SCFHP is compliant at all times with the ten (10) working day turn-around time requirement.
   - Reviews and audits outbound misdirected claims files to ensure correct payer disbursement.
3.

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
4	Revised	Executive/Finance	Recommend	07/28/2022

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.

POLICY

III. Responsibilities

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

A.

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	~~4~~04/22/2021
3	Revised	Executive/Finance	Recommend	07/28/2022

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

Santa Clara Family Health Plan™

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

Santa Clara Family Health Plan™

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/

Santa Clara Family Health Plan™

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 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 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

3. ~~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.

   a.

B. Availability and Accessibility

   1. 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.

   2. 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.

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.

b.

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.~~ 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.

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

D.

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

V.

First Level Approval	Second Level Approval
Arlene Bell Director, Claims ~~12~~5/~~28/2020~~13/2022 Date	Neal Jarecki Chief Financial Officer ~~0~~15/~~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	1/28/2021
6	Revised	Executive/Finance	Recommend	7/28/2022

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

Santa Clara Family Health Plan™

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.

D. Each provider dispute must be acknowledged within two (2) working days of the date of receipt if received electronically and within fifteen (15) working days if received via paper.

E. Capitated subcontractors will be required to adhere to the same statutory, regulatory and contractual requirements governing the timely processing of first level PDRs as the Santa Clara Family Health Plan (SCFHP). SCFHP's annual audit of its capitated subcontractors will ensure that these requirements are being followed.

Santa Clara Family Health Plan™

POLICY

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

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	Approve	05/27/2021
~~3~~4	Revised	Executive/Finance	Recommend ~~5/27/2021~~	~~N/A~~7/28/2022

POLICY

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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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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.

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.

~~B.~~

POLICY

C. ~~Finance~~Claims is responsible for~~-~~ receiving and processing of unsolicited post payment recovery of paid claims for ~~Medi-Cal members with OHC, for reporting,~~MC members with OHC and for 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 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~~05/16/2022 Date	Neal Jarecki Chief Financial Officer ~~04~~05/16/~~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	07/28/2022

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

MEMORANDUM

Date: July 21, 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 Governing Board met and made the above findings in June, and the Executive/Finance Committee 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 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*

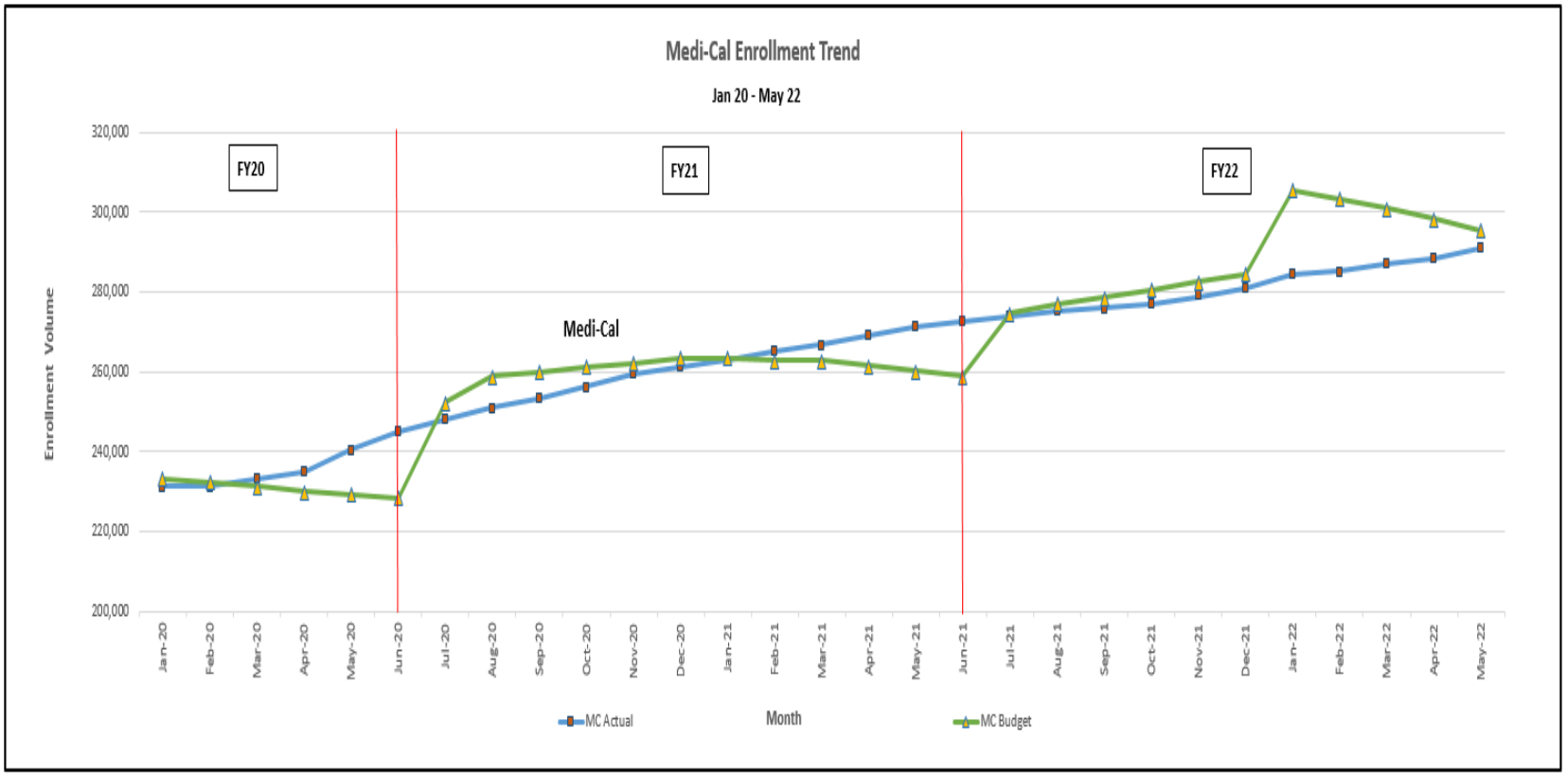
Enrollment By Aid Category

Santa Clara Family Health Plan

SCFHP TRENDED ENROLLMENT BY COA YTD MAY - 2022

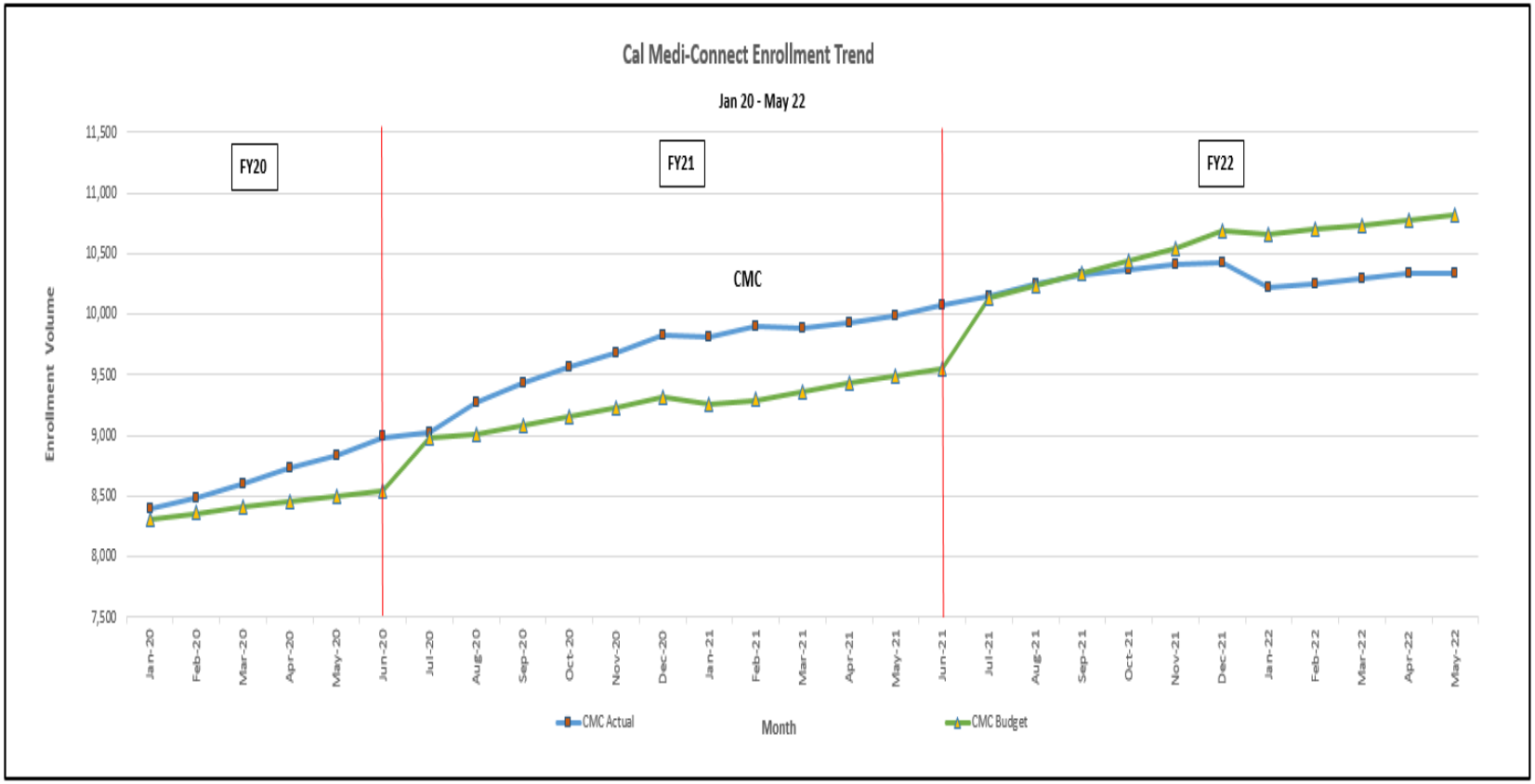
		2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	FYTD var	%
NON DUAL	Adult (over 19)	32,577	32,997	32,995	33,281	33,546	33,809	34,245	34,653	35,652	35,761	36,104	36,529	37,033	4,036	12.2%
	Child (under 19)	100,245	100,477	101,010	101,085	101,093	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

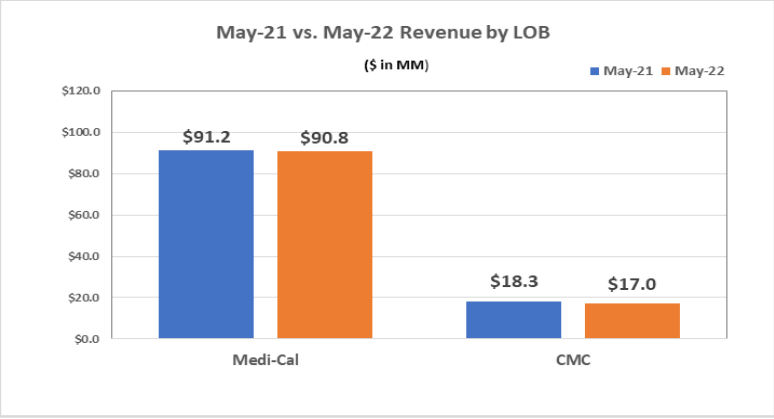


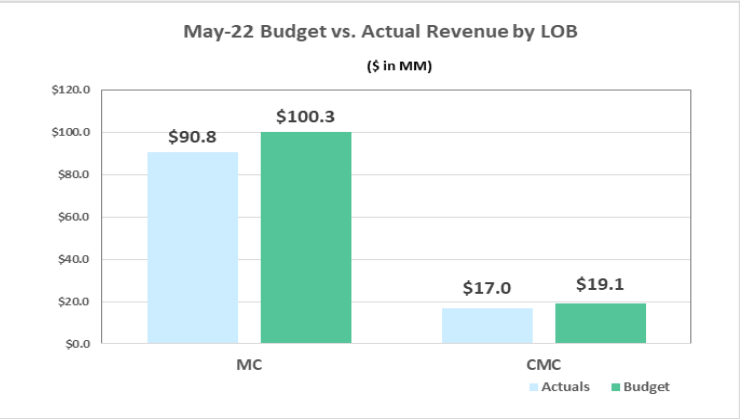
- Actual enrollment, represented by the blue line, showed steeper initial COVID enrollment growth in FY21 followed by a lower growth in FY22 with continued public health emergency.
- Budgeted enrollment, represented by the green line, was presumed to decrease in late FY21 but continues due to sustained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

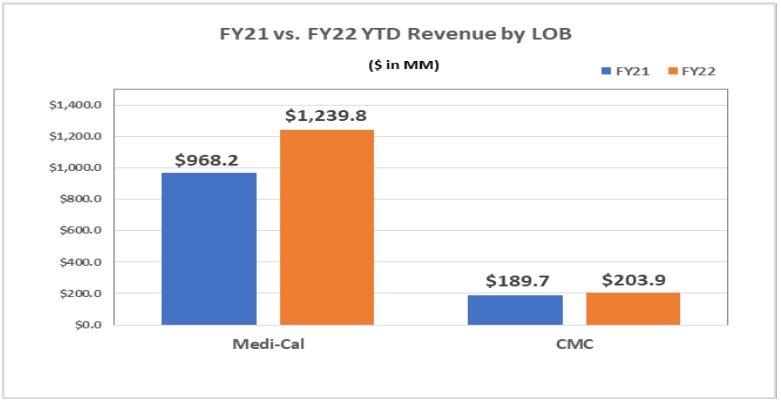


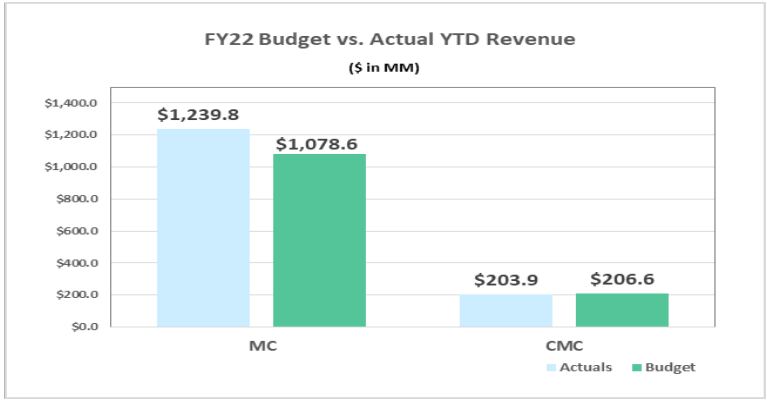


YTD Revenue

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.

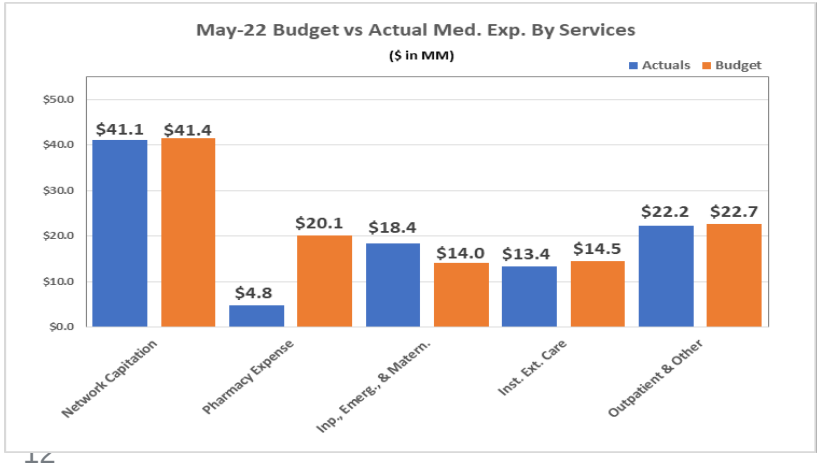


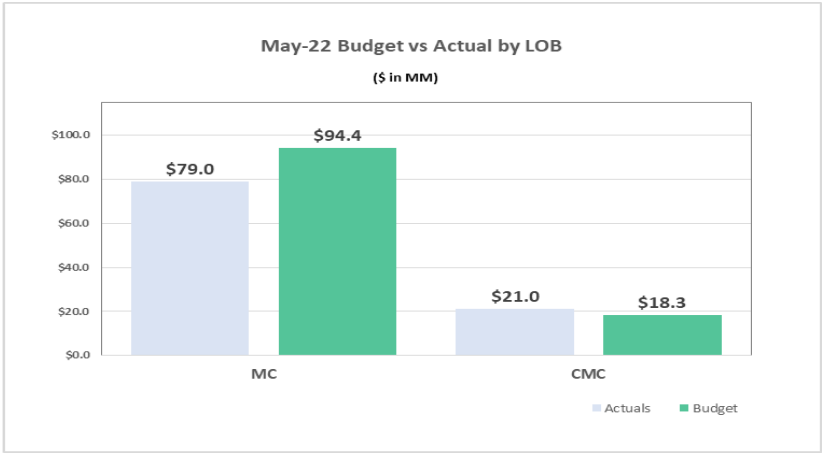


Current Month Medical Expense

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.

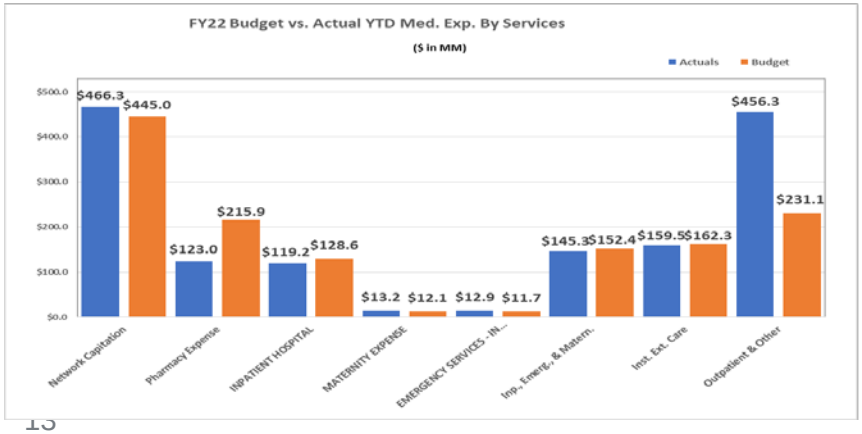


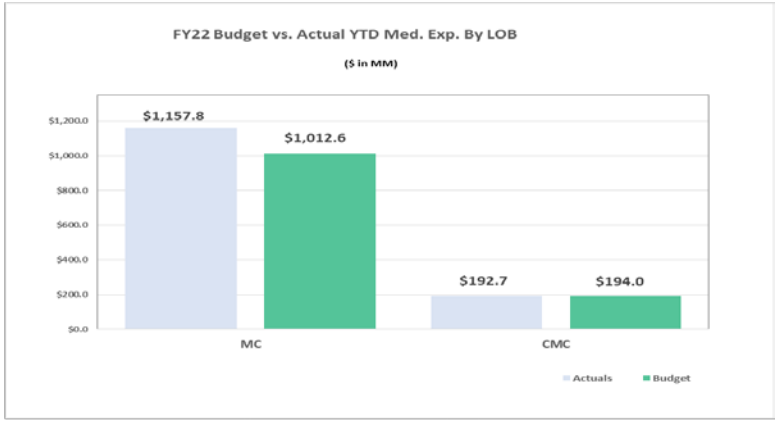


YTD Medical Expense

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.

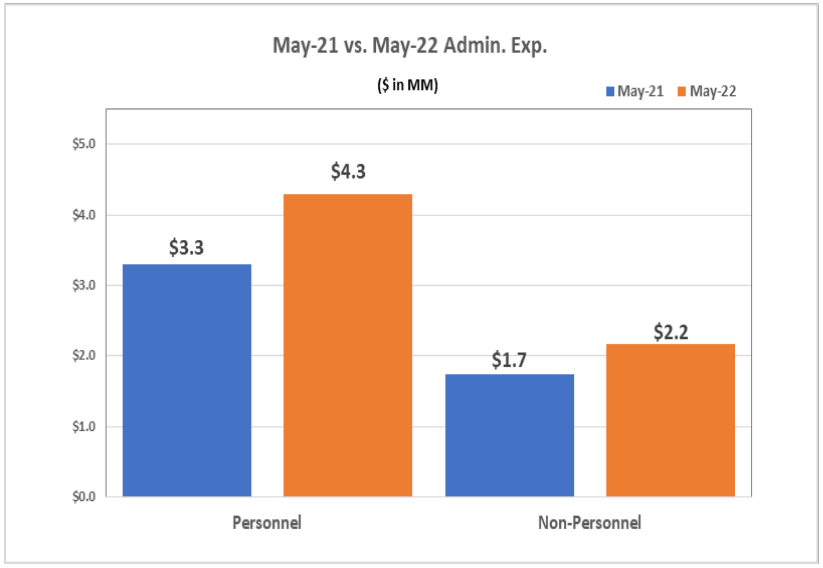


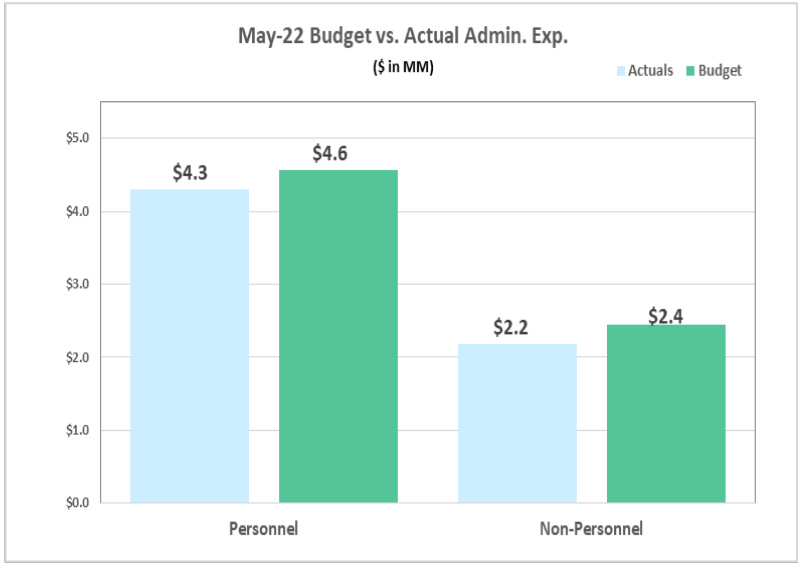


Current Month Administrative Expense

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.

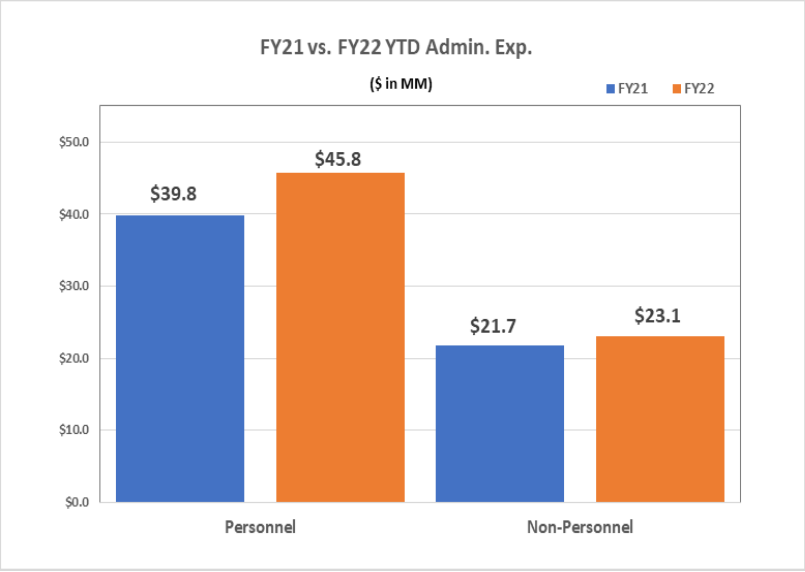


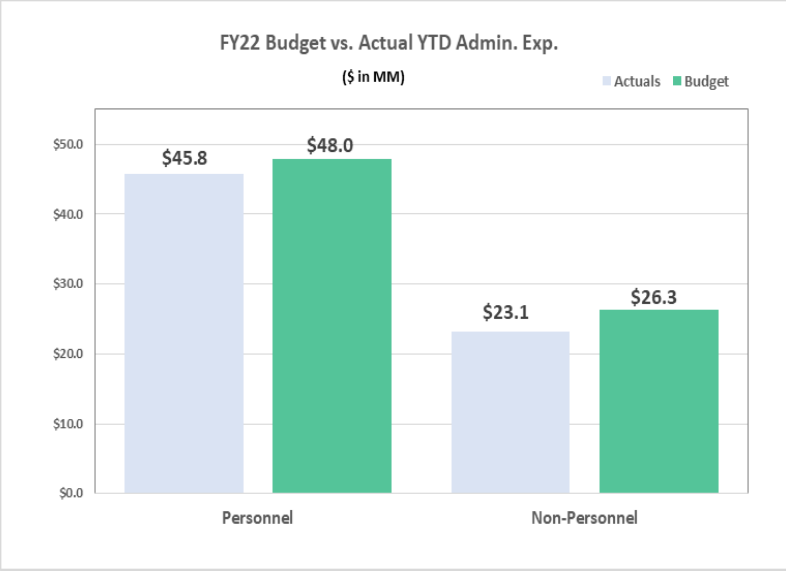


YTD Administrative Expense

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**

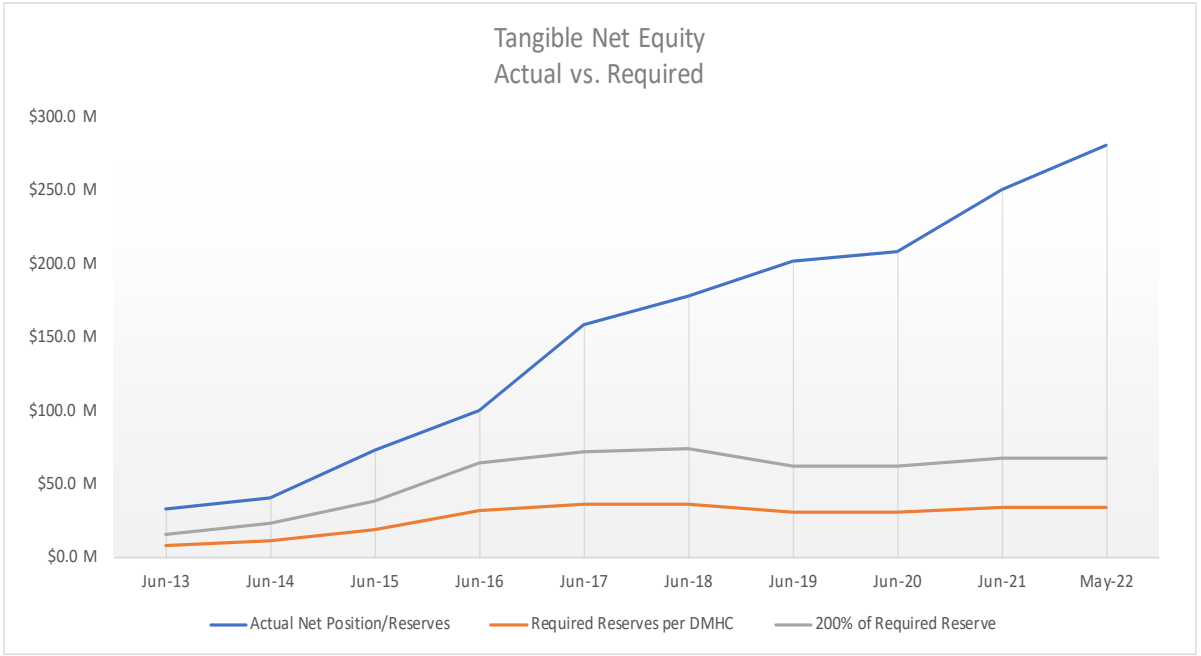
- Cash balances include balances payable to the State of CA for certain items.
- County of Santa Clara Comingled Pool funds have longer-term investments which currently provide a higher yield than WFB Investments.
- The investment transition from Wells Fargo to City National Bank was largely completed 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).

Santa Clara Family Health Plan™

CY21 HEDIS Measure Analysis

Laurie Nakahira, Chief Medical Officer

July 2022

CY21 HEDIS Measure Analysis

Overview:

- FY ‘21-’22 Plan Objective Success Measure
  - Achieve HEDIS average performance score of 2.30 for Medi-Cal and 2.02 for Cal MediConnect
  - Pursue reduction in HEDIS outcome disparities by network & ethnicity on ≥ 2 metrics
- 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

Note: A statistically significant result is unlikely due to chance and can be attributed to a specific variable (e.g. ethnicity). The Chi-Square test was used to determine statistical significance at a p-value of < .05

Medi-Cal MCAS* and CMC** Performance Trend

Point Value	Medicaid HEDIS Percentile	Medi-Cal Measures Held to Minimum Performance Level (MPL)				
		CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
4	**≥ 90th**	1	1	5	3	2
3	**75th**	7	3	5	3	6
2	**50th**	11	11	4	7	5
1	**25th**	1	4	3	2	1
0	**< 25th**	1	0	1	1	1
Total Measures		21	19	18	16	15
Average Point Value		**2.29**	**2.05**	**2.56**	**2.31**	**2.47**

Point Value	Medicare HEDIS Percentile	CMC Measures				
		CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
4	**≥ 90th**	2	2	7	12	5
3	**75th**	10	7	9	2	3
2	**50th**	5	11	10	11	14
1	**25th**	15	13	14	6	12
0	**< 25th**	21	15	11	17	13
Total Measures		53	48	51	48	47
Average Point Value		**1.19**	**1.33**	**1.75**	**1.71**	**1.47**

* MCAS = Managed Care Accountability Set
** CMC measures used are non-utilization measures with benchmarks

Medi-Cal MCAS Measures CY 2021

Measure	Measure Description	HEDIS CY 2019 Final Rate	HEDIS CY 2020 Final Rate	HEDIS CY 2021 Final Rate	Current Percentile	CY 2021 MPL
BCS[2]	Breast Cancer Screening	66.72%	59.78% ↓	56.61% ↓	50th	53.93%
CBP*	Controlling High Blood Pressure	62.04%	57.42% ↓	57.18% ↓	50th	55.35%
CCS*[2]	Cervical Cancer Screening	52.07%	59.85% ↑	60.10% ↑	50th	59.12%
CDC-H9*[1]	Diabetes Care HbA1c Poor Control (>9.0%)	31.14%	34.31% ↓	26.52% ↑	95th	43.19%
CHL	Chlamydia Screening in Women	59.19%	57.43% ↓	61.91% ↑	75th	54.91%
CIS10*[2]	Childhood Immunization Status – Combo 10	66.91%	57.91% ↓	49.88% ↓	75th	38.20%
IMA-2*[2]	Immunizations for Adolescents - Combo 2	46.72%	43.31% ↓	41.36% ↓	50th	36.74%
PPC-Post*	Postpartum Care	85.16%	84.67% ↓	79.81% ↓	75th	76.40%
PPC-Pre*	Timeliness of Prenatal Care	93.19%	92.70% ↓	90.75% ↓	75th	85.89%
W30A-6[2]	Well-Child Visits (0 to 15 Months) – 6 Visits	Did not report	33.89%	51.61% ↑	25th	54.92%
W30B-2[2]	Well-Child Visits (15 – 30 Months) – 2 Visits	Did not report	76.73%	64.94% ↓	10th	70.67%
WCC-BMI*	BMI Assessment	89.29%	80.54% ↓	84.91% ↑	75th	76.64%
WCC-N*	Counseling for Nutrition	Did not report	74.21%	81.51% ↑	75th	70.11%
WCC-PA*	Counseling for Physical Activity	Did not report	72.26%	79.32% ↑	90th	66.18%
WCV	Child and Adolescent Well-Care Visits	Did not report	43.92%	51.11% ↑	50th	45.31%

* Hybrid measure, both claims/encounter data and medical record review
[1] Reverse measure, lower is better
[2] Measure has a lookback period that spans multiple calendar years
Measure met MPL / Measure did not meet MPL

↑: Rate improved compared to prior year
↓: Rate declined compared to prior year
Note: MPL is determined based on the performance from the previous year (i.e. CY20 benchmarks based on CY19 performance)

Medi-CAL HEDIS Measure Percentiles by Network CY2021

			Administrative Rates Only						
Measure	**SCFHP Overall Final Rate**	**SCFHP Overall Admin Rate**	**SCFHP Direct (admin)**	**VHP**	**Kaiser**	**PMG**	**PCNC**	**PAMF**	**NEMS**
Breast Cancer Screening	56.61%	56.61%	51.32%	52.57%	69.61%	61.88%	53.00%	63.17%	61.60%
Controlling High Blood Pressure^	57.18%	40.02%	43.16%	43.30%	76.65%	27.94%	21.58%	1.28%	73.02%
Cervical Cancer Screening^	60.10%	57.25%	58.44%	47.83%	83.55%	60.22%	66.61%	60.99%	71.32%
Diabetes Care HbA1c Poor Control (>9.0%)[1]	26.52%	34.64%	45.96%	33.40%	25.74%	29.29%	29.37%	51.28%	22.36%
Chlamydia Screening in Women	61.91%	61.91%	61.31%	63.39%	63.69%	55.79%	63.41%	55.17%	64.71%
Childhood Immunization Status – Combo 10^	49.88%	24.27%	26.91%	13.94%	53.29%	25.34%	16.96%	28.57%	67.65%
Immunizations for Adolescents - Combo 2^	41.36%	41.61%	35.00%	35.28%	60.33%	44.64%	41.97%	52.29%	54.10%
Postpartum Care^	79.81%	74.80%	70.73%	77.04%	77.27%	67.79%	83.05%	65.22%*	100.00%*
Timeliness of Prenatal Care^	90.75%	84.36%	89.55%	83.37%	87.70%	79.55%	83.05%	86.96%*	77.78%*
Well-Child Visits (0 to 15 Months) – 6 Visits	51.61%	51.61%	25.29%	64.05%	30.50%	44.30%	29.51%	63.89%	69.23%*
Well-Child Visits (15 – 30 Months) – 2 Visits	64.94%	64.94%	52.82%	69.05%	45.91%	72.28%	77.37%	76.56%	74.29%
BMI Assessment^	84.91%	67.25%	62.20%	81.98%	78.60%	43.09%	46.79%	11.21%	96.42%
Counseling for Nutrition^	81.51%	41.07%	40.21%	33.95%	77.87%	34.98%	42.61%	1.72%	88.30%
Counseling for Physical Activity^	79.32%	37.10%	37.48%	29.88%	77.56%	33.44%	17.06%	0.41%	89.43%
Child and Adolescent Well-Care Visits	51.11%	51.11%	46.69%	45.56%	53.30%	59.81%	59.67%	57.54%	63.89%

1. Reverse measure, lower is better
* Small denominator (N < 30)

Administrative: uses claims/encounter data
^ Hybrid: uses a sample size of 411, with claims/encounter data and medical record review

- ≥ 90th percentile
- 75th percentile
- 50th percentile
- 25th percentile
- ≤10th percentile

Medi-Cal CY2021 Disparities by Ethnicity and Language

Santa Clara Family Health Plan

Ethnicity	BCS (Breast Cancer)	CCS (Cervical Cancer)	CHL (Chlamydia)	CBP (Blood Pressure)	CDC-H9 (Diabetes)	PPC-Pre (Prenatal)	PPC-Post (Postpartum)	CIS10 (Child Immunizations)	IMA2 (Adolescent Immunizations)	W30A-6 (Well-Child First 15 Months)	W30B-2 (Well-Child 15-30 Months)	WCV (Child/Adolescent Well-Care Visits)	WCC-BMI (BMI Screening)	WCC-N (Nutrition Counseling)	WCC-PA (Physical Activity)	# Times Low Performer	# Times Highest Performer
African American/Black			o		x			x	x			x		x		5	1
Asian Indian	x	x	x										x	x		5	0
Asian/Pacific/Filipino		x										x				2	0
Caucasian/White	x	x	x		x						x	x	x			7	0
Chinese	x			o	o			o	o			o	o	o	o	1	8
Hispanic					x											1	0
Other/Unknown											x					1	0
Vietnamese	o	o		x			o			x	o		x	x	x	5	4

Language	BCS (Breast Cancer)	CCS (Cervical Cancer)	CHL (Chlamydia)	CBP (Blood Pressure)	CDC-H9 (Diabetes)	PPC-Pre (Prenatal)	PPC-Post (Postpartum)	CIS10 (Child Immunizations)	IMA2 (Adolescent Immunizations)	W30A-6 (Well-Child First 15 Months)	W30B-2 (Well-Child 15-30 Months)	WCV (Child/Adolescent Well-Care Visits)	WCC-BMI (BMI Screening)	WCC-N (Nutrition Counseling)	WCC-PA (Physical Activity)	# Times Low Performer	# Times Highest Performer
Chinese	x			o	o			o				o	o	o	o	1	7
English	x				x	x	x		x	x	x	x				8	0
Other/Unknown		x		x						o			x	x		4	1
Spanish					x		x									2	0
Tagalog		x										x				2	0
Vietnamese	o	o		x			o	x			o		x	x	x	5	4

x	Lowest performer(s) (statistically significant)
o	Highest performer (statistically significant)

Medi-Cal Three Year Comparison for Select[1] Focus Measures by Race and Ethnicity

Ethnicity	Breast Cancer			Cervical Cancer			Chlamydia			Diabetes			Well-Child First 15 Months			Well-Child 15-30 Months			Child/Adolescent Well-Care Visits			
	BCS			CCS			CHL			CDC2			W30A			W30B*			WCV**			
	CY 2019	CY 2020	CY 2021	CY 2019	CY 2020	CY 2021	CY 2019	CY 2020	CY 2021	CY 2019	CY 2020	CY 2021	CY 2019	CY 2020	CY 2021	CY 2019	CY 2020	CY 2021	CY 2019 (AWC)	CY 2019 (W34)	CY 2020	CY 2021
African American/Black								o	o			x		x					x	x	x	x
Asian Indian		x	x	x	x	x			x													
Asian/Pacific/Filipino				x	x	x											x		x		x	x
Caucasian/White	x	x	x	x	x	x			x	x	x	x	x					x	x		x	x
Chinese	x	x	x							o	o	o										o
Hispanic										x	x	x										
Other/Unknown							o										x	x		x		
Vietnamese	o	o	o	o	o	o		x							x		o	o	o		o	

Language																						
Chinese	x	x	x							o	o	o							o			o
English	x	x	x	x	x		o			x	x	x	x		x		x	x	x	x	x	x
Other/Unknown						x									o							
Spanish								o				x		o								
Tagalog				x	x	x													x			x
Vietnamese	o	o	o	o		o												o			o	

x	Lowest performer(s) (statistically significant)
o	Highest performer (statistically significant)

* Was a new measure in CY 2020 so no CY 2019 rates

** Was a new measure in CY 2020 so no CY 2019 rates, using similar measures as proxy

[1] Low-performing measures below or borderline MPL

FY21-’22 Plan Objective Success Measure

Pursue reduction in HEDIS outcome disparities by network and ethnicity on ≥ 2 metrics

Women’s Health:

1. Breast Cancer Screening (BCS) Asian and Caucasian/White focus
    - Rates decreased for all ethnicities and networks
    - Remained at 50th percentile
    - Asian Indian, Chinese, and Caucasian/White disparities remained the same compared to plan average
    - SCFHP Direct Network disparity gap narrowed from 7.79% (CY2020) to 5.29 % (CY2021) compared to plan average

FY21-’22 Plan Objective Success Measure

Pursue reduction in HEDIS outcome disparities by network and ethnicity on ≥ 2 metrics

Women’s Health:

2. Cervical Cancer Screening (CCS) Asian and Caucasian/White focus
    - Overall Plan improvement from 25th to 50th percentile, but rate only increased 0.30%
    - Asian Indian, Asian/Pacific/Filipino, and Caucasian/White disparities remained the same compared to plan average
    - Network disparities remained the same compared to plan average

FY21-’22 Plan Objective Success Measure

Pursue reduction in HEDIS outcome disparities by network and ethnicity on ≥ 2 metrics

Diabetes:

3. Comprehensive Diabetes Care – HbA1c Poor Control > 9% (CDC-H9)^ Hispanic and Caucasian/White
    - Improved from 50th to 95th percentile, rate improved from 34.31% to 26.52%
    - Rates improved for all ethnicities and all were statistically significant
    - Rates improved for all networks
    - Hispanic and Caucasian/White disparities remained the same compared to plan average
    - PAMF disparity gap narrowed from 56.18% (CY2020) to 16.64% (CY2021) compared to plan average largely due to improved data completeness

^ Inverted measure, lower is better

Reducing Disparities

Actions taken to identify root causes

- Focus group for DM management
  - 1 Hispanic-English;
  - 1 Hispanic-Spanish;
  - 1 Caucasian/White-English
- Focus Groups Conducted for Women's Health
  - 2 Asian-English
- Quality Outreach Calls Conducted for Women's Health
  - 29 Asian Indian
  - 178 Caucasian/White
- Implemented a Diabetes Care Management Program

Root Causes

Low Breast Cancer Screenings (BCS) & Cervical Cancer Screenings (CCS)

- Provider did not recommend screening
- Member is not sexually active
- Member had an unpleasant or painful experience
- Member has no family risk factors for the cancers
- Member has past trauma/abuse
- Member has a fear of a positive diagnosis of cancer
- Member has a lack of women's health education as a youth
- Member has depression and/or social isolation
- Member has distrust of the medical system
- Member has experienced difficulties with navigating the health system (i.e. long wait times to schedule appt., specialty referrals)

Root Causes

Diabetes Mellitus - Uncontrolled

- Member is overwhelmed by the disease and the management (i.e. polymeds, frequent tests, appts, diet)
- Member has hesitancy about insulin shots, testing blood sugar via finger sticks
- Member has a busy life with work long hours, taking care of other family members
- Member has a lack of understanding of the long-term effects of Diabetes
- Member has a fatalistic view of the conditions from family experience(s); childhood trauma
- Member has changed doctors and lacked continuity of care
- Member experienced lack of sufficient time spent during the visits
- Member has language limitation
- Member has painful co-morbidities
- Member has depression and social isolation
- Member has experienced difficulties with navigation to specialist and getting durable medical equipment (DME)

Root Causes

Delivery System

- Members experienced long Valley Connection* wait times to re/schedule appointment
- Members had a provider visit but service gaps were not completed
- Members had a negative experience with Providers (perceived lack of empathy)
- Providers cancelling clinics; lack of timely appts., especially during COVID redeployment of staff
- Providers not able to answer all questions during office visit & long wait time for care process

*Valley Medical Center (VMC) appointment line

Department of Health Care Services (DHCS) BOLD Goals

DHCS Statewide BOLD Goal

1. Close racial/ethnic disparities in well-child visits and immunizations by 50%

Measure	CY 2020 CA Baseline	CY 2021 SCFHP Rate	CY 2021 Disparities**
Well-Child Visits (0 – 15 Months) – 6 Visits	66.40%	51.61%	Vietnamese: 44.10%
Well-Child Visits (15 – 30 Months) – 2 Visits	37.70%	64.94%	Caucasian/White: 57.21%
Child and Adolescent Well-Care Visits (WCV)	41.13%	Final: 51.11%	African American/Black: 46.06% Asian/Pacific/Filipino: 46.79% Caucasian/White: 46.40%
Childhood Immunization Status - Combo 10	37.95%	Admin*: 24.27% Hybrid: 49.88%	African American/Black: 12.62%
Immunizations for Adolescents - Combo 2	46.05%	Admin*: 41.61% Hybrid: 41.36%	African American/Black: 28.14%

* Using admin rate for comparison due to hybrid data not reportable by ethnicity
** Disparities determined based on if an ethnicity was in the bottom three performers and was statistically significant or 10% lower than plan average

DHCS Statewide BOLD Goal

2. Close maternity care disparity for Black and Native American persons by 50%

Measure	CY 2020 CA Baseline	CY 2021 SCFHP Admin Rate	CY 2021 Disparities
Prenatal & Postpartum Care - Timeliness of Prenatal Care	87.88%	Admin*: 84.36% Hybrid: 90.75%	African American/Black: 74.39% (61/82) Native American: 100% (8/8)
Prenatal & Postpartum Care - Postpartum Care	78.87%	Admin*: 74.84% Hybrid: 79.81%	African American/Black: 67.07% (55/82) Native American: 75.00% (6/8)

* Using admin rate for comparison due to small sample size of hybrid rate

DHCS Statewide BOLD Goal

3. Improve maternal and adolescent depression screening by 50%

Measure	CY 2020 CA Baseline*	CY 2021 SCFHP Final Rate
Prenatal Depression and Follow Up - Screening	N/A	22.42%
Postpartum Depression and Follow Up - Screening	N/A	14.38%
Screening for Depression and Follow-up - 12 - 17 years	N/A	5.12%

* No CY 2020 CA baselines due to being newly reported measures

DHCS Statewide BOLD Goal

4. Improve follow up for mental health and substance use disorder by 50%

Measure	CY 2020 CA Baseline*	CY 2021 SCFHP Final Rate
Follow-Up After Emergency Department Visit for Substance Use – 30 days	N/A	11.60%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 days	N/A	34.16%
Follow-Up After Emergency Department Visit for Mental Illness – 30 days	N/A	55.62%
Follow-Up After Hospitalization for Mental Illness – 30 days	N/A	46.94%

* No CY 2020 CA baselines due to being newly reported measures

DHCS Plan-Specific BOLD Goal

5. Ensure all health plans exceed the 50th percentile for all children's preventive care measures

Measure	CY 2021 SCFHP Final Rate	CY 2021 50th Percentile
Lead Screening in Children	63.26%	71.53% (-8.3%)
Developmental Screening in the First Three Years of Life	11.12%	TBD
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	9.93%	TBD
Dental Fluoride Varnish	TBD	TBD

CMC HEDIS/Stars Rate Overview – CY 2021

Santa Clara Family Health Plan

Measure Abbreviation	Measure Description	CY 2020 Rate	CY 2021 Rate	CY 2021 Percentile (National)	Current STAR Rating
BCS	Breast Cancer Screening	65.01%	64.91% ↓	25th	★★★
COL	Colorectal Cancer Screening	60.34%	63.99% ↑	25th	★★★
COA-ACP	Care For Older Adults – Advanced Care Planning	20.92%	24.57% ↑	< 25th	Not STAR measure
COA-MR	Medication Review	84.67%	86.62% ↑	< 25th	★★★★
COA-FSA	Functional Status Assessment	43.07%	47.45% ↑	< 25th	No benchmarks
COA-PA	Pain Assessment	82.97%	84.91% ↑	< 25th	★★★
CBP	Controlling High Blood Pressure	59.85%	59.85% --	25th	No benchmarks
CDC-HT	Comprehensive Diabetes Care - HbA1c Testing	87.59%	91.97% ↑	25th	Not STAR measure
CDC-H9^	HbA1c Poor Control (>9%)	28.71%	20.19% ↑	50th	★★★★
CDC-H8	HbA1c Control (<8%)	62.53%	69.34% ↑	50th	Not STAR measure
CDC-E	Eye Exam	77.13%	73.72% ↓	50th	★★★★
CDC-N	Attention for Nephropathy	88.08%	91.73% ↑	< 25th	★★★
CDC-BP	BP Control (<140/90 mmHg)	55.96%	57.91% ↑	< 25th	Not STAR measure
OMW	Osteoporosis Management in Women Who Had a Fracture	42.86%	20.45% ↓	< 25th	★
SPC	Statin Therapy for Patients With Cardiovascular Disease	83.19%	89.35% ↑	90th	★★★★★
TRC-I	Transitions of Care - Notification of Inpatient Admission	54.26%	57.18% ↑	75th	No benchmarks
TRC-D	Receipt of Discharge Information	45.26%	53.04% ↑	90th	No benchmarks
TRC-E	Patient Engagement After Inpatient Discharge	83.94%	86.62% ↑	75th	No benchmarks
TRC-M	Medication Reconciliation	54.99%	68.86% ↑	50th	★★★
AAP	Adults' Access to Preventive/Ambulatory Health Services	91.26%	91.67% ↑	< 25th	Not STAR measure

Improved rates for all measures compared to CY20 except for BCS, CDC-E, CBP, and OMW

↑: Rate improved compared to prior year

↓: Rate declined compared to prior year

^ : Inverse measure; lower is better

Metrics on this slide are STAR rating measures, Display measures, and metrics measuring overall Medicare health services access

Planned Interventions

FY23 activities

Health Equity and Health Disparity Focus

- Host peer support groups for Diabetes
- Continue & expand the SCFHP's Diabetes Care Management Program beyond uncontrolled members

All HEDIS Measure Focus

- Continue and expand Provider Performance Program and supplemental data pursuits
- Implement Quality withhold for VHP and Kaiser
- Continue member incentive for low performing metrics
- Identify root causes for network disparities through provider focus groups
- Requested VHP to expand contracts with Mammography network beyond VMC
- Fund practices to deploy dedicated resource for outreach, scheduling, and/or navigation for SCFHP members
- Provide targeted training, practice transformation support, and financial offset for the independent providers during clinic hours

Thank you

Santa Clara Family Health Plan™

Housing & Homelessness Incentive Program

July 28, 2022

Terminology

Housing Terminology Refresher

- CoC – Continuum of Care
- HAPP – Homeless Housing, Assistance and Prevention Program
- HHIP – Housing & Homelessness Incentive Program
- HMIS – Homeless Management Integration System(coordinated entry system)
- LHP – Local Homelessness Plan
- OSH – Office of Supportive Housing
- OSIT – Office of System Integration and Transformation
- PIT – Point in Time count of homeless population

HHIP

Background & Overview

DHCS Goals

1. Reduce and prevent homelessness
2. Ensure Medi-Cal MCPs develop necessary capacity & partnerships to connect members to housing services

DHCS Expectations

- Work with the CoC, local governments, and other stakeholders to create an LHP in alignment with HHAP-3 proposal
- Meet specific metrics to draw down funds in 3 Priority Areas:
  1. Building capacity and partnerships to support referrals for services
  2. Infrastructure to coordinate and meet member housing needs
  3. Delivery of services and member engagement

HHIP

Background & Overview

Program Timeline: 1/1/2022 – 12/31/2023, with funding available through 3/31/2024

HHIP Incentive Funds:

- 85% must go to beneficiaries, providers, local CoC or counties
- Allocations based on Point in Time (PIT) count and other housing data/metrics
- DHCS will disburse funds to MCPs and MCPs will partner with CoCs and other community stakeholders to determine strategies for use of HHIP funds.

HHIP Deliverables

There is an approximate total of $48.8M available funds to draw down.

DHCS Submission	Available Funds Allocation	Due	Status
Letter of Intent	0%	April 4, 2022	Complete
Local Homelessness Plan	5% (~2.4M)	June 30, 2022	Complete
Investment Plan	10% (~4.9M)	September 30, 2022	In progress
Submission 1 for Measurement Period May to December 2022	35% (~17.1M)	February 2023	Start 1/2023
Submission 2 for Measurement Period January to October 2023	50% (~24.4M)	December 2023	Start 1/2023

HHIP Update

Activities To-Date

- Partnered with Anthem Blue Cross
- Conducted outreach and engagement meetings with housing sector stakeholders:
  - OSH, Destination: Home, CoC, City of San Jose, City of Mountainview, and others
- Identified strategy that will impact DHCS metrics to maximize total funds and gaps within the existing Community Plan to End Homelessness
- Contracted with Homebase, policy and consultative services provider that is heavily involved in CoC's housing strategy, to help foster relationships and facilitate engagement to accomplish deliverables
- Submitted required deliverables to DHCS
  - Letter of Intent
  - Local Homelessness Plan
- Identified advisors to provide input on prioritizing strategies

HHIP Update

Next Steps

- Develop Guiding Principles to facilitate discussions on what will be included and prioritized in the Investment Plan
- Coordinate with CoC members and advisors to flesh out strategies to:
  - Meet DHCS metrics to maximize score to draw down on funds
  - Fund gaps identified in the Community Plan to End Homelessness
- Develop action plan to implement necessary changes to attain DHCS metrics
- Submit Investment Plan by September 30

Possible SCFHP HHIP Strategies

These strategies are based off the HHIP metrics DHCS has set forth.

- Data exchange between CoC/OSH to identify all SCFHP and Anthem members in HMIS
- Housing Specialist role within SCFHP to navigate housing resources for members including referrals to existing benefits and supports such as ECM and Community Supports
- Increase funds to Homelessness Prevention System – financial aid for those facing eviction
- Incentivize providers to complete homelessness (and other social needs screening)
- Implement process for hospitals to complete homelessness screening in in-patient and emergency department settings
- Deploy staff or temporary staff for PIT count

HumanGood

Commitment to partner with HumanGood for the residents of an 81 unit planned housing development in the City of Morgan Hill

- HumanGood will set aside 14 apartment units for SCFHP members
- Population: aged 62+ with special needs defined as "i*ndividuals living with physical or sensory disabilities and transitioning from hospitals, nursing homes, development centers or other care facilities*"
- Impact: Housing for SCFHP members requiring assisted living which includes providing care coordination for all residents (i.e. assessing resident needs and assisting them with navigating and accessing services and supports in the community and through SCFHP)

HumanGood

Commitment to partner with HumanGood for the residents of an 81 unit planned housing development in the City of Morgan Hill

- SCFHP would commit to a minimum five year partnership that includes the following:
  1. Identification and referral of appropriate health plan members
  2. On-site Care Coordination to work in tandem with the Resident Adviser
- Estimated cost: $500,000
- Potential funding sources: HHIP dollars, Housing Vouchers

Santa Clara Family Health Plan™

Thank you!

HHIP Two-Year Timeline

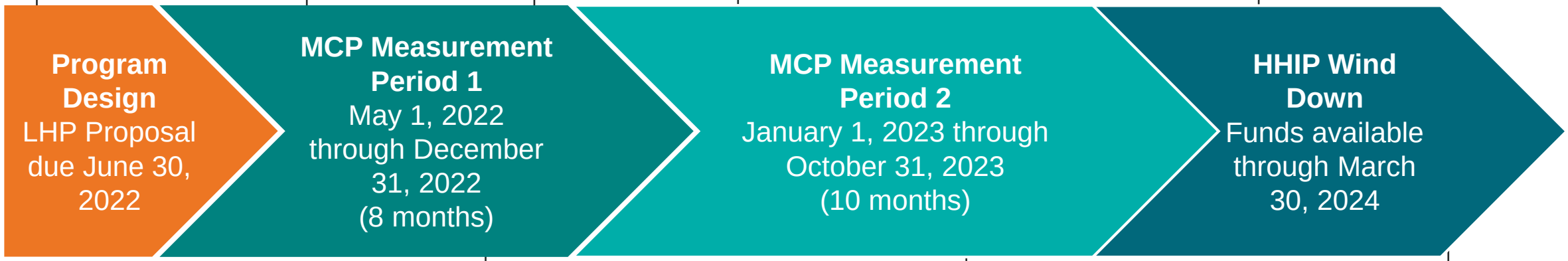
✓ **April 4:** Letter of Intent

✓ **June 30:** Local Homelessness Plan

September 30: Investment Plan

February 2023: Report due for Measurement Period 1

December 2023: Report due for Measurement Period 2



September 2022: Payment Issued in response to LHP Submission

May 2023: Payment issued in response to Measurement Period 1 Report

March 2024: Final Payment issued in response to Measurement Period 2 Report

***Note:** Although the LHP is due on June 30, 2022, the first measurement period for HHIP began on May 1, 2022.*

DHCS HHIP Program Measures

Priority Area 1: Partnership and Capacity to Support Referrals for Services	Priority Area 2: Infrastructure to Coordinate and Meet Member Housing Needs	Priority Area 3: Delivery of Services and Member Engagement
1.1 Engagement with CoC, such as, but not limited to: attending CoC meetings, joining the CoC board, subgroup or workgroup, and attending CoC webinars. *Throughout HHIP, CoCs will respond to surveys administered by DHCS to verify MCP engagement.*	2.1 Connection with street medicine team providing healthcare for individuals who are homeless **Priority Measure****	3.1 Percent of MCP Members screened for homelessness/risk of homelessness
1.2 Connection and integration with the local homeless Coordinated Entry System **Priority Measure****	2.2 MCP connection with the local Homeless Management Information System (HMIS) **Priority Measure****	3.2 MCP Members screened for homelessness/risk of homelessness transitioning from inpatient settings or have been to the emergency department for services two or more times in a 4- month period
1.3 Outreach and engagement efforts and approach to provide housing-related Community Supports services that MCP members who are experiencing homelessness need and are not receiving	2.3 MCP process for tracking and managing referrals for housing-related Community Supports offered during the measurement period, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs	3.3 MCP efforts to support the CoC in the collection of point in time (PIT) count of members determined as homeless
1.4 Partnerships with counties, CoC, and/or organizations that deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion) with whom the MCP has a data sharing agreement that allows for timely exchange of information and member matching **Priority Measure****		3.4 MCP Members in the ECM Population of Focus ("Individuals and Families Experiencing Homelessness") receiving at least one housing related Community Supports, including: 1. Housing Transition Navigation 2. Housing Deposits 3. Housing Tenancy and Sustaining Services 4. Recuperative Care 5. Short-Term Post-Hospitalization Housing 6. Day Habilitation Programs
1.5 Data sharing agreement with county MHPs and DMC-ODS (if applicable)		3.5 MCP Members who were successfully housed **Priority Measure****
1.6 Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention (Aligns with HHAP Round 3 Application)		3.6 MCP Members who remained successfully housed **Priority Measure****

Investment Plan

- **Investment Activity:** Investment that will be made throughout CY 2022 and CY 2023 toward achieving the HHIP program goals to (1) ensure MCPs have the necessary capacity and partnership to connect their members to needed housing services, and (2) reduce and prevent homelessness.
- **Gap or Need Addressed:** Identify the existing funding gaps or county needs that the investment is intended to address, and specify how the MCP identified this gap/need (i.e. in reviewing the HHAP, through conversations with the CoC). Funding gaps and county needs are defined as gaps/needs in housing-related infrastructure, capacity and provider partner capabilities that are not sufficiently funded to meet the needs of Medi-Cal beneficiaries.
- **Description:** Details of the investment activity, including anticipated:
  - ***Dollar amount.*** If the specific dollar amount is not known at this time, the MCP may provide a dollar range, which should be as narrow as possible.
  - ***Recipient(s).*** If the specific organization is not known at this time, the MCP may provide the type of recipient which should be defined as specifically as possible (i.e. all FQHCs in a defined geographic region, short-term housing shelters in need of beds).
  - ***Timelines*** for the investment activity, including potential plans for sustainability after the conclusion of the HHIP.
- **HHIP Measures Impacted:** Specify HHIP measure(s) that the investment activity is intended to impact. In total across all investments, a minimum of ten measures that are designated "P4P" in either Submission 1 or Submission 2, or both, must be impacted.
- **Domain Targeted:** Specify whether the investment will support MCP or provider/partner infrastructure and capacity (or both), or serve as a direct member intervention.
- Materials for each round of HHAP can be accessed on the **HHAP website**. MCPs should use the HHAP-3 assessment of funding availability to inform their IP submission (or the HHAP-2 assessment, if the HHAP-3 assessment is unavailable).

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Government Relations Update

July 28, 2022

Federal Issues

CMS

- Public Health Emergency renewed

Congress

- Prescription drug reform + extended premium subsidies
- Coding intensity adjustment

State Issues

Budget

- Final budget
- Trailer bills

Legislation

- AB 2724 – Kaiser direct Medi-Cal contract update

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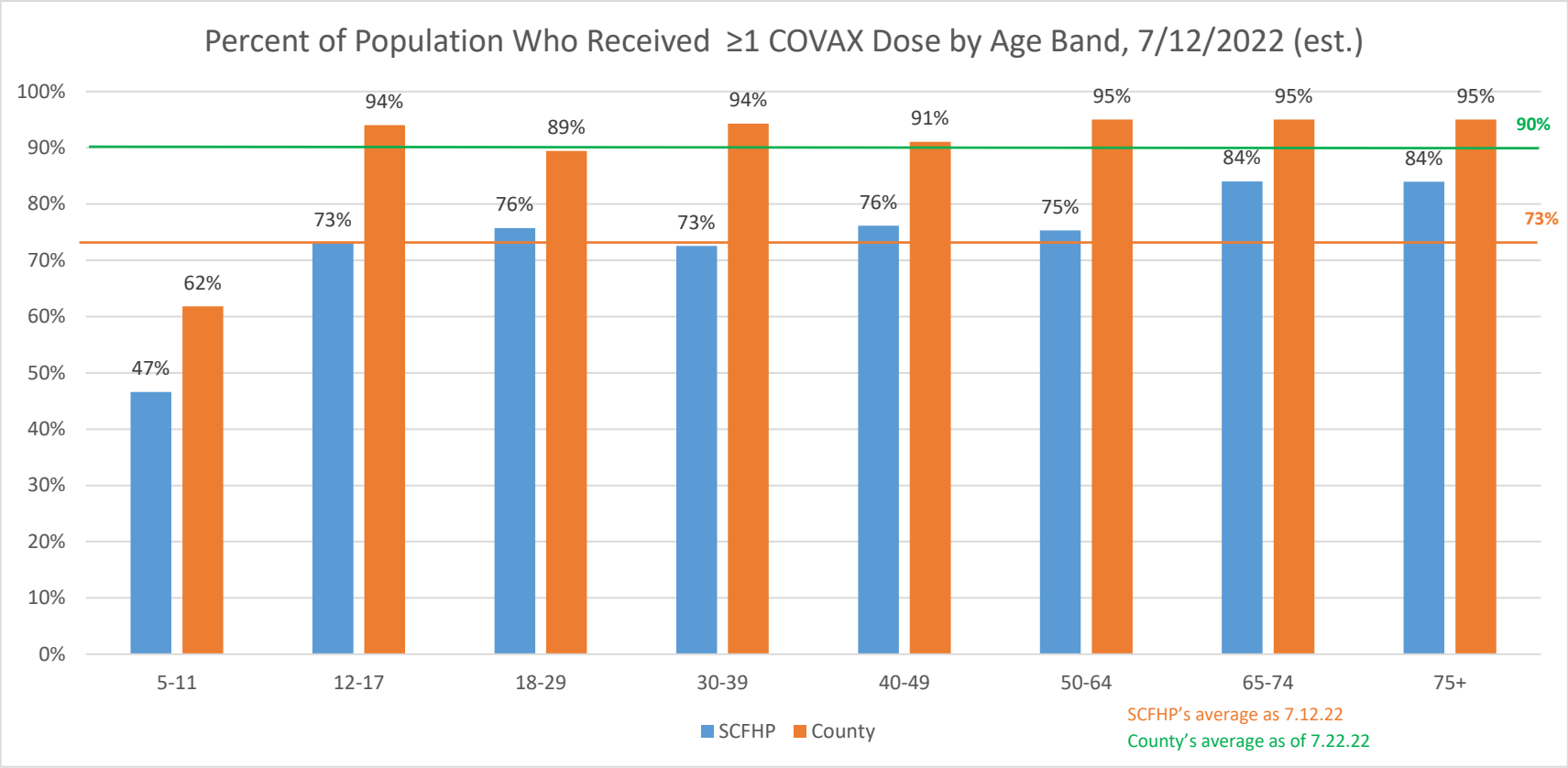
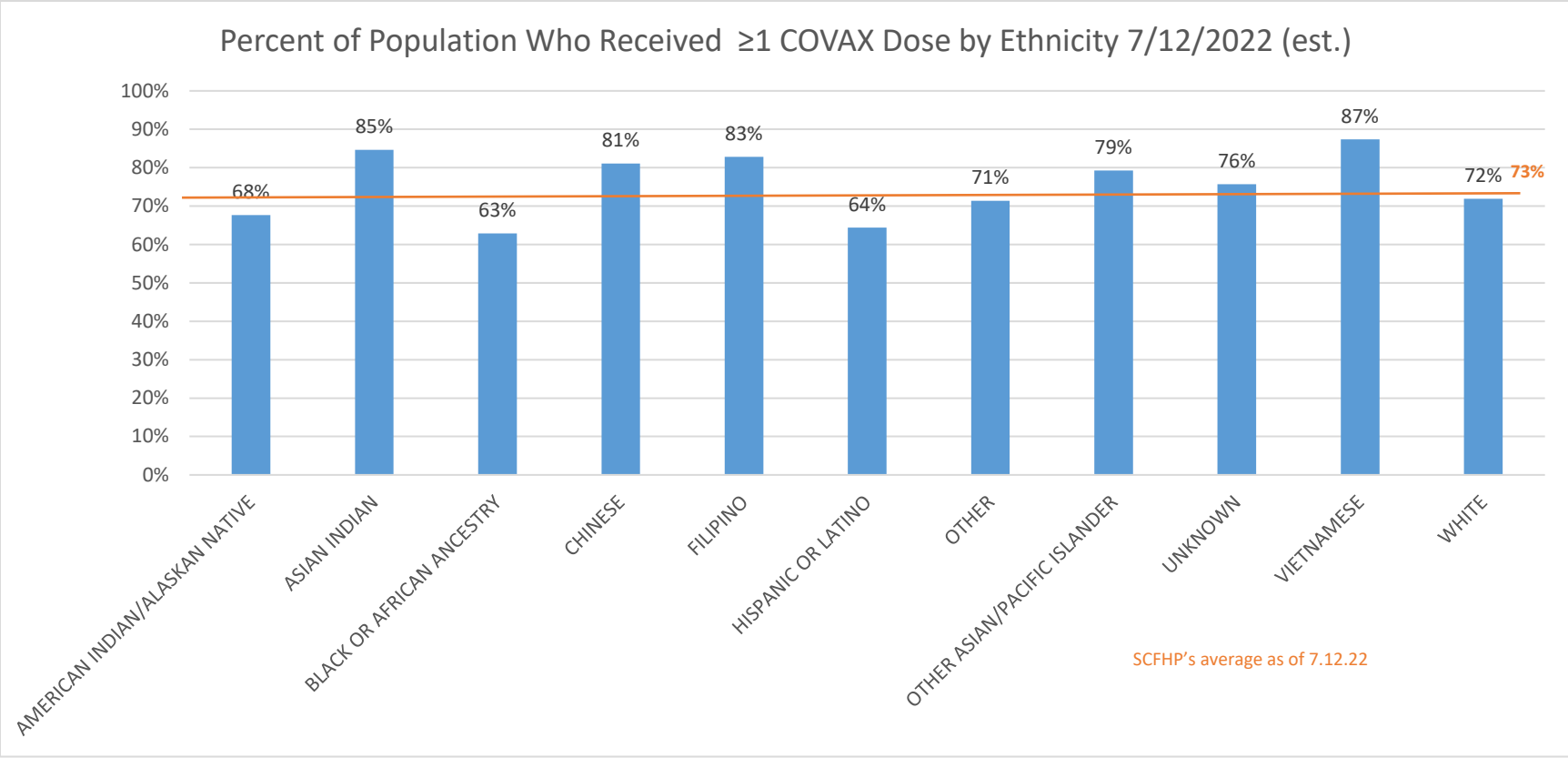


Age Band	5-11	12-17	18-29	30-39	40-49	50-64	65-74	75+	Total
Vaccinated	17,870	27,791	45,523	22,388	18,130	38,532	20,684	20,103	211,021
Unvaccinated	20,474	10,236	14,578	8,467	5,671	12,614	3,938	3,842	79,820
Boosted	450	10,142	24,468	12,771	11,082	25,715	15,806	15,954	116,388
Membership	38,344	38,027	60,101	30,855	23,801	51,146	24,622	23,945	290,841
% boosted	1%	27%	41%	41%	47%	50%	64%	67%	40%

Santa Clara Family Health Plan



	% of membership				% vaccinated			
Ethnicity/Age Band	5-11	12-17	18+	Overall % of SCFHP	5-11	12-17	18+	Overall
BLACK OR AFRICAN ANCESTRY	12%	13%	75%	3%	35%	61%	68%	63%
HISPANIC OR LATINO	21%	21%	58%	39%	44%	70%	70%	64%
Remaining Ethnicities	8%	8%	84%	58%	53%	80%	81%	79%

Santa Clara Family Health Plan