

Regular Meeting of the Santa Clara County Health Authority Governing Board

Thursday, December 15, 2016
2:45 PM – 5:00 PM
210 E. Hacienda Avenue
Campbell, CA 95008

Agenda

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|---|----------------|------|--------|
| <p>1. Roll Call</p> | Mr. Brownstein | 3:00 | 5 min. |
| <p>2. Public Comment
Members of the public may speak to any item not on the agenda; two minutes per speaker. The Board reserves the right to limit the duration of public comment period to 30 minutes.</p> <p><u>Announcement Prior to Recessing into Closed Session</u>
Announcement that the Governing Board will recess into closed session to discuss Item Nos. 3(a) and (b) below.</p> | Mr. Brownstein | 3:05 | 5 min. |
| <p>3. Adjourn to Closed Session</p> <p>a. <u>Anticipated Litigation</u> (Government Code Section 54956.9(d)(2):
It is the intention of the SCCHA Governing Board to meet in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation involving a CalPERS administrative claim for damages.</p> <p>b. <u>Pending Litigation</u> (Government Code Section 54954.5(c)):
It is the intention of the SCCHA Governing Board to meet in Closed Session to confer with Legal Counsel regarding Guillen v. Department of Health Care Services, et al.; Santa Clara County Superior Court, and Guillen v. Sylvia Mathews Burwell, et al.; U.S District Court, Northern District of California.</p> | | 3:10 | |
| <p>4. Report from Closed Session</p> | Mr. Brownstein | 3:20 | 5 min. |
| <p>5. Approve Consent Calendar and Changes to the Agenda</p> | Mr. Brownstein | 3:25 | 5 min. |

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

Possible Action: Approve Consent Calendar

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| <p>a. Approve minutes of the September 22, 2016 Regular Board Meeting</p> <p>b. Accept minutes of the June 16, 2016 Bylaws Committee Meeting</p> <p>c. Accept minutes of the November 29, 2016 Bylaws Committee Meeting</p> <p>d. Accept minutes of the October 27, 2016 Executive/Finance Committee Meeting and:</p> <ul style="list-style-type: none"> • Ratify the FY'2015-16 External Audit Report • Ratify August/September 2016 Financial Statements • Accept DMHC Audit and Management Response • Authorize CEO to contract with selected Care Management System vendor in an amount not to exceed \$550K <p>e. Accept minutes of the November 9, 2016 Quality Improvement Committee Meeting and:</p> <ul style="list-style-type: none"> • Ratify three Quality Improvement Policies • Accept Credentialing, Pharmacy & Therapeutics and Utilization Management Committee Reports <p>f. Accept minutes of the October 6, 2016 Provider Advisory Council Meeting</p> <p>g. Accept minutes of the December 13, 2016 Consumer Affairs Committee Meeting</p> | <p>Mr. Darrow</p> <p>Mr. Darrow</p> <p>Ms. Lew</p> <p>Dr. Robertson</p> <p>Dr. Robertson</p> <p>Dr. Wenner</p> | <p>Ms. Tomcala</p> <p>Ms. Brownstein</p> <p>Ms. Tomcala</p> <p>Ms. Paige</p> | <p>3:30</p> <p>3:40</p> <p>3:45</p> <p>3:50</p> | <p>10 min.</p> <p>5 min.</p> <p>5 min.</p> <p>5 min.</p> |
|---|--|--|---|--|

Possible Action: Accept Compliance Report

10. Committee Charters Consider charters for the Compliance Committee and Provider Advisory Council. Possible Action: Approve Compliance Committee Charter Possible Action: Appoint Board representative to the Compliance Committee Possible Action: Approve Provider Advisory Council Charter	Mr. Tomcala	3:55	5 min.
11. October 2016 Financial Statements Review recent organizational financial performance and related variables. Possible Action: Approve October 2016 Financial Statements	Mr. Cameron	4:00	10 min.
12. Space Planning Discuss approaches to address the space needs of SCFHP. Possible Action: Authorize Chief Executive Officer to purchase cubes to expand Employee seating capacity at a cost up to \$275K.	Ms. Tomcala Mr. Cameron	4:10	5 min.
13. Annual Benefit Review Discuss annual renewal of employee medical, dental, vision, and life Insurance coverage. Possible Action: Approve the proposed enhancement to employee life insurance coverage	Ms. Valdez Ms. Tomcala	4:15	5 min.
14. CalPERS Medical Benefit Resolution Consider adoption of a resolution updating the method used to calculate the employer contribution for medical benefits. Possible Action: Adopt Resolution Fixing the Employer Contribution at an Equal Amount for Employees and Annuitants under the Public Employees' Medical and Hospital Care Act	Ms. Valdez	4:20	5 min.
15. Publicly Available Salary Schedule Ranges Consider changes to the Publicly Available Salary Schedule. Possible Action: Approve Publicly Available Salary Schedule	Ms. Valdez	4:25	5 min.
16. Fiscal Year 2016-2017 Team Incentive Compensation Consider proposed team incentive compensation program. Possible Action: Approve Fiscal Year 2016-2017 Team Incentive Compensation Program	Ms. Tomcala	4:30	5 min.
17. Conflict of Interest Code Consider revisions to the Conflict of Interest Code. Possible Action: Adopt Resolution approving the revised	Ms. Pianca	4:35	5 min.

Conflict of Interest Code

- | | | | |
|--|----------------|------|---------|
| 18. 2017 Board Meeting Calendar | Ms. Tomcala | 4:40 | 5 min. |
| Consider the proposed 2017 SCCHA Governing Board and Committee meeting calendar.
Possible Action: Approve the 2017 SCCHA Governing Board Committee meeting calendar | | | |
| <u>Announcement Prior to Recessing into Closed Session</u>
Announcement that the Governing Board will recess into closed session to discuss Item No. 19(a) below. | | | |
| 19. Adjourn to Closed Session | | 4:45 | 10 min. |
| a. <u>Public Employee Performance Evaluation</u> (Government Code 54957(b)):
It is the intention of the Governing Board to meet in Closed Session to consider the performance evaluation of the Chief Executive Officer. | | | |
| 20. Report from Closed Session | Mr. Brownstein | 4:55 | 5 min. |
| 21. Adjournment | Mr. Brownstein | 5:00 | |

Notice to the Public—Meeting Procedures

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

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

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

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

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



Regular Meeting of the Santa Clara County Health Authority Governing Board

Thursday, September 22, 2016
210 E. Hacienda Avenue
Campbell, CA 95008

Minutes - **DRAFT**

Board Members Present

Bob Brownstein, Chair
Michele Lew, Vice-Chair
Dolores Alvarado
Brian Darrow
Chris Dawes
Kathleen King
Paul Murphy
Jolene Smith
Brenda Taussig
Wally Wenner, MD

Board Members Absent

Darrel Evora
Liz Kniss
Linda Williams

Staff Present

Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Jeff Robertson, Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Chris Turner, Interim Chief Operations Officer
Sharon Valdez, VP, Human Resources
Neal Jarecki, Controller
Robin Bilinski, Interim Board Scribe

Others Present

Maria Bejarano, SEIU Representative
Stacy Renteria, SEIU Representative

1. Roll Call

Bob Brownstein, Chair, called the meeting to order at 2:39 pm. Roll call was taken, and a quorum was not yet established.

2. Public Comment

There were no public comments.

Jolene Smith arrived at 2:43 pm.

A quorum was established, and the Board went into closed session.

3. Announcement Prior to Recessing into Closed Session

4. **Adjourn to Closed Session**

a. **Anticipated Litigation**

The Board conferred with legal counsel regarding an administrative claim submitted on behalf of Kathleen King.

Paul Murphy arrived into closed session at 2:45 pm.

Chris Dawes arrived into closed session at 2:50 pm.

5. **Report from Closed Session**

Kathleen King arrived at 3:10.

Mr. Brownstein reported that the Board voted unanimously to reject the claim.

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

Michele Lew requested discussion on the Weiser Mazars risk assessment prior to a vote on section 6.c.

- a. Approve Minutes of the June 23, 2016 **Regular Board** Meeting.
 - Accept minutes of the July 28, 2016 **Executive/Finance Committee** meeting and:
 - Accept May 2016 Financial Statements
- b. Accept minutes of the August 25, 2016 **Executive/Finance Committee** Meeting and:
 - Accept Annual Investment Policy Report
 - Review FY '15-'16 Donation/Sponsorship Report
 - Review Draft Provider Incentive Program
 - Appoint temporary, ad hoc subcommittee to conduct annual CEO Evaluation
- c. Accept minutes of the August 10, 2016 **Quality Improvement Committee** Meeting and:
 - Ratify eight Case Management Policies
 - Ratify three Health Education Policies
 - Ratify Case Management Program Description
 - Ratify Health Education Program Description
 - Ratify Health Education Work Plan
 - Accept Credentialing, P&T, & UM Committee Reports
- d. Accept minutes of the minutes of the July 27, 2016 **Provider Advisory Council** Meeting.
- e. Accept minutes of the September 13, 2016 **Consumer Affairs Committee** Meeting.

It was moved, seconded, and the Consent Calendar was unanimously **approved** with the exception of section 6.c.

Mr. Cameron reported that the Weiser Mazars audit report included an internal audit plan that will be completed over the next twelve to eighteen months, which is based on risk to the Plan. Mr. Brownstein inquired about the risks, and the timeframe to resolve. Mr. Cameron provided a summary of risks, which are overall considered moderate. Ms. Tomcala confirmed this is only one element of the effort to bring the entire organization into compliance.

It was moved, seconded, and section 6.c of the Consent Calendar was unanimously **approved**.

7. CEO Update

Ms. Tomcala thanked Robin Bilinski for her assistance as scribe during Rita Zambrano's absence. Ms. Tomcala also introduced Neal Jarecki, SCFHP's new Controller. Mr. Jarecki joined the health plan in June, has prior CFO experience with Alameda Alliance, and is familiar with Medi-Cal Managed Care. Dave Cameron noted that Mr. Jarecki has been a personal colleague for over eight years and is excited to have him join the Plan.

Ms. Tomcala reported, pursuant to the March 2015 request from Supervisors Chavez and Yeager to develop recommendations to strengthen the partnership of SCFHP and Valley Health & Hospital Systems (VHHS), Mr. Santiago reported to the Health and Hospital Committee on September 14th that leaders from the organizations had made significant progress in working together and provided the Collaboration Work Plan (in section 14 of the Board packet).

Ms. Tomcala updated the Board that QNXT, the Cal MediConnect claims payment system, was successfully de-hosted in August 2016. The Health Plan is currently upgrading QNXT for CMC, with training and testing in October 2016. Leadership will develop teams at both the Executive level and operational level to kick off implementation of QNXT for Medi-Cal. So far the transition is progressing well with no issues to report.

First 5 invited SCFHP to participate in their proposed pilot program for coordination of medical and dental services for prenatal to 5-year-old members. The Plan agreed to partner with First 5 and will provide staffing to assist with coordination of services. Ms. Smith confirmed a grant application was submitted. The full Dental Transformation Initiative (DTI) grant is for 0-20-year-olds, in order to create a systems approach to oral healthcare. The pilot program with First 5 will cover only prenatal to 5-year-olds, and is included in the broader DTI grant.

As of April 1, 2016, Covered California enrollment was enhanced to enable screening of children for eligibility in the Healthy Kids/C-CHIP program. SCFHP is contracted for the C-CHIP program through 2019. On May 16, 2016, SB75 expanded Medi-Cal to cover all children under 19 regardless of immigration status. Before the 2016 changes, Healthy Kids enrollment was 4,341; as of September, enrollment is 2,956, resulting in a 'loss' of 1,385 kids. Enrollment in Medi-Cal has increased 1,726, while 1,143 children who left Healthy Kids have not yet returned through Medi-Cal enrollment. Additionally, there were 672 kids identified with SB75 that have enrolled in Medi-Cal who were not part of Healthy Kids originally. The Plan is obligated to cover Healthy Kids for 12 months from the time of their enrollment, even if they are eligible for another program. However, the goal is to help these children make the transition to full scope Medi-Cal if they are eligible. Kathleen King noted the Healthier Kids Foundation is partnering with SCFHP to outreach to these families, educating them on the benefits of transitioning to Medi-Cal, and has successfully assisted 46 kids thus far.

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

8. Election of Officers

Mr. Brownstein indicated the need to elect the offices of Chairperson, Vice-Chairperson, Treasurer, and Secretary. It was confirmed that all incumbents are still willing to hold these roles.

It was moved, seconded, and approved to elect Bob Brownstein to the office of Chairperson, Michele Lew to the office of Vice-Chairperson, Dave Cameron to the office of Treasurer, and Elizabeth Pianca to the office of Secretary.

9. Consumer Advisory Committee Charter

Ms. Tomcala presented the draft Consumer Advisory Committee Charter and informed the Board of the need and intent to expand the diversity of representatives on the Consumer Advisory Committee. The charter identifies diversity as a responsibility of the Committee.

It was moved, seconded, and the Consumer Advisory Committee Charter was unanimously **approved**.

10. Compliance Report

Beth Paige presented the July – September 2016 Compliance Report. The Plan received a Notice of Non-Compliance from CMS on July 6, 2016 for failure to properly process out of area disenrollment. The Plan self-disclosed this issue in January 2016, and the letter was expected. Ms. Paige confirmed that due to the timely self-disclosure the Plan has already implemented corrective action.

The Plan also underwent the annual CMS Data Validation Audit in May 2016, SCFHP's first audit of this kind. The audit covered review of the Plan's data collection methodologies, and data reporting accuracy. The current compliance standard is 95% and SCFHP scored 81%. As a result the Plan is under a Corrective Action Plan (CAP), identifying improvement practices. It was noted that in 2017 the new compliance standard will be 100%.

A compliance gap task list was developed that consolidates areas identified in the consultant review conducted earlier in the year, the DHCS audit, CMS Data Validation audit, and anticipated findings of the DMHC audit. Respective departments are actively working on closing those gaps.

It was noted that Board members are required to complete annual compliance training. Board members received an email with a link for online training from SCFHP's vendor, Litmus. If Board members have completed compliance training through other means, Ms. Paige indicated credit may be allocated if the materials reflect coverage of the required topics.

Paul Murphy requested that the status of the CAPs be presented going forward.

SCFHP just received the final audit report from DHCS regarding the DHCS/DMHC joint audit. SCFHP received 36 findings, of which two were overturned, resulting in a final total of 34 findings. This is the same number of findings in the 2014 audit and Ms. Tomcala indicated this is consistent with the average number of findings for other Local Initiative Health Plans in 2015.

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

11. Fiscal Year 2015-2016 Unaudited Financials

Mr. Cameron presented the 2016 unaudited financial statements and noted that the Plan was in the second week of the external audit.

The Plan increased revenue by \$100M due to higher Medi-Cal membership numbers; however, expenses increased due to the cost of care for its Long Term Care members.

Mr. Cameron explained that while the Cash on Hand indicates \$146.1M, there is technically \$14M net cash available due to two key factors: 1) the State owes the Plan \$70M for an erroneous initial blended rate for the CCI and CMC population, and 2) the Plan owes the State \$100M for an overpayment of MCE rate payments, which the State has not yet recouped.

SCFHP's membership has stabilized from a recent spike in membership due to the CCI in July of 2014 and Cal MediConnect in Jan of 2015. Overall, there were no significant changes in Network enrollment, but direct contracts with physicians did increase for the CMC line of business.

Mr. Cameron reminded the Board that, last year the Board authorized the CEO, based on historical practices, to enter into provider incentive agreements. It was budgeted and reported at just over \$3M.

It was moved, seconded, and unanimously approved to approve the unaudited FY 2015-2016 financial statements with authorization to distribute the budgeted Provider Incentive Program payments.

12. July 2016 Financial Statements

Mr. Cameron reported that the Medi-Cal Expansion rates decreased by 15% for the new fiscal year beginning July 1, 2016. The net surplus for July is reported at \$148K. Mr. Cameron reiterated that there are a lot of moving parts and volatility in claims (playing catchup) this first month of the new fiscal year. The process for the State to recoup the \$100M of Expansion overpayments has yet to be determined. Membership continues to grow slightly, and the trending is positive. Administrative expenses are on budget; however there are still around 35 open positions.

It was moved, seconded, and unanimously approved to approve the July 2016 Financial Statements.

13. Reserve & Liquidity Strategies

Mr. Cameron and Mr. Jarecki presented the recommendations for the Reserve and Liquidity Strategy. The goal is to review reserves and make recommendation for targets for reserve & liquidity The Plan's current Equity goal is to accumulate two months of capitation revenue and the Plan has no Liquidity goal. TNE reserves are closely monitored by the Department of Managed Health Care (DMHC), and many other Local Initiative Health Plans are also conducting Reserve & Liquidity analyses. DMHC guides plans to establish 300% of Required TNE or above, with a preference of them achieving 500%, and closely monitors plans with TNE at or below 200% of Required TNE. Additionally, California TNE requirements are still lower than the national TNE requirements. Mr. Jarecki informed the Board that financial changes can happen very quickly for plans due to a combination of moving factors.

Per the Reserve and Liquidity Strategy presentation, Mr. Cameron recommended establishing (a) an Equity Target of 350-500% of Required TNE, (b) a Liquidity Target of 45-60days of total expenses in cash and (c) recurring review of reserves and liquidity targets in the financial statements.

Mr. Brownstein expressed concern that Health Plans might prioritize TNE targets at the expense of safety net services. He will consider higher reserves with explicit recognition that increases must be taken into consideration simultaneous to the health and safety of the members. Mr. Murphy requested information on how 500% TNE compares to health plan months, which Mr. Jarecki advised was average for the public plans.

It was moved, seconded, and approved that an Equity Target of 350-500% of Required TNE be established with annual review by the Executive Committee with a stipulation that future decisions involving reserves must include consideration of member safety.

Mr. Brownstein requested to know the line-items for each ordinary and extraordinary balance sheet items for future discussions. Mr. Cameron advised this information would be included in the financial statements.

It was moved, seconded, and approved that a Liquidity Target of 45-60 days of total expenses be established with a stipulation to provide the Board with information be provided detail of pass-through receivables and payables per the balance sheet.

14. Fiscal Year 2015-2016 Year in Review

Ms. Tomcala presented the year-end status of the Fiscal Year 2015-2016 Plan Objectives. Compliance continues to be the primary focus. She highlighted last year's efforts, which included engaging consultants to identify and assist with closing gaps, an overhaul of policies and procedures, and creation of a compliance dashboard.

The second objective focused on pursuit of NCQA accreditation for the CMC line of business. Ms. Tomcala indicated a readiness assessment was conducted and a project plan was drafted.

Ms. Tomcala reminded the Board that the SEIU contract was successfully negotiated and ratified last April, and a compensation committee was formed, with re-benchmarking of all positions currently in process.

With respect to the fourth objective, Ms. Tomcala presented the Collaboration Work Plan, which was developed in the spirit of collaboration with Valley Health and Hospital System. Joint strategic planning efforts are also underway.

Ms. Tomcala further discussed efforts to upgrade systems, improve quality as reflected in Medi-Cal HEDIS measures, and achieve budgeted financial performance.

In further summary of the fiscal year, Ms. Tomcala noted that SCFHP experienced a 19% increase in member months, a 29.5% increase in revenue, and staff growth of 27 employees. Opportunities for the upcoming year were also discussed.

It was moved, seconded, and unanimously approved to accept the FY 2015-16 Plan Objective Performance Report.

15. Fiscal Year 2016-2017 Plan Objectives

Ms. Tomcala presented the FY 2016-17 Plan Objectives and the 2016-2020 Strategic Plan Framework. The priorities for 2017 continue to focus on compliance and systems implementations. Other key objectives address provisional NCQA accreditation and quality performance, and strengthening routine reporting and analytics. Additional objectives include membership growth and retention, complex care delivery, collaboration with VHHS, benchmarking pay ranges, and achieving the budgeted net surplus.

Paul Murphy departed at 4:45.

It was moved, seconded, and unanimously **approved** to accept the FY 2016-17 Plan Objectives.

16. Fiscal Year 2015-2016 Team Incentive Compensation

Ms. Tomcala reminded the Board that the Fiscal Year 2015-16 Team Incentive Compensation program was previously discussed, and subsequently presented to SEIU, with eligibility of both represented and non-represented staff. Based on the year-end Net Operating Surplus, staff earned a 1% bonus. The Compliance Metric target for payout was not met. However, due to the tremendous efforts by staff in working toward identifying and closing compliance gaps and developing the compliance dashboard, Ms. Tomcala asked the Board to consider recognizing the non-executive staff with an additional 2% payout.

Mr. Brownstein supported the team incentive compensation and recognized the hard work of staff, noting the importance of maintaining morale. Mr. Darrow agreed incentive costs are relatively low compared to the size of the organization.

It was moved, seconded, and the proposed team incentive payout was unanimously **approved**, with an amendment to distribute the additional 2% to the executive staff as well, for a total of 3% to all staff.

17. Credentialing System RFP

Mr. Tamayo presented the need for the Plan to procure a provider credentialing software program. Procurement includes software licenses, staff training, and technical assistance; details to be negotiated dependent on vendor selection. The Board discussed credentialing with Plan delegates. Currently SCFHP delegates credentialing to affiliated networks and only credentials providers who are directly contracted with the Plan. However, the Plan must maintain all provider information in a system in order to pay claims and meet provider directory requirements. Mr. Tamayo noted the Plan requested proposals from vendors familiar with health plan regulatory requirements and respected in the industry.

It was moved, seconded, and approved to augment the fiscal year 2016-2017 budget and authorize the Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected credentialing system vendor in an amount not to exceed \$360K for licensing and implementation.

18. Publicly Available Salary Schedule Ranges

Ms. Valdez reported that the Plan has been forming a compensation committee as proposed in the SEIU contract. Updating job descriptions is underway as a precursor for re-benchmarking, to ensure the Plan is competitive in hiring and retaining skilled staff.

It was moved, seconded, and the Publicly Available Salary Schedule was unanimously **approved**.
It was moved, seconded, and delegation of approval of salary range re-benchmarking to the Executive/Finance Committee was unanimously **approved**.

19. Adjournment

The meeting was adjourned at 5:10pm.

Elizabeth Pianca, Secretary to the Board



Santa Clara
Family Health Plan
The Spirit of Care



Santa Clara County Health Authority Bylaws Committee Special Meeting

Thursday, June 16, 2016
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

Minutes - **DRAFT**

Members Present

Brian Darrow
Paul Murphy

Staff Present

Christine Tomcala, Chief Executive Officer
Rita Zambrano, Executive Assistant

Members Absent

Liz Kniss

Others Present

Elizabeth Pianca, Secretary

1. Roll Call

The meeting was called to order at 10:45 am. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Amendments to the Bylaws

The Committee met, discussed, and considered amendments to the Santa Clara County Health Authority Bylaws. The Committee members agreed to reconvene to continue the process of reviewing and recommending revisions of the Bylaws to the Board.

4. Adjournment

The meeting was adjourned at 11:00 am.

Elizabeth Pianca, Secretary to the Board



Santa Clara
Family Health Plan
The Spirit of Care

Santa Clara County Health Authority Bylaws Committee Special Meeting

Tuesday, November 29, 2016
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

Minutes – **DRAFT**

Members Present

Brian Darrow
Liz Kniss
Paul Murphy

Staff Present

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

Others Present

Elizabeth Pianca, Secretary

1. Roll Call

Brian Darrow called the meeting to order at 3:50 pm. Roll Call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the June 16, 2016 Bylaws Committee were reviewed.

It was moved, seconded, and the June 16, 2016 Bylaws Committee minutes were **approved** as presented. Liz Kniss abstained.

4. Amendments to the Bylaws

Proposed amendments to the Santa Clara County Health Authority Bylaws were discussed, including revisions consistent with the proposed amendments to the Community Health Authority Bylaws.

The Committee members agreed to reconvene in January to continue review and revision of the Bylaws.

5. Adjournment

The meeting was adjourned at 4:40 pm.

Elizabeth Pianca, Secretary to the Board

**SANTA CLARA FAMILY HEALTH PLAN
 PROVIDER ADVISORY COUNCIL
 OCTOBER 8, 2015
 BOARDROOM**

PAC Attendees: Dr. Thad Padua, IHC Pediatric Center; Dr. Peter Nguyen, Kelly Park Clinic; Sherri Sager, Lucile Packard Children’s Hospital; Steve Church, Willow Glen Center; Bridget Harrison, Valley Medical Center, Dr. Tuyen Ngo, Premier Care; Dolly Goel, MD

SCFHP Attendees: Christine Tomcala, CEO; Ngoc Bui-Tong, Director of Health Care Economics; Jennifer Clements, Director of Provider Operations, Jimmy Lin, MD; Irene Walsh, Provider Services Rep, LTSS; Phuong Au, Provider Services Rep; Robyn Esparza, Administrative Assistant

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Meeting Called To Order	Dr. Thad Padua, Chairperson, called the meeting to order at 12:30. A quorum was not present when the meeting was called to order. Committee members individually introduced themselves.	None		
Public Comment	<p><u>Lucile Packard Children’s Hospital Open House</u> Ms. Sherri Sager, LPCH representative, apologized because she was not in charge of the actual invitation, but advised the Committee that there will be an Open House tonight at 6pm for their new clinic next to Good Samaritan Hospital, and all Committee members are welcome to attend.</p> <p><u>Conference on Adolescent Mental Health Wellness</u> Ms. Sager also announced LPCH will be hosting, along with Stanford University School of Medicine, Department of Psychiatry, and the Stanford University School of Medicine, Division of Adolescent Medicine, a conference on August 5th and 6th on adolescent mental health wellness. It will look at issues around suicide prevention, depression, early diagnosis and will have tracks for clinicians, although no CME’s will be available. Ms. Sager will provide more information in the near future. LPCH is very excited about letting the community know what resources exist, what resources are needed, and what the whole continuum of care for children with mental health issues looks like. Ms. Sager noted that young people are actually on the Steering Committee to help develop and design the program and provide input to the speakers. Ms. Sager invited the Committee members to be sponsors, and to contact her if they are interested.</p>	None		

**SANTA CLARA FAMILY HEALTH PLAN
 PROVIDER ADVISORY COUNCIL
 OCTOBER 8, 2015
 BOARDROOM**

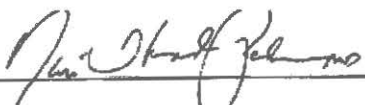
ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	<p>discussions continue to happen and we are hopeful it will happen quickly.</p> <p>Jennifer Clements, Provider Operations, indicated that she has been communicating with the O'Connor contracting team almost daily and we are moving forward quickly.</p> <p>Dr. Padua asked the Committee if anyone had additional questions for Ms. Tomcala.</p> <p>Dr. Ngo inquired as to how the change in the adult population is affecting the Health Plan financially? Ms. Tomcala advised that Medi-Cal expansion has actually done very well from a financial perspective. However, at the same time, the State has actually has been trying to determine exactly how much these members cost. Some of the rates for the program had three (3) different reductions for different time periods going back to July 2014, all retroactive. One was 6%, one was 5% and then there was another for 20%. Overall, the Health Plan has been doing well. In regards to Cal MediConnect (CMC), the Health Plan is not doing as well, which is not surprising. It's a new program and so some loss was budgeted for that. But, it's something that we need to pay attention to and make sure that going forward we do it in a profitable way.</p> <p>Dr. Ngo asked how is CMC is different from Healthy Generations. Ms. Tomcala advised it is hard for her to know what the Health Plan did or did not do that contributed to the losses since she was not with the plan at that time. Ms. Tomcala did note that one thing the Health Plan is trying to identify gaps from a compliance perspective so that we are actually running the program in a compliant manner. At the same time, we need to be looking at all of our operations and making sure we are coordinating care.</p>			

**SANTA CLARA FAMILY HEALTH PLAN
 PROVIDER ADVISORY COUNCIL
 OCTOBER 8, 2015
 BOARDROOM**

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
MLTSS	<p><u>Community Based Adult Services (CBAS)</u></p> <p>Ms. Irene Walsh, Provider Services Representative, Managed Long Term Services and Supports (MLTSS), presented a draft of a flyer regarding the CBAS benefit and services. The flyer is currently with the Health Plan's Marketing Department and will be presented at the next meeting.</p> <p>Ms. Walsh introduced Suzanne Pouransari and Manooch Pouransari, both Program Directors of Grace Adult Day Care, who shared some of the clinical benefits of the program, which is an all-day health care facility for patients 18 years and older, whom usually have multiple diagnosis (geriatric, as well as cognitive).</p> <p>Mr. Pouransari shared some back ground, indicating the name changed from Adult Day Health Care (ADHC) to CBAS in 2012. There is a big push for this type of care facility. They service more than 250 adults in this county, most of their patients are with SCFHP. They provide care at a very cost effective budget to keep members out of institutional care facilities. The facility is open Monday through Friday and their daily attendance ranges from 145 to 150 per day.</p> <p>Mr. Pouransari presented the May 2010 Lewin Group Study Fact Sheet (copy attached herein). He advised that he was a board member for two (2) years. They did a study in 2010 of the impact of the population and the budget if Adult Day Health Care (ADHC) is eliminated. This study showed that there is no cost savings if this program is eliminated. There were 340 centers all over California. However, after the budget cuts in 2010 and the change to CBAS, there are only 242 centers left.</p> <p>Mr. Pouransari also presented to the Committee some success stories (copy attached herein), which provides examples of what they do and how they benefit the members.</p> <p>The Committee asked how to refer a patient for this benefit. Ms. Pouransari stated that patients are referred through their PCP. Patients can self-refer, however the CBAS centers eventually need the patient's diagnosis, medications and any pertinent information from their PCP. The center does their assessment and in addition, a face to face meeting is conducted by</p>	The CBAS flyer will be presented at the next PAC meeting.	L. Anderson	01/07/16

**SANTA CLARA FAMILY HEALTH PLAN
 PROVIDER ADVISORY COUNCIL
 OCTOBER 8, 2015
 BOARDROOM**

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	<p>The other piece for us is a parallel track. LPCH has a complex care clinic and we have a grant from the federal government and from the Centers for Medicare Medicaid Services, that is encouraging us to, along with what we were already doing, increase the care coordination between providers and families. We use a care map for the kids in the shape of a tree with lots of leaves that reflect their care management. They might have a dozen physician providers, plus family resources, social workers and ancillary care. In a 3-year period, we will do an evaluation. We are trying to enroll around 500 kids in the program and we are talking to PCPs in multiple counties. We are focusing primarily on Medi-Cal population, but we will take kids outside of the population. It's really about how do we improve care and if we do this right, we'll keep kids out of the hospital or reduce their hospitalizations, which will reduce costs.</p>			
<p>Participation Requirements</p>	<p>Dr. Thad Padua, Chair, reviewed the Committee roster, the participation requirements and the Bylaws. Dr. Padua noted that at the end of 2016, more than half of the Committee members will have reached their maximum term limit. The Committee discussed revising the participation requirements, creating a Committee Charter, and revising the Bylaws to allow for additional terms if a member requests to serve on the Committee longer. The Committee unanimously agreed to create a Committee Charter and make recommendations to the Governing Board to revise the Bylaws.</p>	<p>Draft Committee Charter and suggested edits to the Bylaws for review at the next meeting.</p>	<p>J. Clements</p>	<p>01/07/16</p>
<p>PAC 2016 Calendar</p>	<p>Dr. Thad Padua, Chair, presented the 2016 Committee Calendar (copy attached herein). The Committee will meet on January 7th, April 7th, July 7th and October 6th.</p>	<p>Informational</p>		
<p>Adjournment</p>	<p>Meeting Adjourned at 1:30. Next Meeting is scheduled for January 7th, 2016. A meeting invite will be sent out.</p>	<p>Informational</p>		

Signature:  Date: 2/4/16



SANTA CLARA
FAMILY HEALTH PLAN



November 7, 2016/ revised November 17, 2016

COLLABORATIVE PLANNING EFFORT VALLEY HEALTH PLAN AND SANTA CLARA FAMILY HEALTH PLAN

DRAFT #2 – FOR DISCUSSION ONLY

Purpose of Collaborative Planning Process: To develop a joint strategic plan with shared objectives for managed care for 2018-2019 (2 years) with some future focused objectives beyond that timeframe (3-5 years). The plan will include an analysis of the dramatically changed external environment in which the member organizations operate and the challenges and opportunities presented by that new environment. It will also include membership goals, quality of care objectives and planned program innovations.

Timeline for the Planning Process: January – July 2017 (extension to October 2017 if needed)

Membership of Planning Group: Representatives of Santa Clara County and SCFHP

Valley Health Plan

Bruce Butler, CEO, VHP
Rene Santiago, Deputy County Executive
Santa Clara HHS Behavioral Health Director
Others - TBD
Subject Matter Experts from County

Santa Clara Family Health Plan

Christine Tomcala, CEO
Dave Cameron, CFO
Jeff Robertson, MD, CMO
Bob Brownstein, Board Member and Chair
Michelle Lew, Board Member
Wally Wenner, MD, Board Member
Linda Williams, Board Member
Kathleen King, Board Member
Subject Matter Experts from SCFHP

Planning Sessions: Six 4-hour planning sessions beginning in January 2017. Sessions will be from 9:00am – 1:00pm and will generally occur in three week intervals. Sessions will be and end on time.

- **Session #1** – Focus on Environment, Future Financing Issues, Value Principles and Assumptions, and Confirm Key Issues for Exploration at Sessions #2, 3 and 4
- **Session #2** – Focus on Key Issue #1 and Key Issue #2
- **Session #3** – Focus on Key Issue #3 and Key Issue #4
- **Session #4** – Focus on Key Issue #5 and Key Issue #6
- **Session #5** – Review Draft Strategic Plan and Joint Strategic and Bold Priorities and Objectives
- **Session #6** – Confirm Revised Strategic Plan and Next Steps

Planning Process Approach:

1. Planning process will be facilitated by Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group.
2. Subject matter experts (SME) from both Santa Clara County and Santa Clara Family Health Plan will be part of planning sessions #2, 3, 4, depending on their expertise and the key issues addressed at each meeting.
3. Strategic planning members will make every attempt to attend all meetings consistently with no substitutions for their participation.
4. Advance materials will be sent out 3-5 days in advance of each planning session for member preparation.
5. Summaries of each meeting will be distributed within 3-5 days after each planning session.
6. A process for community input will be developed, using the Health Care Reform Task Force as a key stakeholder and feedback group. A summary of the planning process approach will be presented early to the task force and a review of the draft strategic plan will be presented for feedback to the task force later in the process.
7. Santa Clara County's Health and Hospital Committee will be kept informed regularly of the planning process.

Hot Topics Identified So Far: Meetings will be organized around these topics identified by planning process members.

- Environmental changes based on outcomes of election
- System challenges
- Future financing and risk sharing arrangements
- Membership goals for VHP and SCFHP
- Integration
- Reduction of fragmentation between health plans and in care for members/patients
- Managing care for patients and members with complex, multiple conditions
- Behavioral health responsibilities and coordination
- Demographics of aging population and impact on health care system
- Standards of care
- CCI and Dual Eligibles
- Whole Person Care
- Health Homes
- Data sharing and analysis and exchange
- Care for undocumented adults
- Provider supply and reimbursement



Santa Clara County Health Authority

Compliance Committee Charter

Purpose

The primary purpose of the Compliance Committee (Committee) is to assist the Santa Clara Family Health Plan (SCFHP) Governing Board in its oversight of the implementation and effectiveness of SCFHP's Compliance Program. The Committee is accountable to provide support and guidance necessary to the Compliance Officer in overseeing the outcomes and performance of activities initiated under the Compliance Program to ensure compliance with state and federal regulators. The Committee shall provide minutes of its actions to the Board for review, and all actions of the Committee shall be reported at the next regularly scheduled Board meeting.

Members

The Compliance Committee shall be comprised of the Executive Team including the Compliance Officer and a Governing Board member, as appointed by the full Board, who is free from any relationship that in the opinion of the Board would interfere with the exercise of his or her independent judgment as a member of the Committee.

Meetings

Regular meetings of the Compliance Committee shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate.

Committee members may attend each meeting in person or via teleconferencing.

Teleconferencing shall be conducted pursuant to California Government Code section 54953(d).

The presence of a majority of the members of the Committee shall constitute a quorum for the transaction of business.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an agenda item, as necessary.

Meetings of the Committee shall be open and public, except such meetings or portions thereof that may be held in closed session to the extent permitted by applicable law including, but not limited to, the Ralph M. Brown Act (Gov. Code § 54950 et seq.) and Section 14087.28.

Minutes of all meetings of the Committee shall be recorded.

Responsibilities

The following functions shall be the common recurring activities of the Compliance Committee. These functions should serve as a guide with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

- Review and approve the following documents, including but not limited to:
 - Compliance Program
 - Compliance risk assessment;
 - Compliance monitoring and auditing work plan
- Oversee the development, implementation, annual review, and approval of appropriate Standards of Conduct, business ethics, and compliance program policies and procedures.
- Oversee the development and implementation of operational policies to ensure satisfactory relationships with SCFHP's principal regulatory authorities.
- Oversee employee training on the Standards of Conduct, business ethics, SCFHP's Compliance Program and compliance policies, and training on the detection, correction and prevention of fraud, waste, and abuse (FWA) in government programs.
- Ensure that the full Governing Board meets all compliance and FWA training requirements annually.
- Oversee SCFHP's annual Conflict of Interest reporting process.
- Reviewing effectiveness of the system of internal controls, such as dashboards, designed to reveal compliance issues and compliance with key regulatory requirements.
- Ensure that SCFHP maintains clear channels of communication, through which employees and FDRs may seek advice on application of the Plan's Compliance Program.
- Ensure that SCFHP maintains a hotline through which employees, FDRs and members may report potential compliance violations confidentially or anonymously (if desired) without fear of retaliation.
- Oversee and receive periodic reports regarding investigations of compliance violations and potential FWA reported to the SCFHP Compliance Officer.
- Ensure that appropriate internal and external monitoring and auditing (e.g., including first, tier, downstream and related entities (FDRs)) are conducted to verify adherence to SCFHP's Compliance Program guidelines and procedures.

- Monitor audits/examinations/corrective action plans conducted and issued by governmental or other regulatory agencies.
- The Compliance Committee will monitor the overall effectiveness of the Compliance Program. Some indicators of an effective compliance program are:
 - Use of monitoring to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, warning letters, CMS sanctions, training completion/pass rates, etc.;
 - Implementation of new or updated Medicare requirements (e.g., tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation;
 - Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, beneficiaries through customer service calls, or the Complaint Tracking Module (CTM), Parts A, B and D issues, etc.;
 - Timely response to reported noncompliance and potential FWA, and effective resolution (i.e., non-recurring issues);
 - Consistent, timely and appropriate disciplinary action; and
 - Detection of noncompliance and FWA issues through monitoring and auditing.



Santa Clara
Family Health Plan

Santa Clara County Health Authority Provider Advisory Council Charter

Purpose

Pursuant to the Bylaws, the Governing Board shall establish a Provider Advisory Council whose members can provide expertise to the Santa Clara Family Health Plan (SCFHP) relative to their respective specialties. The Provider Advisory Council shall act as an advisory committee to assist SCFHP in creating and maintaining a system of care in accordance with the six C's of care -- Community, Collaboration, Coordination, Communication, Caring, and Compassion.

The Council's mission is to discuss regional or national issues regarding the relationships and interactions between provider, their patients and SCFHP. These issues include improving health care and clinical quality, improving communications, relations, and cooperation between providers and SCFHP, and clinical or regulatory matters that affect interactions between providers and SCFHP.

Members

The Provider Advisory Council shall have a sufficient number of members to provide necessary expertise and work effectively as a group. The Provider Advisory Council shall include contracted providers from a range of specialties as well as other representatives from the community including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All Provider Advisory Council (PAC) members, including the Chairperson, shall be appointed by the SCFHP's Chief Executive Officer.

All PAC members, including the Chair, serve two-year terms which may be renewed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

Provider Advisory Council members shall annually sign a Confidentiality Agreement. Failure to sign the agreement or abide by the terms of the agreement shall result in removal from the Committee.

Meetings

Regular meetings of the Provider Advisory Council shall be scheduled quarterly. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special meetings may be held at any time and place as may be designated by the Chair, the Chief Executive Officer, or a majority of the members of the Committee.

Committee members must attend at least two meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.

The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an agenda item, as necessary.

Meetings of the Provider Advisory Council shall be open and public pursuant to the Ralph M. Brown Act (Gov. Code § 54950 et seq.)

The Director of Provider Network Management is responsible for notifying members of the dates and times of meetings and preparing a record of the Council's meetings.

Responsibilities

The following responsibilities shall serve as a guide, with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The Committee shall also carry out any other responsibilities delegated to it by the Board from time to time.

- Address clinical and administrative topics that affect interactions between physicians/providers and SCFHP.
- Discuss regional, state, and national issues related to enhancing patient care.
- Provide input on health care services of SCFHP.
- Provide input on the coordination of services between networks of SCFHP.
- Improve communications, relations, and cooperation between physicians/providers and SCFHP.
- Provide expertise to SCFHP relative to a Committee member's area of practice.



Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Four Months Ended October 2016
(Unaudited)

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

Summary of Financial Results

For the month of October 2016, SCFHP recorded a net surplus of \$2.2 million compared to a budgeted net surplus of \$1.0 million resulting in a favorable variance from budget of \$1.2 million. For year to date October 2016, SCFHP recorded a net surplus of \$5.9 million compared to a budgeted net surplus of \$4.4 million resulting in a favorable variance from budget of \$1.5 million. The table below summarizes the components of the overall variance from budget.

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

Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 99,748,423	\$ 94,838,651	\$ 4,909,772	5.2%	Revenue	\$ 395,918,958	\$ 379,705,863	\$ 16,213,095	4.3%
93,487,074	90,212,600	(3,274,475)	-3.6%	Medical Expense	374,913,190	361,257,995	(13,655,195)	-3.8%
6,261,349	4,626,051	1,635,298	35.3%	Gross Margin	21,005,768	18,447,868	2,557,900	13.9%
3,889,557	3,502,274	(387,283)	-11.1%	Administrative Expense	14,690,775	13,752,697	(938,078)	-6.8%
2,371,792	1,123,777	1,248,015	111.1%	Net Operating Income	6,314,993	4,695,171	1,619,822	34.5%
(127,576)	(85,842)	(41,734)	-48.6%	Non-Operating Income/Exp	(416,002)	(343,370)	(72,632)	-21.2%
\$ 2,244,216	\$ 1,037,935	\$ 1,206,281	116.2%	Net Surplus/ (Loss)	\$ 5,898,991	\$ 4,351,802	\$ 1,547,189	35.6%

Member Months

For the month of October 2016, overall member months were higher than budget by 8,841 (+3.1%). For year to date October 2016, overall member months were higher than budget by 23,066 (+2.1%).

In the four months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 4.6%, membership in Healthy Kids program decreased by 40.0%, and membership in CMC program decreased by 4.9%.

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

Revenue

The Health Plan recorded net revenue of \$99.7 million for the month of October 2016, compared to budgeted revenue of \$94.8 million, resulting in a favorable variance from budget of \$4.9 million, or 5.2%. For year to date October 2016, the Plan recorded net revenue of \$395.9 million, compared to budgeted revenue of \$379.7 million, resulting in a favorable variance from budget of \$16.2 million, or 4.3%. The favorable variance was largely due to higher than budgeted members year to date. This positive variance was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Hep C revenue is unfavorable due to lower than budgeted actual rate and Medi-Cal CMC revenue is lower due to lower than budgeted member months. Medicare revenue was favorable due to higher PMPM reflecting the higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.

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

Medical Expenses

For the month of October 2016, medical expense was \$93.5 million compared to budget of \$90.2 million, resulting in an unfavorable budget variance of \$3.3 million, or -3.6%. For year to date October 2016, medical expense was \$374.9 million compared to budget of \$361.3 million, resulting in an unfavorable budget variance of \$13.7 million, or -3.8%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by lower Professional FFS and Pharmacy expenses. Additionally, the Plan has reserved \$6.5 million for risk sharing expenses.

Administrative Expenses

Overall administrative costs were over budget by \$0.4 million (-11.1%) for the month of October 2016, and over budget by \$0.9 million (-6.8%) for year to date October 2016. Personnel costs were over budget due to open positions being filled by temporary staffing and consulting resources. Translation services expenses and Pharmacy administration fees were also higher than budget. Some of this unfavorability was offset by lower information service expenses and postage expenses.

Overall administrative expenses were 3.7% of revenues for year to date October 2016.

Balance Sheet (Page 6)

Current assets totaled \$719.0 million compared to current liabilities of \$607.3 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 vs. the DMHC minimum requirement of 1.0 as of October 31, 2016. Working capital increased by \$4.6 million for the four months year to date ended October 31, 2016.

Cash as of October 31, 2016, increased by \$32.3 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by \$118.8 million during the same four months period ended October 31, 2016. The cash position increased largely due to the receipt of Medicare RAF receivable and an overall increase in the payables.

Liabilities increased by a net amount of \$144.6 million during the four months ended October 2016. Liabilities increased primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State and an increase in IHSS/MCO payables.

Capital Expenses increased by \$2.2 million for four months ended October 31, 2016. The capital expenses include:

Expense	Actual	Budget
Trizetto Upgrade	2,006,021	6,800,000
Computers	167,858	2,584,500
Leasehold Improvement & Furniture	26,054	992,700
TOTAL	2,199,933	10,377,200

Reserves Analysis

Tangible Net Equity (TNE) was \$106.2 million at October 31, 2016 or 311% of the minimum Required TNE per the Department of Managed Health Care (DMHC) of \$34.1 million. A chart showing TNE trends is shown on page 14 of this report.

At the September 2016 Governing Board meeting, a policy was adopted for targeting the organization's capital reserves to include a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

As of October 31, 2016, the Plan's TNE was \$13.2 million below the low-end Equity Target and \$53.1 million above the low-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	\$106,192,447
Current Required TNE	\$34,122,000
Excess TNE	\$72,070,447
Required TNE Percentage	311%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	\$119,427,000
500% of Required TNE (high end)	\$170,610,000
TNE Above/(Below) SCFHP Low End Target	(\$13,234,553)
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	\$178,385,634
Less: Pass-Through Liabilities (Non State of CA *)	(\$5,151,236)
Net Cash Available to SCFHP	\$173,234,398
SCFHP Target Liquidity: **	
45 days of Total Operating Expenses	(\$120,096,122)
60 days of Total Operating Expenses	(\$160,128,162)
Liquidity Above/(Below) SCFHP Low End Target	\$53,138,277

* Supplemental Information: Pass-Throughs from State of CA	
Receivables Due to SCFHP	\$532,063,775
Payables Due from SCFHP	(\$500,521,446)
Net Receivable/(Payable)	\$31,542,329

** Excludes IHSS

**Santa Clara County Health Authority
Balance Sheet**

	<u>OCT 16</u>	<u>SEP 16</u>	<u>AUG 16</u>	<u>JUN 16</u>
Assets				
Current Assets				
Cash and Marketable Securities	\$ 178,385,634	\$ 183,080,604	\$ 161,669,825	\$ 146,082,070
Premiums Receivable	535,990,117	505,588,385	472,494,829	417,166,973
Due from Santa Clara Family Health Foundation - net				
Prepaid Expenses and Other Current Assets	4,605,437	4,612,601	4,697,053	6,766,163
Total Current Assets	718,981,189	693,281,590	638,861,708	570,015,205
Long Term Assets				
Equipment	15,917,732	14,853,860	14,779,896	13,717,799
Less: Accumulated Depreciation	(9,400,200)	(9,244,180)	(9,089,501)	(8,775,886)
Total Long Term Assets	6,517,532	5,609,680	5,690,395	4,941,913
Total Assets	<u>\$ 725,498,721</u>	<u>\$ 698,891,270</u>	<u>\$ 644,552,103</u>	<u>\$ 574,957,118</u>
Deferred Outflow of Resources	<u>\$ 1,570,339</u>	<u>\$ 1,570,339</u>	<u>1,570,339</u>	<u>1,570,339</u>
Total Deferred Outflows and Assets	<u>727,069,060</u>	<u>700,461,609</u>	<u>646,122,442</u>	<u>576,527,457</u>
Liabilities and Net Position				
Current Liabilities				
Trade Payables	\$ 3,918,043	\$ 3,728,676	\$ 3,886,568	\$ 4,824,017
Deferred Rent	125,804	129,955	134,106	142,408
Employee Benefits	1,008,471	984,344	941,677	1,013,759
Retirement Obligation per GASB 45	239,119	151,777	101,185	
Advance Premium - Healthy Kids	40,360	42,072	48,742	65,758
Deferred Revenue - Medicare		8,677,372		
Liability for ACA 1202	3,805,363	5,503,396	5,503,396	5,503,985
Payable to Hospitals (SB90)	55,140	55,140	55,140	55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,326,267	1,305,914	1,306,473	1,717,483
Due to Santa Clara County Valley Health Plan and Kaiser	8,889,476	8,104,013	8,007,431	6,604,472
MCO Tax Payable - State Board of Equalization	38,333,812	30,597,915	22,948,187	10,779,014
Due to DHCS	162,459,261	148,459,120	134,655,041	107,213,315
Liability for In Home Support Services (IHSS)	299,728,373	284,111,659	268,614,754	238,387,141
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	85,040,627	88,830,528	82,457,496	84,321,012
Total Current Liabilities	607,309,106	583,020,871	530,999,187	462,966,494
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	5,318,386	5,243,386	5,168,386	5,018,386
Total Liabilities	<u>618,546,992</u>	<u>594,183,757</u>	<u>542,087,073</u>	<u>473,904,380</u>
Deferred Inflow of Resources	<u>2,329,621</u>	<u>2,329,621</u>	<u>2,329,621</u>	<u>2,329,621</u>
Net Position / Reserves				
Invested in Capital Assets	6,517,532	5,609,680	5,690,395	4,941,913
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	93,470,574	94,378,426	94,297,711	67,383,691
Current YTD Income (Loss)	5,898,991	3,654,775	1,412,292	27,662,502
Net Position / Reserves	<u>106,192,447</u>	<u>103,948,231</u>	<u>101,705,748</u>	<u>100,293,456</u>
Total Liabilities, Deferred Inflows, and Net Assets	<u>\$ 727,069,060</u>	<u>\$ 700,461,609</u>	<u>\$ 646,122,442</u>	<u>\$ 576,527,457</u>
Solvency Ratios:				
Working Capital	\$ 111,672,083	\$ 110,260,719	\$ 107,862,521	\$ 107,048,711
Working Capital Ratio	1.2	1.2	1.2	1.2

Santa Clara County Health Authority
Income Statement for Four Months Ending Oct 31, 2016

	For the Month of Oct 2016					For Four Months Ending Oct 31, 2016				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	\$ 90,782,358	91.0%	\$ 86,418,566	91.1%	\$ 4,363,792	\$ 358,962,925	90.7%	\$ 344,910,242	90.8%	\$ 14,052,683
HEALTHY KIDS	\$ 288,693	0.3%	\$ 221,994	0.2%	\$ 66,698	\$ 1,428,670	0.4%	\$ 1,253,402	0.3%	\$ 175,268
MEDICARE	\$ 8,677,372	8.7%	\$ 8,198,090	8.6%	\$ 479,282	\$ 35,527,363	9.0%	\$ 33,542,220	8.8%	\$ 1,985,144
TOTAL REVENUE	<u>\$ 99,748,423</u>	<u>100.0%</u>	<u>\$ 94,838,651</u>	<u>100.0%</u>	<u>\$ 4,909,772</u>	<u>\$ 395,918,958</u>	<u>100.0%</u>	<u>\$ 379,705,863</u>	<u>100.0%</u>	<u>\$ 16,213,095</u>
MEDICAL EXPENSES										
MEDI-CAL	\$ 83,451,985	83.7%	\$ 82,382,518	86.9%	\$ (1,069,467)	\$ 334,155,504	84.4%	\$ 328,887,631	86.6%	\$ (5,267,873)
HEALTHY KIDS	\$ 218,792	0.2%	\$ 213,876	0.2%	\$ (4,916)	\$ 1,171,942	0.3%	\$ 1,209,184	0.3%	\$ 37,242
MEDICARE	\$ 9,816,297	9.8%	\$ 7,616,205	8.0%	\$ (2,200,091)	\$ 39,585,744	10.0%	\$ 31,161,181	8.2%	\$ (8,424,564)
TOTAL MEDICAL EXPENSES	<u>\$ 93,487,074</u>	<u>93.7%</u>	<u>\$ 90,212,600</u>	<u>95.1%</u>	<u>\$ (3,274,475)</u>	<u>\$ 374,913,190</u>	<u>94.7%</u>	<u>\$ 361,257,995</u>	<u>95.1%</u>	<u>\$ (13,655,195)</u>
MEDICAL OPERATING MARGIN	\$ 6,261,349	6.3%	\$ 4,626,051	4.9%	\$ 1,635,298	\$ 21,005,768	5.3%	\$ 18,447,868	4.9%	\$ 2,557,900
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	\$ 1,705,816	1.7%	\$ 1,954,470	2.1%	\$ 248,653	\$ 6,921,160	1.7%	\$ 6,620,719	1.7%	\$ (300,441)
RENTS AND UTILITIES	\$ 111,170	0.1%	\$ 112,542	0.1%	\$ 1,372	\$ 431,718	0.1%	\$ 465,071	0.1%	\$ 33,352
PRINTING AND ADVERTISING	\$ 141,985	0.1%	\$ 119,108	0.1%	\$ (22,877)	\$ 317,130	0.1%	\$ 386,183	0.1%	\$ 69,054
INFORMATION SYSTEMS	\$ 198,380	0.2%	\$ 141,326	0.1%	\$ (57,053)	\$ 694,619	0.2%	\$ 895,362	0.2%	\$ 200,743
PROF FEES / CONSULTING / TEMP STAFFING	\$ 1,492,611	1.5%	\$ 738,966	0.8%	\$ (753,645)	\$ 4,450,035	1.1%	\$ 3,372,256	0.9%	\$ (1,077,779)
DEPRECIATION / INSURANCE / EQUIPMENT	\$ 200,172	0.2%	\$ 173,634	0.2%	\$ (26,538)	\$ 762,048	0.2%	\$ 699,626	0.2%	\$ (62,422)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	\$ (40,135)	0.0%	\$ 164,180	0.2%	\$ 204,315	\$ 803,301	0.2%	\$ 939,719	0.2%	\$ 136,418
MEETINGS / TRAVEL / DUES	\$ 73,302	0.1%	\$ 82,019	0.1%	\$ 8,717	\$ 271,680	0.1%	\$ 333,393	0.1%	\$ 61,712
OTHER	\$ 6,256	0.0%	\$ 16,030	0.0%	\$ 9,774	\$ 39,084	0.0%	\$ 40,369	0.0%	\$ 1,284
TOTAL ADMINISTRATIVE EXPENSES	<u>\$ 3,889,557</u>	<u>3.9%</u>	<u>\$ 3,502,274</u>	<u>3.7%</u>	<u>\$ (387,283)</u>	<u>\$ 14,690,775</u>	<u>3.7%</u>	<u>\$ 13,752,697</u>	<u>3.6%</u>	<u>\$ (938,078)</u>
OPERATING SURPLUS (LOSS)	\$ 2,371,792	2.4%	\$ 1,123,777	1.2%	\$ 1,248,015	\$ 6,314,993	1.6%	\$ 4,695,171	1.2%	\$ 1,619,822
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	\$ (87,342)	-0.1%	\$ (50,592)	-0.1%	\$ (36,750)	\$ (239,119)	-0.1%	\$ (202,369)	-0.1%	\$ (36,750)
GASB 68 - UNFUNDED PENSION LIABILITY	\$ (75,000)	-0.1%	\$ (75,000)	-0.1%	\$ -	\$ (300,000)	-0.1%	\$ (300,000)	-0.1%	\$ -
INTEREST & OTHER INCOME	\$ 34,766	0.0%	\$ 39,750	0.0%	\$ (4,984)	\$ 123,117	0.0%	\$ 158,999	0.0%	\$ (35,883)
NET SURPLUS (LOSS) FINAL	<u>\$ 2,244,216</u>	<u>2.2%</u>	<u>\$ 1,037,935</u>	<u>1.1%</u>	<u>\$ 1,206,281</u>	<u>\$ 5,898,991</u>	<u>1.5%</u>	<u>\$ 4,351,802</u>	<u>1.1%</u>	<u>\$ 1,547,189</u>

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

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 1,705,816	\$ 1,954,470	\$ 248,653	12.7%	Personnel	\$ 6,921,160	\$ 6,620,719	\$ (300,441)	-4.5%
2,183,741	1,547,805	(635,936)	-41.1%	Non-Personnel	7,769,615	7,131,977	\$ (637,638)	-8.9%
3,889,557	3,502,274	(387,283)	-11.1%	Total Administrative Expense	14,690,775	13,752,697	(938,078)	-6.8%

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

Four Months Ended Oct 31, 2016

	Medi-Cal	CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)				
REVENUE	349,793,066	44,697,222	\$1,428,670	\$395,918,958
MEDICAL EXPENSES	323,512,749	50,228,500	1,171,942	\$374,913,190
(MLR)	92.5%	112.4%	82.0%	94.7%
GROSS MARGIN	26,280,318	(5,531,278)	256,728	21,005,768
ADMINISTRATIVE EXPENSES <i>(% MM allocation except CMC)</i>	12,861,774	1,658,513	170,487	14,690,775
OPERATING INCOME/(LOSS)	13,418,543	(7,189,791)	86,241	6,314,993
OTHER INCOME/(EXPENSE) <i>(% of Revenue Allocation)</i>	(367,536)	(46,965)	(1,501)	(416,002)
NET INCOME/ (LOSS)	\$13,051,007	(\$7,236,755)	\$84,739	\$5,898,991
PMPM (ALLOCATED BASIS)				
REVENUE	\$325.88	\$1,403.67	\$100.41	\$353.67
MEDICAL EXPENSES	301.40	1,577.38	82.37	334.91
GROSS MARGIN	24.48	(173.70)	18.04	18.76
ADMINISTRATIVE EXPENSES	11.98	52.08	11.98	13.12
OPERATING INCOME/(LOSS)	12.50	(225.79)	6.06	5.64
OTHER INCOME/ (EXPENSE)	(0.34)	(1.47)	(0.11)	(0.37)
NET INCOME/ (LOSS)	\$12.16	(\$227.26)	\$5.96	\$5.27
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	1,073,378	31,843	14,228	1,119,449
Member MONTHS by LOB	95.9%	2.8%	1.3%	100%
Revenue by LOB	88.3%	11.3%	0.4%	100%

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

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

Cash flows from operating activities	
Premiums received	\$ 359,896,557
Medical expenses paid	\$ (310,567,338)
Administrative expenses paid	\$ (14,948,838)
Net cash from operating activities	<u>\$ 34,380,381</u>
Cash flows from capital and related financing activities	
Purchases of capital assets	\$ (2,199,933)
Cash flows from investing activities	
Interest income and other income, net	<u>\$ 123,117</u>
Net (Decrease) increase in cash and cash equivalents	<u>\$ 32,303,564</u>
Cash and cash equivalents, beginning of year	<u>\$ 146,082,070</u>
Cash and cash equivalents at Oct 31, 2016	<u><u>\$ 178,385,634</u></u>
Reconciliation of operating income to net cash from operating activities	
Operating income (loss)	\$ 5,775,874
Adjustments to reconcile operating income to net cash from operating activities	
Depreciation	\$ 624,314
Changes in operating assets and liabilities	
Premiums receivable	\$ (118,823,145)
Due from Santa Clara Family Health Foundation	\$ -
Prepays and other assets	\$ 2,160,725
Deferred outflow of resources	\$ -
Accounts payable and accrued liabilities	\$ (2,803,983)
State payable	\$ 82,800,743
Santa Clara Valley Health Plan and Kaiser payable	\$ 2,285,004
Net Pension Liability	\$ 300,000
Medical cost reserves and PDR	\$ 719,615
Deferred inflow of resources	<u>\$ -</u>
Total adjustments	<u>\$ 28,604,506</u>
Net cash from operating activities	<u><u>\$ 34,380,381</u></u>

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Oct 2016			Four Months Ending Oct 2016				
	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	Prior Year <u>Actual</u>	FY17 <u>vs. FY16</u>
Medi-Cal	271,911	263,764	3.1%	1,073,378	1,050,848	2.1%	976,605	9.9%
Healthy Kids	2,662	2,516	5.8%	14,228	14,223	0.0%	17,831	(20.2%)
Medicare	7,801	7,653	1.9%	31,843	31,312	1.7%	31,507	1.1%
Total	282,374	273,933	3.1%	1,119,449	1,096,383	2.1%	1,025,943	9.1%

Santa Clara Health Authority
Oct 2016

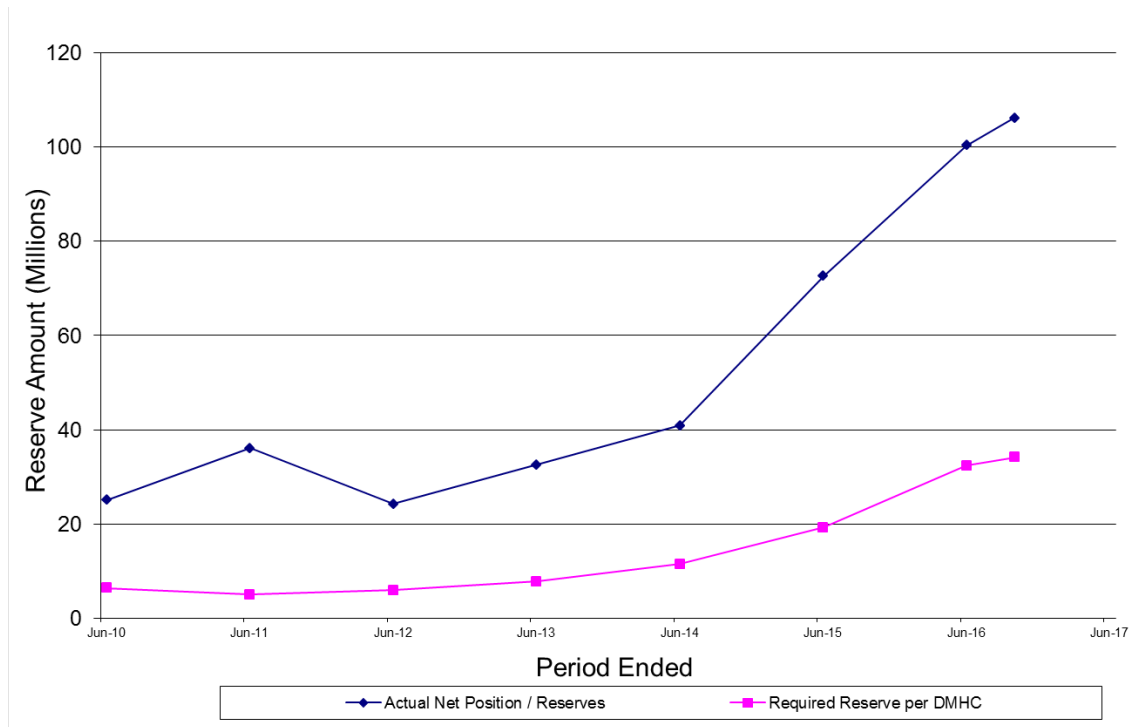
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	25,899	10%	224	8%	7,801	100%	33,924	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	145,414	53%	1,504	56%	-	0%	146,918	52%
Palo Alto Medical Foundation	7,562	3%	45	2%	-	0%	7,607	3%
Physicians Medical Group	48,976	18%	729	27%	-	0%	49,705	18%
Premier Care	16,663	6%	160	6%	-	0%	16,823	6%
Kaiser	27,397	10%	-	0%	-	0%	27,397	10%
Total	271,911	100%	2,662	100%	7,801	100%	282,374	100%
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	4.6%		-40.0%		-4.9%		3.6%	

Santa Clara Family Health Plan Enrollment by Aid-Category

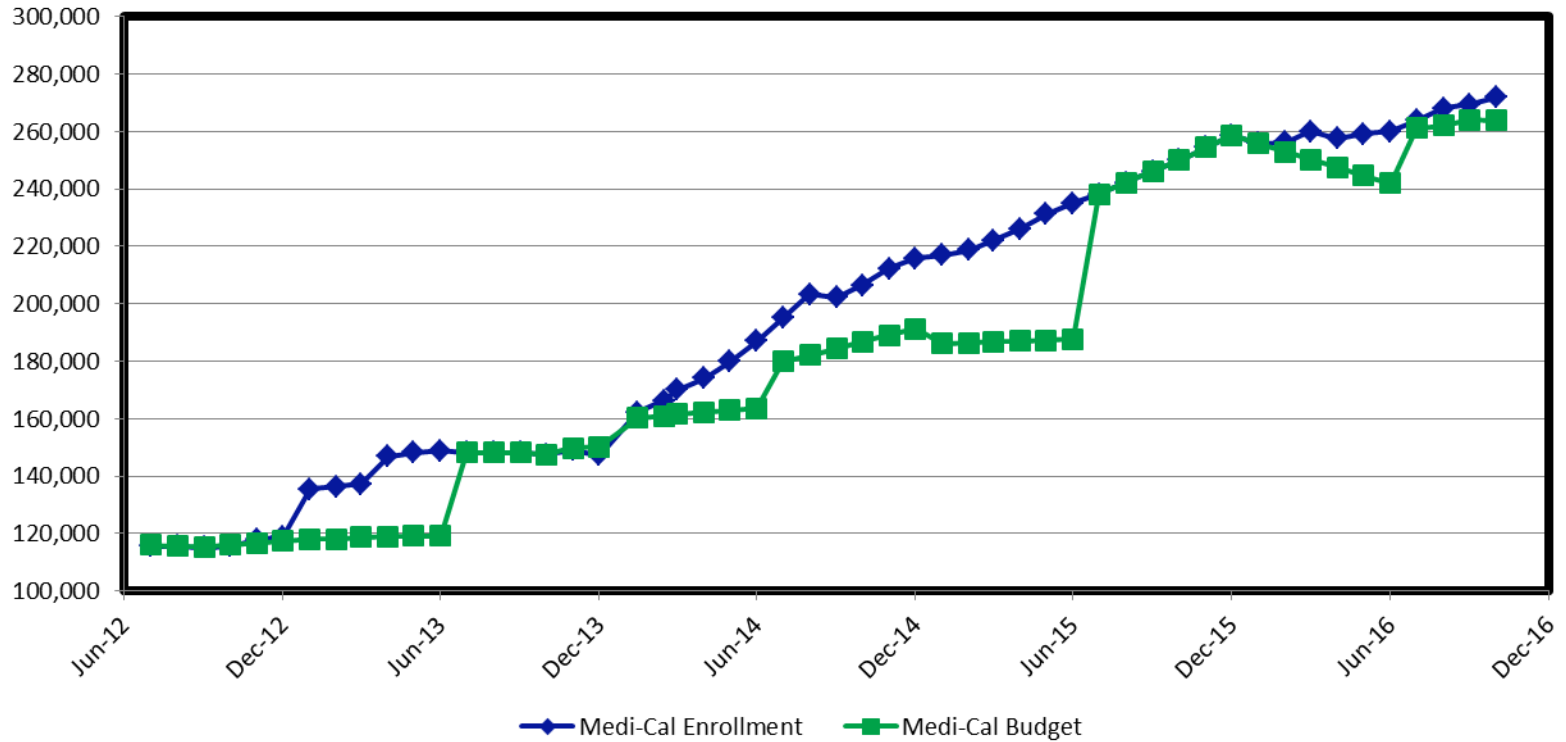
		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200	31,372	31,863
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006	108,797
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150	10,138	10,199
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,262	11,125	11,108	11,067	10,997	10,951	10,893	10,843	10,812	10,910	11,023	11,084
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350	1,298
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572	83,721	84,679
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38	37
	Long Term Care	194	194	205	212	229	247	246	258	259	260	266	266	270	277	280	281
	Total Non-Duals	221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928	248,238
DUAL	Aged	10,003	10,678	11,583	12,426	13,380	14,035	14,074	14,246	14,328	14,301	14,414	14,495	14,522	14,517	14,724	14,793
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083	6,027	6,024
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843	1,856	1,896
	Long Term Care	644	722	814	904	983	1,064	1,058	1,038	1,019	1,006	1,004	999	994	984	974	960
	Total Duals	16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427	23,581	23,673
Total Medi-Cal		238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509	271,911
Healthy Kids		4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962	2,662
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,526	9,305	8,784	8,529	8,377	8,151	8,033	7,869	7,780	7,696	7,584	7,481
	CMC - Long Term Care	294	312	325	352	380	394	375	357	351	337	334	334	328	329	325	320
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909	7,801
Total Enrollment		250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384	280,380	282,374

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

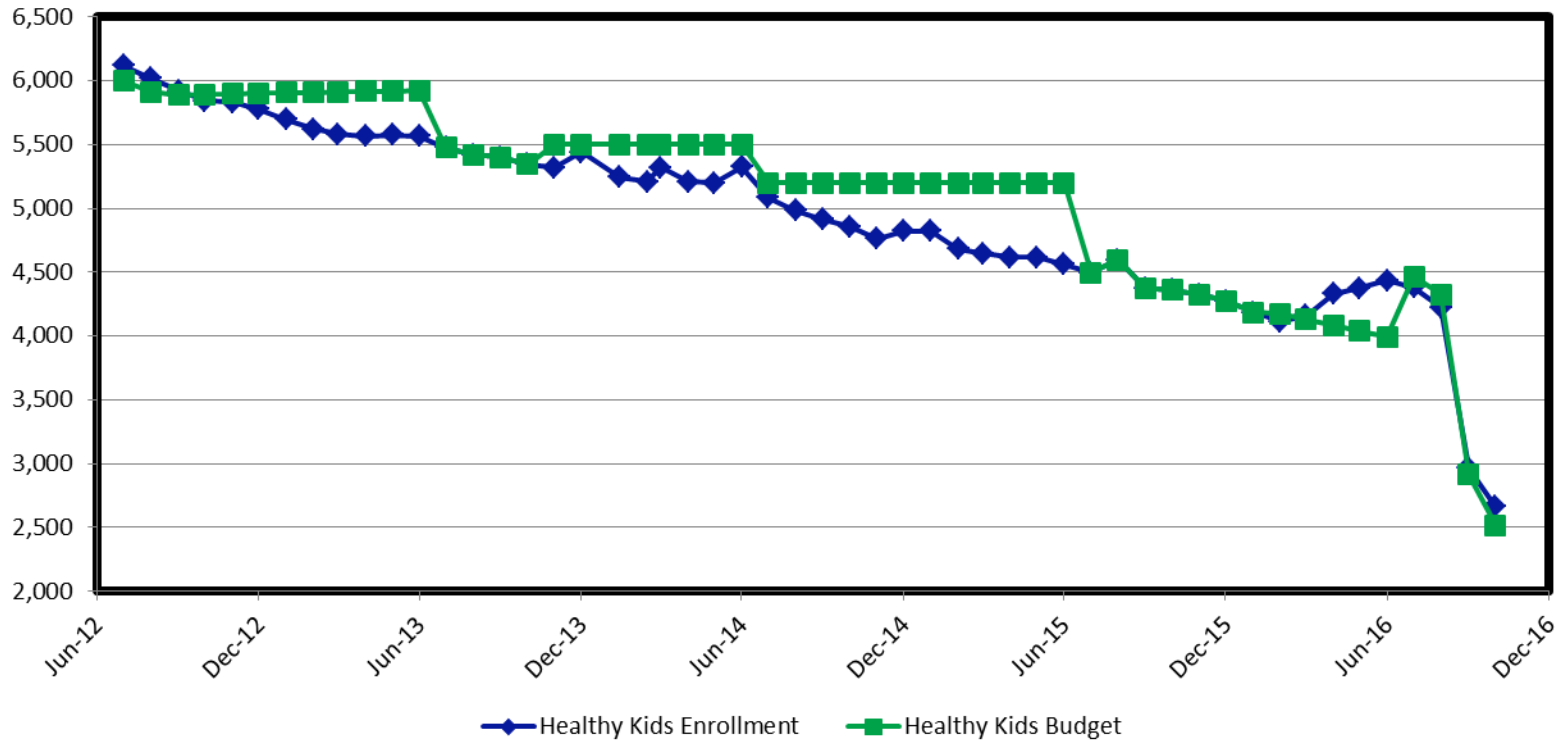
	<u>6/30/2010</u>	<u>6/30/2011</u>	<u>6/30/2012</u>	<u>6/30/2013</u>	<u>6/30/2014</u>	<u>6/30/2015</u>	<u>6/30/2016</u>	<u>10/31/2016</u>
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	106,192,447
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	34,122,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	68,244,000
	3.93	7.22	4.10	4.19	3.57	3.77	3.10	3.11



SCFHP Medi-Cal Enrollment as of Oct 2016



SCFHP Healthy Kids Enrollment as of Oct 2016





October 2016 Financial Summary

SCCHA Governing Board Meeting
December 15, 2016



Fiscal Year 2016-17 YTD Highlights

- **Net Surplus** — Oct \$2.2m surplus and YTD \$5.9m surplus (\$1.5m favorable to budget)
- **Enrollment** — Oct 2016 membership: 282,374 (3.1% favorable to budget) and Oct YTD: 1,119,449 member months (2.1% favorable to budget and 9.1% higher than Oct YTD last year)
 - Continued growth in Adult , Aged and Expansion Medi-Cal membership. CMC membership has been trending downward. HK membership is transitioning to Medi-Cal.
- **Revenue** — over budget by \$16.2 m (+4.3%)
 - Increase is due to higher than budgeted members year to date, which was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.
- **Medical Expenses** — over budget by \$13.7m (-3.8%)
 - Increase is due to higher than budgeted member months resulting in higher capitation costs and higher hospital, LTC, and risk sharing expenses, which are partially offset by lower Professional FFS expenses and Pharmacy expenses.
- **Administrative Expenses** — over budget by \$0.9 million (-6.8%)
 - Increase is due to positions being filled by consulting/temporary resources. Translation and Pharmacy administration fees also contributed to the increase. Lower Information service and Postage expenses offset some of the increase.
- **Other Expenses** — over budget by \$0.1m due to lower interest income than budget
- **Balance Sheet**
 - Cash position increased due to the receipt of Medicare RAF receivable and an overall increase in the payables.
 - Receivables for CCI rate recast continued to increase (partially offset by Medi-Cal Expansion rate overpayments).
 - TNE of \$106.1m or 311% of Required TNE of \$34.1m per DMHC (\$13.2m below the SCFHP low-end Equity Target and \$53.1m above the low-end Liquidity Target).
 - Capital Expenses increased by \$2.2 million due to capitalization of work-in-progress expenses of the Trizetto project.



Consolidated Performance

October 2016 and Year to Date

	Month of October	FYTD through October
Revenue	\$99.7 million	\$395.9 million
Medical Costs	\$93.5 million	\$374.9 million
Medical Loss Ratio	93.7%	94.7%
Administrative Costs	\$3.9 million (3.9%)	\$14.7 million (3.7%)
Other Income/ Expense	(\$127,576)	(\$416,002)
Net Surplus (Loss)	\$2,244,216	\$5,898,991
Cash on Hand		\$178 million
Net Cash Available to SCFHP		\$173 million
Receivables		\$536 million
Current Liabilities		\$607 million
Tangible Net Equity		\$106 million
Pct. Of Min. Requirement		311%



Consolidated Performance

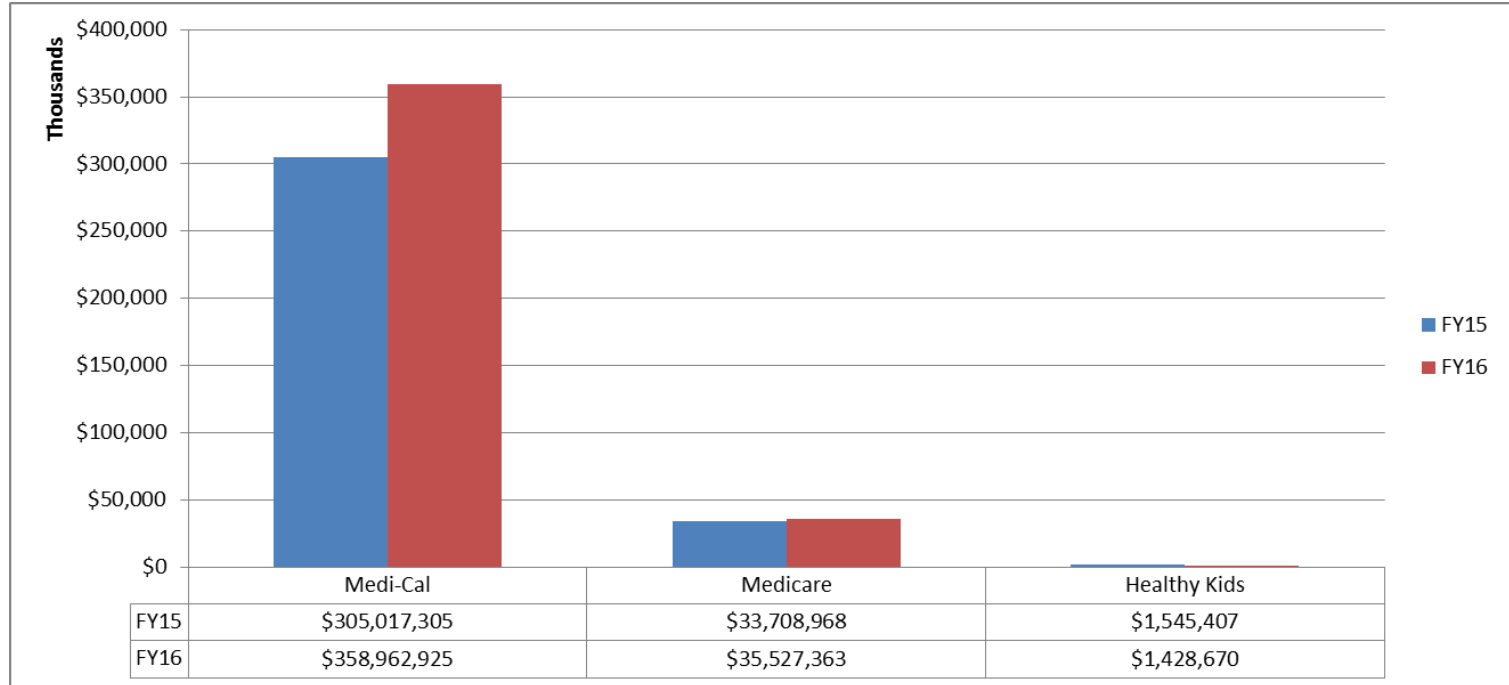
Summary Operating Results - Actual vs. Budget For the Current Month & Fiscal Year to Date - Oct 2016

Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 99,748,423	\$ 94,838,651	\$ 4,909,772	5.2%	Revenue	\$ 395,918,958	\$ 379,705,863	\$ 16,213,095	4.3%
93,487,074	90,212,600	(3,274,475)	-3.6%	Medical Expense	374,913,190	361,257,995	(13,655,195)	-3.8%
6,261,349	4,626,051	1,635,298	35.3%	Gross Margin	21,005,768	18,447,868	2,557,900	13.9%
3,889,557	3,502,274	(387,283)	-11.1%	Administrative Expense	14,690,775	13,752,697	(938,078)	-6.8%
2,371,792	1,123,777	1,248,015	111.1%	Net Operating Income	6,314,993	4,695,171	1,619,822	34.5%
(127,576)	(85,842)	(41,734)	-48.6%	Non-Operating Income/Exp	(416,002)	(343,370)	(72,632)	-21.2%
\$ 2,244,216	\$ 1,037,935	\$ 1,206,281	116.2%	Net Surplus/ (Loss)	\$ 5,898,991	\$ 4,351,802	\$ 1,547,189	35.6%



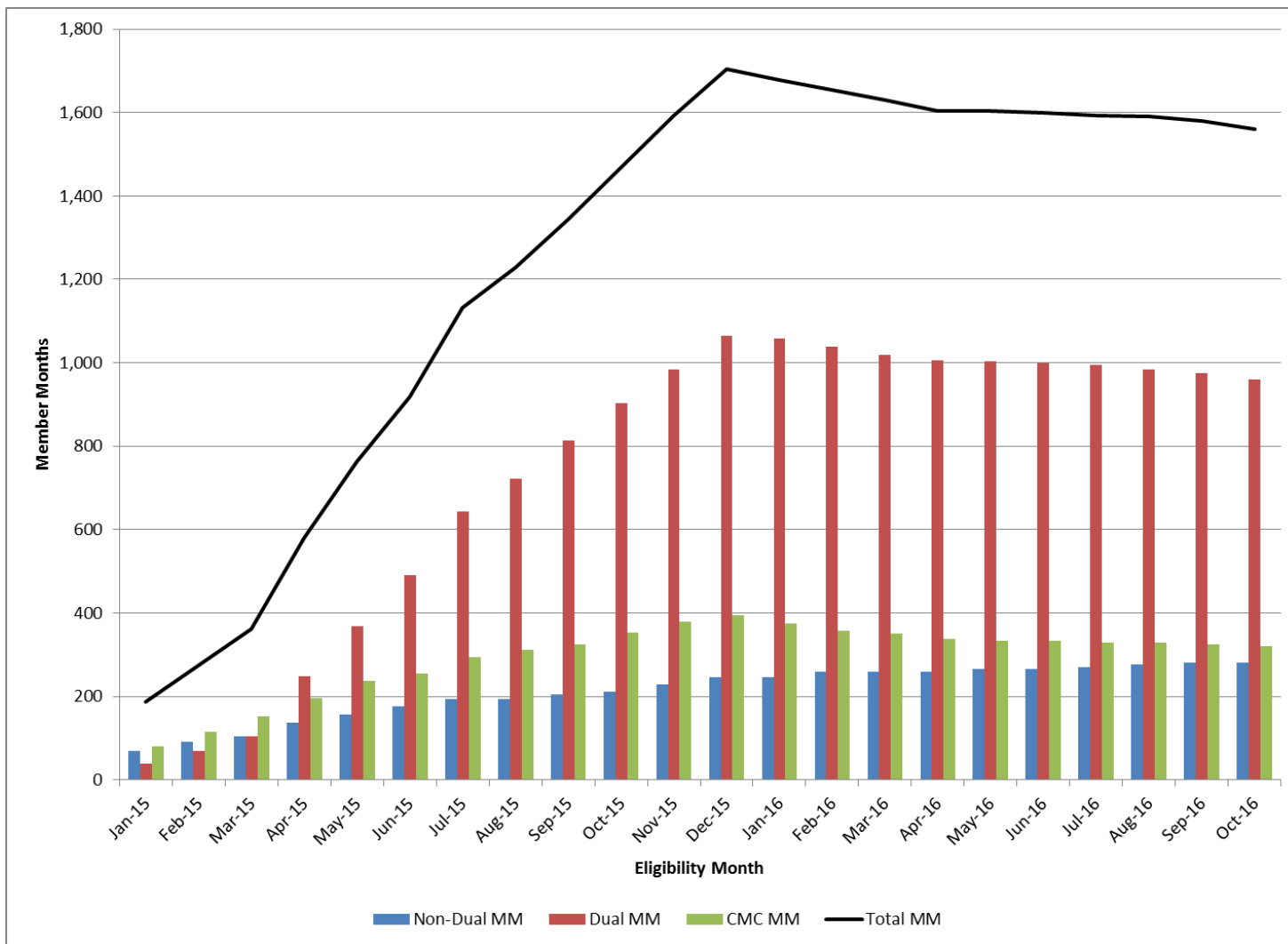
Year Over Year Revenue Trend



Medi-Cal revenue increased by 18% and Medicare revenue increased by 5%.



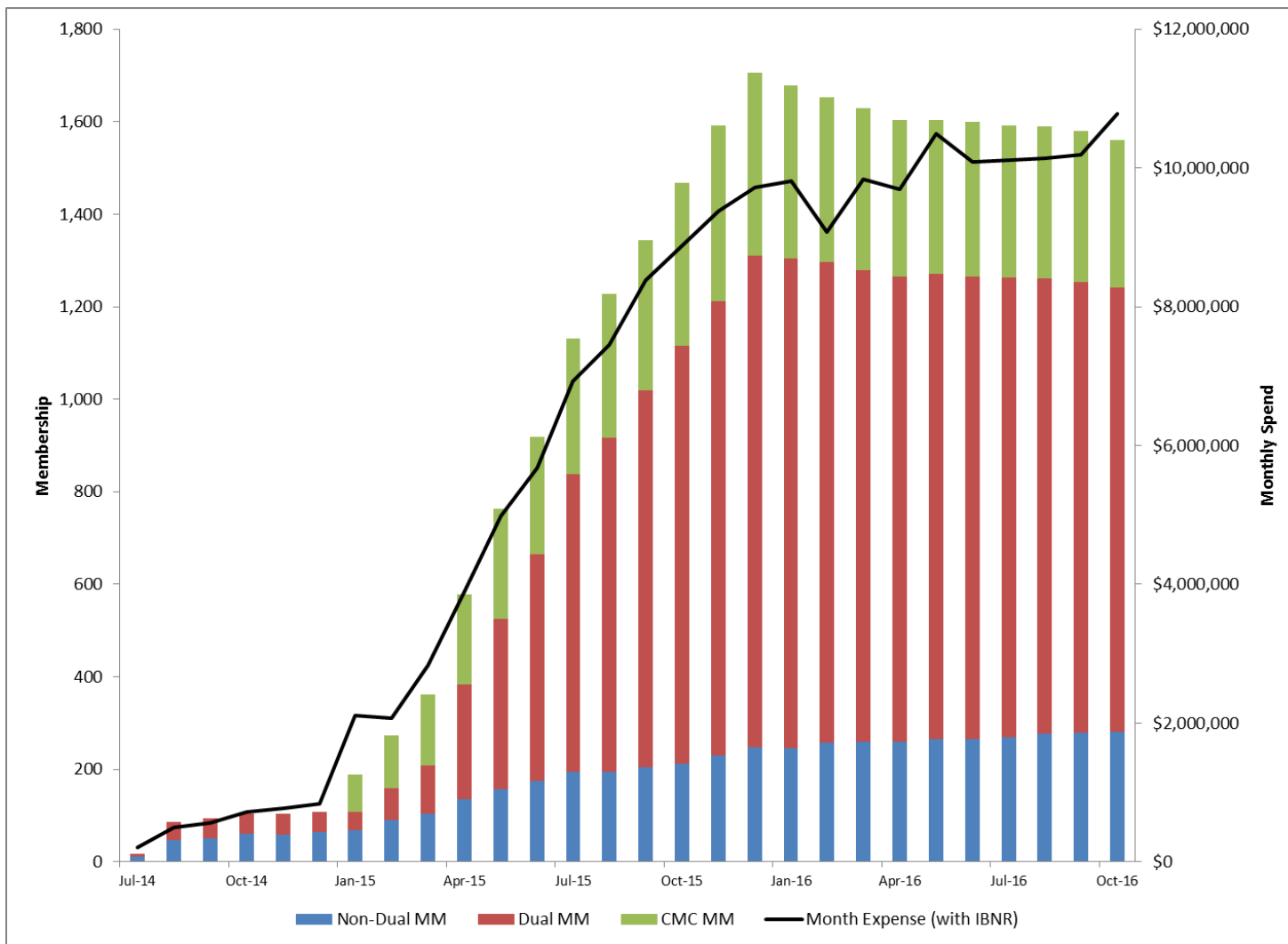
Long Term Care Membership Medi-Cal and CMC





Medi-Cal Long Term Care Experience

Jul 2014 – Oct 2016





Enrollment Summary

October and YTD

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Oct 2016			Four Months Ending Oct 2016				
	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	Prior Year <u>Actual</u>	FY17 <u>vs. FY16</u>
Medi-Cal	271,911	263,764	3.1%	1,073,378	1,050,848	2.1%	976,605	9.9%
Healthy Kids	2,662	2,516	5.8%	14,228	14,223	0.0%	17,831	(20.2%)
Medicare	7,801	7,653	1.9%	31,843	31,312	1.7%	31,507	1.1%
Total	282,374	273,933	3.1%	1,119,449	1,096,383	2.1%	1,025,943	9.1%



Enrollment by Network - YTD

Santa Clara Health Authority
Oct 2016

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	25,899	10%	224	8%	7,801	100%	33,924	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	145,414	53%	1,504	56%	-	0%	146,918	52%
Palo Alto Medical Foundation	7,562	3%	45	2%	-	0%	7,607	3%
Physicians Medical Group	48,976	18%	729	27%	-	0%	49,705	18%
Premier Care	16,663	6%	160	6%	-	0%	16,823	6%
Kaiser	27,397	10%	-	0%	-	0%	27,397	10%
Total	271,911	100%	2,662	100%	7,801	100%	282,374	100%
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	4.6%		-40.0%		-4.9%		3.6%	

Membership has increased 3.6% since the beginning of the Fiscal Year, primarily due to growth in Adult and Aged Medi-Cal membership.



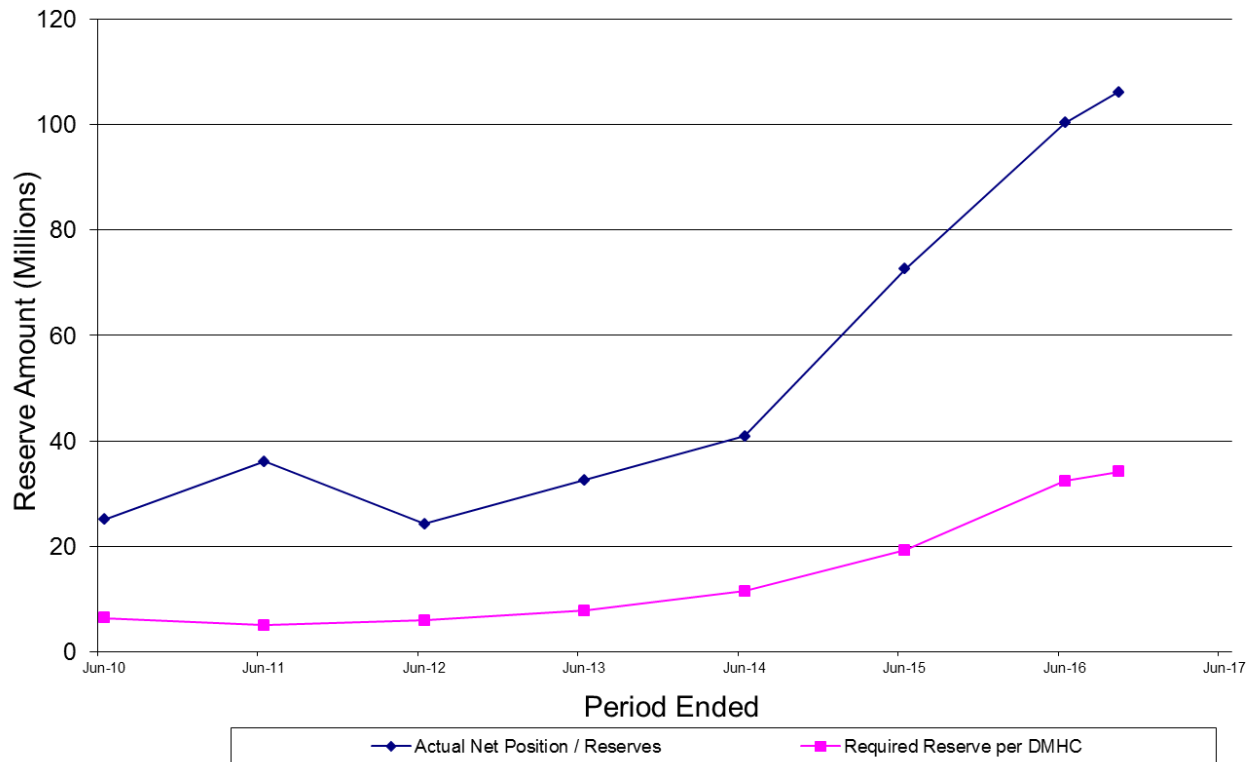
Enrollment by Aid Category

		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200	31,372	31,863
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006	108,797
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150	10,138	10,199
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,262	11,125	11,108	11,067	10,997	10,951	10,893	10,843	10,812	10,910	11,023	11,084
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350	1,298
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572	83,721	84,679
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38	37
	Long Term Care	194	194	205	212	229	247	246	258	259	260	266	266	270	277	280	281
	Total Non-Duals	221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928	248,238
DUAL	Aged	10,003	10,678	11,583	12,426	13,380	14,035	14,074	14,246	14,328	14,301	14,414	14,495	14,522	14,517	14,724	14,793
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083	6,027	6,024
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843	1,856	1,896
	Long Term Care	644	722	814	904	983	1,064	1,058	1,038	1,019	1,006	1,004	999	994	984	974	960
	Total Duals	16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427	23,581	23,673
	Total Medi-Cal	238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509	271,911
	Healthy Kids	4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962	2,662
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,526	9,305	8,784	8,529	8,377	8,151	8,033	7,869	7,780	7,696	7,584	7,481
	CMC - Long Term Care	294	312	325	352	380	394	375	357	351	337	334	334	328	329	325	320
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909	7,801
	Total Enrollment	250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384	280,380	282,374



Tangible Net Equity at October 31, 2016

TNE is \$106.1 million or 311% of the Required TNE of \$32.4m per the Department of Managed Health Care (DMHC). The Plans reserves are roughly \$13.2 million below the SCFHP low end TNE target and \$53.1 million above the SCFHP low end liquidity target.



December 12, 2016

To: Governing Board, Santa Clara County Health Authority

From: Christine Tomcala, CEO

Re: Purchase of workstations to accommodate growth

Background

Over the past several years SCFHP has experienced significant growth in its Membership, driven by the Affordable Care Act (ACA), Medi-Cal expansion, and the launch of new products and benefits including the Coordinated Care Initiative (CCI) pilot, which includes Cal MediConnect (CMC) and MLTSS. As a result of this increase in membership, SCFHP has experienced significant increases in staffing and the need to reconfigure work areas in customer service, Medical management and other administrative areas. By reducing the individual workstation size we can add an additional 35 work stations in our existing second floor office building.

Recommended Action

SCFHP Governing Board authorize the Plan to enter into an arrangement with a single vendor, selected through an RFP process, to provide 77 workstations and ancillary furniture along with new furniture in the existing training room that will allow for multiple uses.

Fiscal Impact

Workstations were priced at a standard configuration with defined basic accessories to ensure consistent pricing by vendors. After reviewing the standard mock-ups, we plan to purchase some alternative configurations, sit/stand options and a limited number of additional storage and filing accessories. These options will significantly increase storage and use efficiencies. Cost not to exceed \$275,000. This amount is included in the FY 16/17 Capital Budget.

Motion: To authorize CEO to execute a contract at a cost not to exceed the amount of \$275,000 to provide additional cubicles for second floor expansion.



To: Governing Board, Santa Clara County Health Authority

From: Christine Tomcala, CEO

Re: Annual Benefit Review

Date: December 12, 2016

Background

Open enrollment was conducted for Medical, Dental, and Vision benefits, as well as the Flex Plan, for 2017. Premiums for medical benefits increased overall by 3.24% and the Employer/Employee cost-sharing remained the same (90%/10%). Premiums for VSP vision benefits increased by 3% for a total of \$745 annually, and the premiums for United Concordia dental benefits remained flat (no increase). Premiums for Lincoln Financial life insurance at \$100,000 per employee remained flat (no increase). The limit increased for the Flex Plan from \$2,550 to \$2,600 annually for unreimbursed medical expenses.

Recommendation

Increase life insurance benefit to 1x salary with a minimum of \$100,000 up to \$300,000 for all employees. This will allow the Health Plan to provide 1x salary for employees.

Fiscal Impact

The financial impact of the increase in life insurance benefit is \$935 annually.

Proposed Board Action

Authorize Chief Executive Officer to increase the employee life insurance benefit to 1x annual salary with a minimum of \$100,000 coverage, not to exceed \$300,000, for all employees.



Santa Clara
Family Health Plan
The Spirit of Care



MEMORANDUM

TO: Santa Clara County Health Authority Governing Board

FROM: Vice President of Human Resources, Sharon Valdez

RE: Resolution Fixing the Employer Contribution at an Equal Amount for Employees and Annuitants

DATE: December 12, 2016

In October 2013, the Board passed a resolution establishing that the employer contribution for medical benefits would not exceed 90% of the Blue Shield Access plan.

As of January 2016, Blue Shield Access was no longer offered for retirees with Medicare coverage. CalPERS automatically updated our employer contribution method to use the United HealthCare premium rates in lieu of Blue Shield Access.

Although not required by CalPERS, I seek the Board's approval to update the Health Plan's Resolution to document the change in structure so that the history is clearly reflected in our records. See attached updated Resolution dated December 15, 2016 for approval by the Board and execution by the Health Plan's CEO and CFO.

**Santa Clara County Health Authority
Updates to Pay Schedule
December 15, 2016**

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Administrative Assistant	Annually	43,867	53,737	65,479
Accounts Payable Clerk	Annually	38,993	47,766	57,367
Appeals & Grievance Intake Specialist	Annually	43,867	53,737	63,607
Appeals & Grievance Operations Manager	Annually	83,102	108,033	132,964
Claims Analyst I	Annually	35,984	43,181	53,956
Claims Clerk	Annually	32,166	38,599	45,032
Data Warehouse Architect	Annually	83,102	108,033	132,964
Delegation Oversight Analyst	Annually	62,706	79,951	97,195
Director of Marketing, Communications, and Outreach	Annually	112,569	149,153	185,738
Enrollment and Eligibility Manager	Annually	83,102	108,033	132,964
Health Services Project Manager	Annually	83,102	108,033	132,964
IT Configuration Manager	Annually	83,102	108,033	132,964
LTSS Support Specialist	Annually	32,166	38,599	45,032
Medicare Compliance Program Manager	Annually	83,102	108,033	132,964
Medicare Outreach Manager	Annually	83,102	108,033	132,964

**Job Titles Removed from Pay Schedule
December 15, 2016**

Database Administrator/ Analyst	Annually	62,706	79,951	98,267
Director Business Development	Annually	112,569	149,153	185,738
Medicare Compliance Manager	Annually	83,102	108,033	132,964

**RESOLUTION OF
THE SANTA CLARA COUNTY HEALTH AUTHORITY
TO ADOPT AN AMENDED
CONFLICT OF INTEREST CODE**

WHEREAS, the Political Reform Act (Government Code Section 81000, eseq.) requires state and local government agencies to adopt and promulgate conflict of interest codes; and

WHEREAS, the Fair Political Practices Commission ("FPPC") has adopted a regulation (2 Cal. Code of Regs. 18730) which contains the terms of a standard conflict of interest code and following public notice and hearing it may be amended by the Fair Political Practices Commission to conform to Amendments in the Political Reform Act; and

WHEREAS, the Santa Clara County Health Authority ("the Health Authority") has recently reviewed its conflict of interest code, its positions, and the duties of each position, and has determined that changes to the current conflict of interest code are necessary; and

WHEREAS, any earlier resolution and/or appendices containing the Health Authority's conflict of interest code shall be rescinded and superseded by this resolution and Appendix;

NOW, THEREFORE BE IT RESOLVED THAT, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the FPPC are hereby incorporated by reference and this regulation and the Appendices, attached hereto and incorporated herein, designating officials and employees, and establishing disclosure categories, shall constitute the Conflict of Interest Code of the Health Authority.

IT IS FURTHER RESOLVED THAT, designated employees shall file their statements of economic interests with the Health Authority's filing official. If a statement is received in signed paper format, the Health Authority's filing official shall make and retain a copy and forward the original of this statement to the filing officer, the County of Santa Clara Clerk of the Board of Supervisors. If a statement is electronically filed using the County of Santa Clara's Form 700 e-filing system, both the Health Authority's filing official and the County of Santa Clara Clerk of the Board of Supervisors will receive access to the e-filed statement simultaneously. The Health Authority shall make a copy of the statements available for public inspection and reproduction in accordance with Government Code section 81008.

PASSED AND ADOPTED by the Santa Clara County Health Authority of the County of Santa Clara, State of California on _____, 2016 by the following vote:

AYES:

NOES:

ABSENT:

Signed:

Chair

Attest:

Secretary

Attachments to this Resolution:

Appendix A-Positions Required to File

Appendix B-Disclosure Categories

**Appendix A - Amended
Santa Clara County Health Authority
Conflict of Interest Code
POSITIONS REQUIRED TO FILE**

The following is a list of those positions that are required to submit Statements of Economic Interests (Form 700) pursuant to the Political Reform Act of 1974, as amended:

Required to File Form 700:

Position	Disclosure Category Number
Health Authority Board Member	1
Chief Executive Officer	1
Chief Financial Officer	2
Chief Operating Officer	2
Chief Medical Officer	2
Chief Information Officer	2
Director of Provider Network Management	6
Director of Infrastructure and System Support	4
Director of Quality and Pharmacy	6
Medical Director	6
Consultant	7
Newly Created Position	*

***Newly Created Positions**

A newly created position that makes or participates in the making of decisions that may foreseeably have a material effect on any financial interest of the position-holder, and which specific position title is not yet listed in the Health Authority's conflict of interest code is included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation: The Chief Executive Officer may determine in writing that a particular newly created position, although a "designated position," is hired to perform a range of duties that are limited in scope and thus is not required to fully comply with the broadest disclosure requirements, but instead must comply with more tailored disclosure requirements specific to that newly created position. Such written determination shall include a description of the newly created position's duties and, based upon that description, a statement of the extent of disclosure requirements. The Health Authority's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

As soon as the Health Authority has a newly created position that must file statements of economic interests, the Health Authority filing official shall contact the County of Santa Clara Clerk of the Board of Supervisors Form 700 division to notify it of the new position title to be added in the County's electronic Form 700 record management system, known as eDisclosure. Upon this notification, the Clerk's office shall enter the actual position title of the newly created position into eDisclosure and the Health Authority filing official shall ensure that the name of any individual(s) holding the newly created position is entered under that position title in eDisclosure.

Additionally, within 90 days of the creation of a newly created position that must file statements of economic interests, the Health Authority shall update this conflict-of-interest code to add the actual position title in its list of designated positions, and submit the amended conflict of interest code to the County of Santa Clara Office of the County Counsel for code-reviewing body approval by the County Board of Supervisors. (Gov. Code Sec. 87306.)

**Appendix B - Amended
Santa Clara County Health Authority
Conflict of Interest Code
DISCLOSURE CATEGORIES**

Category 1. Persons in this category shall disclose (1) all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority; and (2) all investments, business positions and income, including gifts, loans and travel payments, from all sources.

Category 2. Persons in this category shall disclose all investments, business positions and income, including gifts, loans and travel payments, from all sources.

Category 3. Persons in this category shall disclose all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority.

Category 4. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority.

Category 5. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that either contract to provide education or training required by the Authority to qualify for or maintain a license, or that provide education or training services which courses or curricula are approved by the Authority.

Category 6. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from (1) all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority, and (2) all sources that are of the type to receive grants or other monies from or through the Authority, including, but not limited to, nonprofit organizations.

Category 7. Each Consultant, as defined for purposes of the Political Reform Act, shall disclose pursuant to the broadest disclosure category in the conflict of interest code subject to the following limitation: The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements of the broadest disclosure category, but instead must comply with more tailored disclosure requirements specific to that consultant. Such a determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. All such determinations are public records and shall be retained for public inspection along with this conflict of interest code.



2017 Board Meeting Calendar

January 2017						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
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29	30	31				

April 2017						
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30						

July 2017						
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30	31					

October 2017						
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29	30	31				

February 2017						
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May 2017						
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August 2017						
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November 2017						
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26	27	28	29	30		

March 2017						
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26	27	28	29	30	31	

June 2017						
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September 2017						
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24	25	26	27	28	29	30

December 2017						
S	M	T	W	T	F	S
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24	25	26	27	28	29	30
31						

SCCHA Governing Board 2:30 – 5:00 PM	SCCHA Executive/Finance Committee 8:30 – 10:00 AM
March 23	January 26
June 22	February 23
September 28	April 27
December 14	May 25
	July 27
	August 24
	October 26
	November 16



Santa Clara
Family Health Plan
The Spirit of Care

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

Thursday, October 27, 2016
8:30 AM - 10:00 AM
210 E. Hacienda Avenue
Campbell CA 95008

VIA TELECONFERENCE AT:

Residence
1985 Cowper Street
Palo Alto, CA 94301

Minutes - DRAFT

Members Present

Michele Lew, Chair
Bob Brownstein
Linda Williams
Wally Wenner

Members Absent

Liz Kniss

Staff Present

Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Finance Officer
Neil Jarecki, Controller
Jeff Robertson, Chief Medical Officer
Rita Zambrano, Executive Assistant

Others Present

John Kennedy, Nossaman LLP (via phone)
Chris Pritchard, Moss Adams
Rianne Giselle Suico, Moss Adams

1. Roll Call

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

2. Meeting Minutes

The minutes of the August 25, 2016 Executive/Finance Committee Meeting were reviewed.

It was moved, seconded, and the August 25, 2016 Executive/Finance Committee minutes were unanimously **approved** as presented.

3. Public Comment

There were no public comments.

4. Fiscal Year 2015-16 External Audit Report

Dave Cameron introduced Chris Pritchard and Rianne Suico, Audit Partner and Senior Manager, respectively, from the Plan's independent accountants, Moss Adams LLP. The auditors gave an overview of the Plan's audited financial statements for the fiscal year ended June 30, 2016 - which reflected a final surplus of \$27 million. The auditors also reviewed suggested improvements to the Plan's financial system and noted management's concurrence with its recommendations. Members of the Executive Committee thanked the auditors for their work.

It was moved, seconded, and the FY'2015-16 External Audit Report was approved as presented.

5. Adjourn to Closed Session

- a. **Significant Exposure to Litigation (Government Code Section 54956.9(d)(2)):** The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding one item of significant exposure to litigation.

6. Report from Closed Session

Ms. Lew reported that no action was taken in Closed Session.

7. August/September 2016 Financial Statements

Mr. Cameron presented the financial results for the months of August & September 2016. For the three months ended September 2016 (the first quarter of the fiscal year), SCFHP reported a net surplus of \$3.7 million versus budget of \$3.3 million, or a favorable variance of \$341,000. Member months, revenue, medical expense and administrative expense all slightly exceed budget for the quarter. At the end of September, the Plan's reserves exceed the low end of the liquidity target range and trailed the low end of the equity target range.

It was moved, seconded, and the August/September 2016 Financial Statements were approved as presented.

8. DMHC Audit and Management Response

Mr. Cameron noted that, following a routine financial examination of SCFHP in late summer, DMHC had issued its preliminary report on August 18, 2016. Mr. Cameron reviewed the report and the Plan's response, filed on September 30, 2016. SCFHP concurred with the six items noted by DMHC. DMHC noted that claims which were the financial responsibility of the Plan's delegates which were not forwarded in a timely manner, a repeat deficiency. SCFHP staff is currently completing a voluntary corrective action plan (CAP) regarding improved processing of such misdirected claims and Mr. Cameron advised that he will provide a copy of the final CAP and Final Audit Report to the Executive Committee.

It was moved, seconded, and approved to accept DMHC Audit and Management Response as presented.

9. Case Management System

Dr. Jeff Robertson, Chief Medical Officer, presented an overview of the Case Management System Request for Quote (RFQ) process and noted out the Plan is currently using Altruista, which has limited functionality and capacity for expansion to SPD. Implementing a new case management system will help ensure compliance with regulations regarding case management.

An RFQ was submitted to four vendors, Casenet, TriZetto, ZeOmega, and Essette. The finalist selected will be based on a combination of highest functionality, meeting compliance, and best price.

It was moved, seconded, and approved to augment the fiscal year 2016-2017 budget and authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected case management system vendor in an amount not to exceed a \$550K for licensing and implementation.

10. Fiscal Year 2016-17 Team Incentive Compensation Proposal

Christine Tomcala presented a draft Fiscal Year 2016-2017 Team Incentive Compensation program. She noted the proposal is similar to the prior year program, and highlighted the changes. In addition to compliance, two additional metrics were added at a lower weight, QNXT implementation and provisional NCQA accreditation.

It was moved, seconded, and unanimously approved to recommend approval of the FY 2016-17 Team Incentive Compensation Proposal to the Board.

11. CEO Update

Ms. Tomcala provided a Unified Managed Care update and noted plans to continue to moving forward with joint strategic planning after the November election, utilizing Bobbie Wunsch with Pacific Health Consulting Group as facilitator. Mr. Rene Santiago recommended that Jon Freedman, Health Management Associates, also participate. There is a planning meeting scheduled for November 2nd, to discuss the process moving forward.

She also noted that CMS accepted the County's Whole Person Care (WPC) application and there will be a second round of applications for WPC pilots due in March 2017.

Ms. Tomcala mentioned there is new leadership at O'Conner and Verity, and she will be reaching out to meet with them.

It was reported Shelley Rouillard, Director of DMHC, visited the plan in October. Ms. Rouillard noted DMHC is hiring a Chief Medical Officer and reviewed current areas of focus, such as the financial strength of sub-delegates. the timely access methodology. The current focus going forward is sub delegate financial strength. Mr. Cameron raised the issue of the timing of MCO tax payments.

Ms. Tomcala gave a brief update on the CCI Budget, noting a sense of cautious optimism this year.

Ms. Tomcala provided an update on the Healthy Kids transitions, noting that children have been transitioning since May. Most of the children enrolled in restrictive scope MediCal prior to May 16 have now transitioned to full scope MediCal and have either chosen a management care plan or have been auto assigned to a managed care plan.

Ms. Tomcala gave an update on Team Incentive Compensation. Now that the financial audit has been completed, it is time for the Board-approved team bonus payments to be issued. She noted that the Executive Team respectfully declined the Board approved bonus over 1% earned but appreciates the recognition.

Efforts are on track for the Medicare QNXT upgrade, and initial implementation efforts are underway for the Medi-Cal QNXT implementation.

Lastly, Ms. Tomcala updated the Committee on space planning, noting the Plan has two years left on the lease. Management is looking at replacing some existing cubes with smaller cubes to accommodate additional staff. Alternate building locations are also being researched.

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

12. Adjournment

The meeting was adjourned at 10:00 am.

Elizabeth Pianca, Secretary to the Board



Santa Clara
Family Health Plan

The Spirit of Care

September 30, 2016

Mr. Bill Chang,
Supervising Examiner
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814

Dear Mr. Chang:

Santa Clara Family Health Plan (the Plan) is in receipt of the Department of Managed Health Care's (DMHC's) Preliminary Report of Routine Examination of Santa Clara County Health Authority dated August 18, 2016. Below, we have reviewed and summarized all findings and required actions included in the Preliminary Report and have provided our responses:

1. Forwarding of Misdirected Claims

Deficiency: The Department's examination found that 5 out of 50 denied claims reviewed were not forwarded to the appropriate capitated provider by the Plan within ten (10) working days from receipt (a non-compliant rate of 10 percent). The Plan's failure to forward misdirected provider disputes related to referral claims is a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated October 11, 2013. This examination disclosed that the Plan's remediation efforts in response to this prior report have not achieved the necessary level of compliance.

Required Action: The Plan is required to submit a policy and procedure to ensure that misdirected claims are forwarded within ten (10) working dates of receipt to the appropriate capitated provider. The Plan is also required to state the date the policy and procedure was implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance. The Plan is required to explain why the corrective actions implemented to resolve the deficiency of timely forwarding of misdirected claims found in the Department's prior examination were not effective in ensuring ongoing compliance.

Plan's Response:

Following the prior DMHC audit, the Plan implemented an automated process to scan and forward misdirected claims to our delegates on a nightly basis. However, after reviewing the errors noted during this audit, the Plan determined that this automated process was unknowingly impaired by two issues:

- First, some claims did not contain the member name and/or provider name and were therefore not able to be forwarded via the Plan's automated 837 process. During the examination period, the Plan had a backlog of such claims, for which manual intervention is needed. To address this backlog, the

Plan's Interim Claims Director added additional claims staff resources and the backlog of such claims was 119 as of September 27, 2016. On September 28, 2016, the Claims Director made process changes to ensure that this issue does not resurface and will actively monitor the misdirected activity log. See revised Claims Policy, attached.

Second, the automated process had a system limitation that imposed a 30 day maximum lookback window on misdirected claims. This limitation was removed by the Interim Claims Director on August 18, 2016 to ensure that all misdirected claims are forwarded in a timely manner. Attached is a revised Claims policy that incorporates these additional issues.

The changes implemented will ensure that claims which are the financial responsibility of the Plan's delegates are forwarded in a timely manner. See revised Claims policy & procedure, attached.

Recognizing this is a repeat deficiency, the Plan is preparing a Corrective Action Plan, which will be submitted to the DMHC for review by October 14, 2016.

2. Fidelity Bond

Deficiency: The Department's examination found that the fidelity policy provided for review did not provide the required thirty (30) days' notice. The policy includes a cancellation notice that states the insurer will "endeavor" to provide such notice to the Director of the DMHC. In addition, the policy contains a negate clause which provides that "Failure to provide notice of cancellation to a scheduled party shall impose no liability of any kind or nature whatsoever on the underwriter and shall not amend or extend the effective date of policy cancellation or invalidate the cancellation." The Regulations state that the fidelity bond "shall" provide for 30 days' notice to the Director prior to cancellation. The word "endeavor" and the negate clause must be removed from the policy in order to comply.

Required Action: The Plan is required to electronically file a copy of its fidelity bond policy that is in compliance with the above section and rule. The Plan is also required to provide the written procedures implemented, the date of implementation, and to state the management position(s) responsible for ensuring continued compliance.

Plan's Response: The Plan obtained the revised fidelity policy verbiage as requested by DMHC and uploaded the revised verbiage electronically to the DMHC web portal on August 30, 2016. A copy of the revised Finance policy is attached, which requires the Plan's Controller to ensure that the required verbiage is included with each annual fidelity policy renewal henceforth.

3. Management Changes

Deficiency: The Department's examination disclosed that the Plan had multiple management changes; however, the Plan did not file amendments within five (5) days as required by rule.

Required Action: The Plan is required to state the policies and procedures implemented to ensure that any changes in personnel are filed within five (5) working days as required by Section 1352(c), the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Section stated above.

Plan's Response: The Plan will ensure that the DMHC is notified of all future changes in key personnel in a timely manner per regulation via the DMHC web portal. A copy of the revised Compliance policy attached, which requires the Plan's Compliance Department to ensure that all required notifications of management changes are made in a timely manner per regulation.

4. Untimely Upload of New Contract Rates

Deficiency: The Department's examination disclosed that the new contract rates for Santa Clara Valley Medical Center were not uploaded timely, resulting in an underpayment of claims. Two identified claims were paid at 120% (of Medi-Cal) instead of the new contract rate of 132%.

Required Action: The Plan is required to describe the required action taken to correct the noted deficiency including the management position responsible for overseeing the corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action was implemented.

Plan's Response: This audit finding identified a limitation of the Plan's current Xpress claims system in which certain CPT codes must be priced individually rather than en masse. Long term, this issue will be addressed when the Plan converts to the QNXT system for all claims, anticipated by July 2017.

To address this issue immediately, the IT Department's P&P for Database Configuration Standards has been updated to include short-term focused audits by Claims Auditors following all major configuration or facility contract changes. The Claims Director, Finance Director and Director of Provider Network Management will review the results of such focused audits for accuracy. This process commenced September 28, 2016. See updated Configuration Policy & Procedure, attached.

5. Overpayment of Interest:

Deficiency: The Department's examination disclosed several instances of overpayments of interest. The overpayment of interest indicates that the Plan needs to review its methodology of calculating claims interest to safeguard its assets.

Required Action: The Plan is required to describe the required action taken to correct the noted deficiency including the management position responsible for overseeing the corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action was implemented.

Required Action: The Plan is required to state the policies and procedures implemented to resolve the above concerns, the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

Plan's Response: The interest overpayments noted in this finding results from the Xpress claims system's limitation that interest is calculated only on the entire claims balance (and not simply the additional amount due). Long term, this issue will be addressed when the Plan converts to the QNXT system for all claims anticipated by July 2017.

To address this issue immediately, the Claims Department Desktop procedure has been updated to ensure that all claims adjustments of previously underpaid claims that now require interest payments must be manually calculated as the Xpress system only calculates interest on the entire amount paid. Claims department staff have begun to receive training on this change. See updated Claims Policy & Procedure, attached.

6. State-Dated Checks / Escheat of Unclaimed Property

Deficiency: The Department's examination disclosed that the Plan did not follow its policy and procedures for stale-dated checks as follows: (a) nine outstanding checks totaling \$7,654 were more than three years old, and (b) multiple outstanding checks totaling \$112,527 were more than 180 days old in the Wells Fargo A/P account. These checks should be voided and a specific liability account created for uncashed checks.

Required Action: The Plans is required to state the policies and procedures implemented to resolve the above concerns, the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

Required Action: The Plan is required to describe the required action taken to correct the noted deficiency including the management position responsible for overseeing the corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action was implemented.

Plan's Response: The Plan revised its monthly processes to ensure that stale-dated checks are reclassified to a liability account effective as of September 2016. A copy of the revised Finance policy is attached, which requires the Plan's Controller to ensure that the process is followed on a monthly basis.

We sincerely hope that the Department considers these responses effective and appropriate. Should you have any questions, or wish to discuss any matter further, please contact me at (408) 874-1710 or via email at camerdav@sfcfh.com.

Best regards,



Dave Cameron, CFO

CC: **Santa Clara Family Health Plan**

- Robert Brownstein, SCFHP Board Chair
- Christine Tomcala, CEO, SCFHP
- SCFHP Executive Team
- Neal Jarecki, Controller, SCFHP
- Arlene Bell, Claims Director, SCFHP
- Beth Paige, Compliance Officer, SCFHP

Department of Managed Health Care

- Sang Le, Supervisor, DMHC Division of Financial Oversight
- Tom Chan, Examiner, DMHC Division of Financial Oversight
- Ashika Chiu, Examiner, DMHC Division of Financial Oversight
- Cassidy Draeger, Esq., DMHC Office of Plan Licensing
- Laura Dooley-Beile, DMHC Division of Plan Surveys
- Dan Southard, DMHC Help Center
- Paula Hood, DMHC Help Center



Santa Clara
Family Health Plan

The Spirit of Care

**DMHC Routine Examination
Preliminary Report**



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
**DEPARTMENT OF MANAGED
HEALTH CARE**
980 9th Street, Suite 500,
Sacramento, CA 95814
Telephone: 916-255-2441 | Fax:
916-255-2280

August 18, 2016

Robert Brownstein, Chair of the Board
Santa Clara County Health Authority
210 East Hacienda Avenue
Campbell, CA 95008

PRELIMINARY REPORT OF ROUTINE EXAMINATION OF SANTA CLARA COUNTY HEALTH AUTHORITY

Dear Mr. Brownstein:

This is a Preliminary Report of a routine examination of the fiscal and administrative affairs of Santa Clara County Health Authority (Plan) for the quarter ended March 31, 2016. The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 (Act).¹

Section 1382 (c) states, "Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the plan has had an opportunity to review the examination report and file a statement or response within 45 days of the date that the department provided the report to the plan. After reviewing the plan's response, the director shall issue a final report that excludes any survey information, legal findings, or conclusions determined by the director to be in error, describes compliance efforts, identifies deficiencies that have been corrected by the plan on or before the time the director receives the plan's response, and describes remedial actions for deficiencies requiring longer periods for the remedy required by the director or proposed by the plan."

A Final Report will be prepared upon receipt and analysis of the Plan's response, which is due within forty-five (45) days of the Plan's receipt of the Department's Preliminary Report.

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

The Plan is hereby advised that any violations listed in this Report may be referred to the Office of Enforcement for appropriate administrative action, upon the issuance of the Final Report.

The Department performed a routine examination of the financial report filed with the Department for the quarter ended March 31, 2016, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

The Department's findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non-Routine Examination

Where requested, please comment and state the action taken to correct the noted deficiencies. Such corrective action should include the management position responsible for overseeing the corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action was implemented.

Please file the Plan's response electronically via the Department's eFiling web portal at <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling."
- From the eFiling (Home) menu, select "File Documents."
- From the File Documents Menu for:
 - 1) File Type: select "Amendment to Prior Filing."
 - 2) Original Filing, select the "Filing No. 20152417" assigned by the Department; and
 - 3) Select "Create Filing."
- From the Original Filing Details Menu, select link "Upload Amendments"; select # of documents; select document type: "Plan's Response to Preliminary Report (FE13)"; then "Select File" and select "Upload."
- Upload all documents, and then upload a cover letter as Exhibit E-1 that references to your response.
- After upload is complete, select "Complete Amendment", complete "Execution" and then select "Complete Filing."

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at (916) 255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpsso@dmhc.ca.gov.

If there are any questions regarding this Report, please contact me at 916-255-2441 or email: Bill.Chang@dmhc.ca.gov.

Sincerely,

Bill Chang
Supervising Examiner
Office of Financial Review

cc: Christine Tomcala, Chief Executive Officer, Santa Clara County Health Authority
Gil Riojas, Deputy Director, Office of Financial Review
Sang Le, Examiner IV (Supervisor), Division of Financial Oversight
Tom Chan, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Cassidy Draeger, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Dan Southard, Health Program Manager III, Help Center
Paula Hood, Staff Services Manager I, Help Center

SECTION I. FINANCIAL REPORT

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended March 31, 2016, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpsso.dmhc.ca.gov/fe/search/#top> and selecting Santa Clara County Health Authority on the second drop down menu.

No response is required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Tangible Net Equity reported as of Quarter Ended March 31, 2016	\$ 83,637,000
Required TNE	29,952,000
TNE Excess per Examination	<u>\$ 53,685,000</u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of March 31, 2016.

No response is required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES

FORWARDING MISDIRECTED CLAIMS – *Repeat Deficiency*

Rule 1300.71(b)(2)(A) and (B) states that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan shall do the following:

- If the claim involves emergency services, the plan must forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.
- For those claims that do not involve emergency service or care, if the provider that filed the claim is contracted with the plan's capitated provider, the plan must, within ten (10) working days from receipt of the claim, either send the claimant a notice of denial including instructions to bill the capitated provider or send the claim to the appropriate capitated provider.
- For all other claims, the plan must, within ten (10) working days from receipt of the incorrectly sent claim, forward the claim to the appropriate capitated provider.

DEFICIENCY

The Department's examination found that 5 out of 50 denied claims reviewed were not forwarded to the appropriate capitated provider by the Plan, within ten (10) working days from receipt (a non-compliance rate of 10 percent). The denied claims include samples D-3, D-12, D-29, D-30, and D-37.

The Plan's failure to forward misdirected provider disputes relating to referral claims is a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated October 11, 2013. This examination disclosed that the Plan's remediation efforts in response to this prior report have not achieved the necessary level of compliance.

REQUIRED ACTION

The Plan is required to submit a policy and procedure for ensuring that misdirected claims are forwarded within ten (10) working days of receipt to the appropriate capitated provider. The Plan is also required to state the date the policy and procedure was implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan is required to explain why the corrective actions implemented to resolve the deficiency of timely forwarding misdirected claims found in the Department's prior examination were not effective in ensuring ongoing compliance.

B. OTHER COMPLIANCE ISSUES

1. FIDELITY BOND

Section 1351(o) requires every plan to demonstrate adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for a thirty (30) day notice to the Director prior to cancellation.

DEFICIENCY

The Department's examination found that the fidelity policy provided for review did not provide the required thirty (30) days' notice. The policy includes a cancellation notice that states the insurer will "endeavor" to provide such notice to the Director. In addition, the policy contains a negate clause which provides that: "Failure to provide notice of

cancellation to a Scheduled Party shall impose no liability of any kind or nature whatsoever on the underwriter and shall not amend or extend the effective date of policy cancellation or invalidate the cancellation". The word "endeavor" is defined as an "earnest attempt". The Regulations state that the fidelity bond "shall" provide for 30 days' notice to the Director prior to cancellation. The word "endeavor" and the negate clause must be removed from the policy in order to comply.

REQUIRED ACTION

The Plan is required to electronically file a copy of its fidelity bond policy that is in compliance with the above Section and Rule. The Plan is also required to provide the written procedures implemented, the date of implementation, and to state the management position(s) responsible for ensuring continued compliance.

2. MANAGEMENT CHANGES

Section 1352(c) and Rule 1300.52.2 set forth the requirements that a plan shall, within five (5) days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions; duties, and relationships which are referred to in this subdivision.

DEFICIENCY

The Department's examination disclosed that the Plan had multiple management changes; however, the Plan did not file an amendment within five (5) days as required by the above Section and Rule. The following changes were noted:

- Board Member Appointed Effective 9/24/15
- Board Member Resigned Effective 9/24/15
- Board Member Resigned Effective 11/20/15

REQUIRED ACTION

The Plan is required to state the policies and procedures implemented to ensure that any changes in personnel are filed within five (5) working days as required by Section 1352(c), the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Section stated above.

SECTION IV. INTERNAL CONTROL

Section 1384, 1345 (s), and Rule 1300.45 (q) include requirements for filing financial statements in accordance with generally accepted accounting principles (GAAP) and

other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

The Department's examination disclosed the following weaknesses in internal control:

1. UNTIMELY UPLOAD OF NEW CONTRACT RATE

The Department's examination disclosed that the new contract rates for Santa Clara Valley Medical Center were not uploaded timely, resulting in an underpayment of claims. Samples PD-15 and PD-28 were paid at the old contract rate of 120 percent instead of the new contract rate of 132 percent.

2. OVERPAYMENT OF INTEREST

The Department's examination disclosed the following concerns with overpayments of interest:

- An overpayment of interest was noted in sample HD-11. The claim was paid \$12,189 timely with no interest due. Subsequently, the Plan made an adjustment to correct the underpayment, and paid an additional amount of \$15,440 with interest and penalty. The Department's calculation of interest and penalty was \$581.05, and the Plan's payment of interest and penalty was \$1,047.83, resulting in an overpayment of interest by \$466.78, or 80 percent. The Plan's calculation of interest was based on the total claim amount of \$28,331 instead of the net adjusted amount.
- An overpayment of interest was noted in sample PD-34. The claim was paid \$12,240 timely with no interest due. Subsequently, the Plan made an adjustment to correct the underpayment, and paid an additional amount of \$13,507 with interest and penalty. The Department's calculation of interest and penalty was \$366.35, and the Plan's payment of interest and penalty was \$719.47, resulting in an overpayment of interest by \$353.12, or 96 percent. The Plan's calculation of interest was based on the total claim amount of \$25,746 instead of the net adjusted amount.
- Overpayments of interest were noted in samples L-32, L-37, and L-38. The claims

were paid late and small amounts of interest ranging from 9 cents to \$1.08 were due but not paid by the Plan. Subsequently, the Plan made adjustments to pay the remaining amounts of interest owed plus additional penalties; however, it overpaid interest by incorrectly calculating the interest using the total claim amount that was previously paid instead of only the interest amount owed.

The overpayment of interest indicates that the Plan needs to review its methodology of calculating claims interest to safeguard its assets.

3. STALE DATED CHECKS/ESCHEAT UNCLAIMED PROPERTY

The Department's examination disclosed that the Plan did not follow its policy and procedures for stale dated checks as follows:

- Nine outstanding checks totaling \$7,654 that were more than three years old.
- Multiple outstanding claim checks totaling \$112,526.80 that were more than 180 days old in the Wells Fargo A/P account. These checks should be voided, and a specific liability account should be created for uncashed checks.

REQUIRED ACTION

The Plan is required to state the policies and procedures implemented to resolve the above concerns, the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response is required to this Section.



Santa Clara
Family Health Plan

The Spirit of Care

**DMHC Routine Examination
Finding #1 – Misdirected Claims
Updated Policy & Procedure**

CONFIDENTIAL

POLICY



Santa Clara
Family Health Plan

Policy Title:	Misdirected Claims	Policy No.:	CL02
Replaces Policy Title (if applicable):	Misdirected Claims	Replaces Policy No. (if applicable):	CL001_04
Issuing Department:	Claims	Policy Review Frequency:	At least annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> 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

Requirements:

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 (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

The Information Technology Department is responsible to post the outbound misdirected claims file 5010 "837i / 837p to a secure FTP site for pick-up.

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

- May provide feedback to other departments and/or divisions within SCFHP to ensure that the misdirected claims process is operating effectively and efficiently.
- Validates and confirms that all outbound misdirected claims files are successfully transmitted.
- 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.

POLICY

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

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

IV. References

Title 28, California Code of Regulations, Section 1300.71(b) (2)
 Claims Processing Time Limits and Measurements - Assembly Bill -AB1455

V. Approval/Revision History

First Level Approval			Second Level Approval	
<div style="font-family: cursive; font-size: 1.2em;">Arlene Bell</div>			<div style="font-family: cursive; font-size: 1.2em;">David Cameron</div>	
Signature			Signature	
Arlene Bell			DAVID CAMERON	
Name			Name	
Interim Claims Director			CFO	
Title			Title	
9/29/16			9-29-16	
Date			Date	
Version Number	Change (Original/Reviewed/Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original			

PROCEDURE



Santa Clara
Family Health Plan

Procedure Title:	Misdirected Claims Procedures	Procedure No.:	CL02.01
Replaces Procedure Title (if applicable):	Misdirected Claims	Replaces Procedure No. (if applicable):	CL001_04
Issuing Department:	Claims	Procedure Review Frequency:	At least Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

1. PROCEDURE

A. Misdirected Claims Received

1. Santa Clara Family Health Plan (SCFHP) is to identify who is financially responsible for services between SCFHP and a capitated sub-contracted provider group or IPA.
2. For all provider claims, both contracted and non-contracted, which involve both emergency and non-emergency services, SCFHP is to forward any claim whereby all claim lines are denied as the financial responsibility of another payer, and the payment amount is zero, to the financially responsible party within ten (10) working days from the date of receipt.
 - a) If all services are the capitated sub-contracted provider group's risk, SCFHP will forward misdirected claims to the appropriate payer by using an Event Category code of "CEDI – Claims EDI" with Event Code of "MCLM – Misrouted Claims" from the claims processing system module.
 - b) If services are "split risk", SCFHP's Claims Department is to deny "split risk" claims lines with a denial reason of "the financial responsibility of another payer" and send a Remittance Advice (RA) to providers with instructions to bill the capitated provider. Split risk is not considered to be a "Misdirected Claim".
 - c) If all services are not the capitated sub-contracted provider group's risk, SCFHP will process claims accordingly.
 - d) If the member is not on file, the Claims Department will review the claim image in order to verify eligibility, process claim accordingly, and send a notice of denial to provider.

B. Misdirected Outbound Claims Files

1. A daily automated active batch job process extracts all claims data from the claims processing

PROCEDURE

system for those claims that were denied as the financial responsibility of another payer.

2. Once claims data is extracted from the claims processing system, SCFHP creates an outbound file of 5010 837i/837p.
3. The outbound 837i/837p misdirected claims files are then posted to SCFHP's secure FTP site for pick-up by trading partners.

C. Misdirected Outbound Claims File Validation

1. The Claims Manager is to validate if outbound misdirected claims files are transmitted successfully by:
 - a) Reviewing the Misrouted Claims Activity Log report which is sent in a daily e-mail.
 - b) Performing daily monitoring of misdirected claims to ensure that the ten (10) working day standard is met and that misdirected claim files are sent to the correct payer. For example, misdirected claims found to be approaching un-timeliness, such as misdirected claims batch received by SCFHP greater than eight (8) days from the original received date, are to be immediately fast tracked to ensure these claims do not fall out of compliance.
2. If misdirected claim files are not transmitted successfully, then the Claims Manager is to report the issue to the Information Systems Department and ensure that any required follow-up is performed.
3. Upon notification from a capitated sub-contracted provider group or IPA of a failed misdirected claim file, the SCFHP Information System Department is to fix the failed outbound misdirected claim file within two (2) working days of the date of receipt.

D. Misdirected Provider Disputes Resolution

1. First Level Provider Dispute Resolutions (PDRs) are to be forwarded to capitated sub-contracted provider groups or IPAs within ten (10) working days of the date of receipt.
2. Second Level PDRs are to be acknowledged and processed within the SCFHP PDR Unit. through SCFHP PDR unit.

E. Misdirected Tracer Claims

1. EDI or Paper claims are to be forwarded to capitated sub-contracted provider group or IPA within ten (10) working days of the date of receipt.

2. DEFINITIONS

PROCEDURE

“Misdirected Claim” means a claim submitted by a provider to SCFHP, either on paper or electronically, that is not the financial responsibility of SCFHP, but where claim lines are the financial responsibility of one of its capitated sub-contracted provider groups.

“Working Days” means Monday to Friday, excluding federal holidays.

“Day of Receipt” means the working day when the claim, by physical or electronic means, is first delivered to SCFHP. In the situation where a claim is sent to the incorrect party, the date of receipt shall be the working day when the claim, by physical or electronic means, is first delivered to the party responsible for processing the claim.

“Remittance Advice” (RA) is a statement that explains claim payments or reason of denial that is sent to the provider of service. SCFHP listing services provided, amount billed, discounts, withholds, patient coinsurance and copayments, and payable amounts.

“Independent Practice Association” (IPA) means an organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA, in turn, contracts with individual providers to provide services with on a capitated or fee-for-service basis.

“Participating Provider Group (PPG)” means group of doctors contracted with health plan or a plan partner, that members must receive their medical care from.

3. APPROVAL/REVISION HISTORY

Version Number	Change (Original/Reviewed/Revised)	First Level Approval	Second Level Approval
1	Original	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"><i>Arlene Bell</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature <i>Arlene Bell</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name <i>Interim Claim Director</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title <i>9/29/16</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"><i>David Cameron</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature <i>DAVID CAMERON</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name <i>CEO</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title <i>9-29-16</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>



Santa Clara
Family Health Plan

The Spirit of Care

DMHC Routine Examination
Finding #2 – Fidelity Policy Notification
Updated Policy

CONFIDENTIAL

POLICY



Santa Clara
Family Health Plan

Policy Title:	Fidelity Policy Cancellation - DMHC Notification	Policy No.:	
Replaces Policy Title:		Replaces Policy No.:	
Issuing Department:	Finance	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose:

The purpose of this policy is to specify Santa Clara Family Health Plan's (SCFHP) notification requirements to the Department of Managed Health Care (DMHC) in the event of notification of cancellation of its fidelity insurance policy.

II. Policy:

Section 1351(o) requires SCFHP to demonstrate adequate insurance coverage to respond to claims for damages arising out of the furnishing of health care services.

Rule 1300.76.3 requires each Plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner and employees of the Plan, whether or not compensated. The fidelity bond shall provide for notification of the Director of the DMHC thirty (30) days prior to cancellation.

SCFHP shall ensure that the requisite notification verbiage is included on the current and subsequent fidelity insurance policies, as per the attached example (Attachment A) which reads:

"In consideration of the premium charged, if the Underwriter cancels this Policy, the Underwriter will provide notice of such cancellation to the individual(s) or entity(ies) identified in the schedule below (each a "Scheduled Party") at the address set forth net to the Scheduled Party's name, stating when, not less than thirty (30) days thereafter, such cancellation shall be effective. Scheduled Party: Director, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814"

III. Responsibilities:

SCFHP's Controller is responsible for carrying out the terms of this policy as follows:

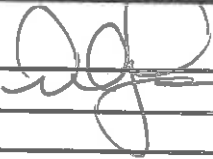

- Ensuring the required verbiage is included in each fidelity insurance policy
- Ensuring that the insurance carrier sends the proper notification to DMHC annually

IV. References:

DMHC: Section 1351(o); Rule 1300.76.3

POLICY

V. Approval/Revision History

First Level Approval		Second Level Approval		
Signature 		Signature 		
Name: Neal Jarecki		Name: David Cameron		
Title Controller		Title CFO		
Date: 9.28.16		Date: 9.29.16		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Revised			

ENDORSEMENT NO. MPE-1SNTCLRAHA-08-16
NOTICE OF CANCELLATION TO SCHEDULED PARTY ENDORSEMENT

This Endorsement, effective at 12:01 a.m. on December 31, 2015, forms part of

Policy No. MCM-01059-15
Issued to Santa Clara County Health Authority
Issued by Atlantic Specialty Insurance Company
Section(s) GT&C

In consideration of the premium charged, if the Underwriter cancels this Policy, the Underwriter will provide notice of such cancellation to the individual(s) or entity(ies) identified in the schedule below (each a "Scheduled Party"), at the address set forth next to the Scheduled Party's name, stating when, not less than thirty (30) days thereafter, such cancellation shall be effective.

<u>Scheduled Party:</u>	<u>Scheduled Party Address:</u>
California Department of Managed Health Care	980 9 th Street, Suite 500 Sacramento, CA 95814-2725

All other terms, conditions and limitations of the Policy shall remain unchanged.



Santa Clara
Family Health Plan

The Spirit of Care

DMHC Routine Examination
Finding #3 – Changes in Key Personnel
Updated Policy

CONFIDENTIAL

POLICY



Santa Clara
Family Health Plan

Policy Title:	Key Personnel Filing	Policy No.:	CP35
Replaces Policy Title:		Replaces Policy No.:	
Issuing Department:	Compliance	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose:

The purpose of this policy is to establish the Santa Clara Family Health Plan requirements to file a confidential key personnel filing with the Department of Managed Health Care (DMHC).

II. Policy:

Santa Clara Family Health Plan (SCFHP), a public agency, will provide a key personnel filing to DMHC, in the form required, within five (5) calendar days of any of the following changes in SCFHP personnel or governing board:

- (a) There is an addition or deletion of a governing board member, executive officer, or principal management person or persons occupying similar positions or performing similar functions, or a substantial and material change in the duties of any such person.
- (b) There is the addition or deletion of a principal creditor, a material change in the terms of the obligation to a principal creditor, a material increase or decrease in the amount due a principal creditor other than (except in the case of a demand obligation) by the normal terms of the obligation, or a default in the obligation to a principal creditor.

III. Responsibilities:

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

- The Compliance Department is responsible for:
 - Initiating, monitoring, reporting, auditing, and documenting processes related to key personnel filings with DMHC.
 - Reporting Compliance activities, requirements, and issues to the Compliance Committee related to key personnel filings with DMHC.
 - Communicating to the Business Units regarding all applicable requirements, changes, and issues related to key personnel filings.
- The business units are responsible for:
 - Participating in all applicable key personnel filing activities as assigned.
 - Submitting all required documents to the Compliance Department related to a key personnel filing.


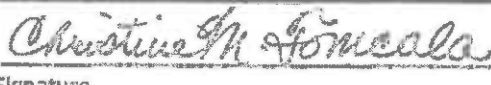
POLICY

- o Immediately notifying the Compliance Department of any new or terminating staff or governing board members requiring a key personnel filing.

IV. References:

28 CCR § 1300.52.2

V. Approval/Revision History

First Level Approval			Second Level Approval	
				
Signature			Signature	
Name: Beth Paige			Name: Christine Tomcala	
Title Compliance Officer			Title Chief Executive Officer	
Date 9-23-16			Date 9-23-16	
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Revised			



Santa Clara
Family Health Plan

The Spirit of Care

DMHC Routine Examination
Finding #4 – Contract Rate Change
Configuration
Updated Policy & Procedure

CONFIDENTIAL



Policy Title:	Database Configuration	Policy No.:	IT35
Replaces Policy Title (if applicable):	Database Configuration Standards	Replaces Policy No. (if applicable):	IT040
Issuing Department:	Information Technology	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose

The purpose of this policy is to ensure all changes to core system databases requested by business users and regulatory agencies are configured in accordance with accepted standards.

II. Policy

Santa Clara Family Health Plan (SCFHP) configures changes requested by the business users and regulatory agencies in the core system databases.

III. Responsibilities

The Information Technology Department is responsible for:

- Reviewing requirements and documenting configuration requests.
- Testing the implementation as needed and providing the business units with documentation for additional testing or approval.
- Implementing the approved changes.
- Communicating the implemented changes to the business units.

The business units are responsible for:

- Providing requirements for requested and regulatory configuration changes.
- Reviewing configuration testing and performing additional testing of the changes implemented.
- Approving major changes prior to production implementation.

IV. References

DHCS: SCFHP Contract with DHCS Exhibit A, Attachment 3

CMS: Three-Way contract between SCFHP, DHCS, CMS

NCQA: NCQA Health Plan Standards, 2016

V. Approval/Revision History

First Level Approval			Second Level Approval	
Signature Daniel Welch			Signature Jonathan Tamayo	
Name Director, Business Integration			Name Chief Information Officer	
Title			Title	
Date			Date	
Version Number	Change (Original/Reviewed/Revised)	Reviewing Committee (If applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Revised			



Procedure Title:	Implementation of Database Configuration	Procedure No.:	IT35.1
Replaces Procedure Title (if applicable):	NA	Replaces Procedure No. (if applicable):	NA
Issuing Department:	Information Technology	Procedure Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose

The purpose of this procedure is to establish the Santa Clara Family Health Plan (SCFHP) requirements for implementing configuration changes requested by business users or required by regulatory agencies in the core systems.

II. Procedure

- a. When the business submits a ticket for a change request or a regulatory agency advises there are program changes, SCFHP IT reviews the request to determine the complexity of the change.
- b. For Major changes, SCFHP IT:
 - i. Reviews and documents the change requirements
 - ii. Meets with the applicable business unit(s) to review the requirements
 - iii. Performs the updates in the test system(s) and creates documentation for business unit approval
 - iv. Obtains written approval from the applicable business unit(s) prior to implementing changes in the production system(s)
 - v. Logs changes in the applicable system(s) Config Log
 - vi. Reviews and validates the changes in production
 - vii. Notifies applicable business unit(s) that the changes have been implemented in production and provides the documentation.
 - viii. Notifies the Claims Audit department that the changes have been implemented in production and provides the documentation to support focused audits.
- c. For Minor changes, SCFHP IT:
 - i. Implements the changes based on the information provided by the business unit(s) in the ticket or documentation from the regulatory agency
 - ii. Creates documentation for business unit(s)
 - iii. Logs changes in the applicable system(s) Config Log
 - iv. Reviews and validates the changes in production
 - v. Notifies applicable business unit(s) that the changes have been implemented in production and provides the documentation.
 - vi. Notifies the Claims Audit department that the changes have been implemented in production and provides the documentation to support focused audits.
- d. The business unit(s):

- i. Provide initial requirements for requested changes
- ii. Review and approve applicable changes in the test system(s)
- iii. Review and validate the changes in the production system(s).
- iv. The Claims Audit department performs focused audits based on the changes.

III. Policy Reference

IT35 Database Configuration

IV. Approval/Revision History

Version Number	Change (Original/ Reviewed/ Revised)	First Level Approval	Second Level Approval
1	Original	<div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name Daniel Welch</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title Director, Business Integration</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>	<div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name Jonathan Tamayo</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title Chief Information Officer</div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>



Santa Clara
Family Health Plan

The Spirit of Care

**DMHC Routine Examination
Finding #5 – Claims Interest
Updated Policy & Procedure**

CONFIDENTIAL

POLICY



Santa Clara
Family Health Plan

Policy Title:	Interest on the Late Payment of Claims	Policy No.:	CL01
Replaces Policy Title (if applicable):	Interest on the Late Payment of Claims	Replaces Policy No. (if applicable):	CL034, CL-03-03 and CL002-02
Issuing Department:	Claims Department	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose

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

II. Policy

Interest Payment Requirements

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

Medi-Cal (Contracted & Non-Contracted Providers)

All claims shall be paid within forty-five (45) working days; otherwise, interest shall begin accruing on the first day following the forty-fifth (45th) working day. The payment of interest applies to both contracted and non-contracted providers for the Medi-Cal and Healthy Kids lines 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 (Non-Contracted Providers)

Interest on late payment of Cal Medi-Connect (CMC) claims applies only to non-contracted providers. 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.

Cal Medi-Connect (Contracted Providers)

Interest does not apply to Cal Medi-Connect (CMC) sixty-day (60) claims.

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.

POLICY

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, 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



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

V. Approval/Revision History

First Level Approval		Second Level Approval		
 Signature		 Signature		
Arlene Bell Name		DAVID CAMERON Name		
Interim Claim Director Title		CFO Title		
9/29/16 Date		9-29-17 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			

PROCEDURE



Santa Clara
Family Health Plan

Procedure Title:	Interest on the Late Payment of Claims Procedure	Procedure No.:	CL01.01
Replaces Procedure Title (if applicable):	Interest on the Late Payment of Claims	Replaces Procedure No. (if applicable):	CL03-03, CL034
Issuing Department:	Claims	Procedure Review Frequency:	Annually
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

1. PROCEDURE

A. Reasonable and Customary Claims Payment of Claims

Payment to non-contracted physicians for a member shall be at a reasonable and customary fee schedule that meets State and Federal regulatory requirements, including the Gould criteria.

B. Interest Calculations for Non-Emergency Services on Contracted and Non-contracted Claims

1. Medi-Cal and Healthy Kids

For the purposes of calculating interest, the calculation begins with the first calendar day after the 45th working day period (or 62nd calendar day), and continues to include every calendar day up to, and including, the "Date of Payment" (date mailed).

Late payments on clean/complete claims shall automatically include interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

Failure to comply with this requirement shall result in payment to the claimant of a ten dollar (\$ 10) fee in addition to the interest amount.

Interest Calculation Formula: # of Delayed Days X total Claims Payment X (Interest rate/365)¹

2. Medicare

a) Contracted 60-day claims

Interest, as well as the CMS Provider Dispute Resolution, process does not apply to Medicare Contracted 60-day claims.

b) Non-contracted 30-day claims

Both interest and the CMS Provider Dispute Resolution process shall be applicable. Late

¹ Use 366 days during a Leap Year

PROCEDURE

interest payment shall be calculated for “clean/complete” claims not paid within 30 calendar days from the oldest (original) date of receipt to the date the check is mailed.

For the purposes of calculating interest, the calculation begins with the first calendar day after the 30th calendar day and continues to include every calendar day up to and including the “Date of Payment” (date mailed).

Interest Calculation Formula: # of Delayed Days X total Claims Payment X (Interest rate/365)²

Interest Rates used are the "Prompt Payment Interest Rates" determined by the U.S. Department of Treasury's Bureau of Fiscal Service. These rates are listed on the Bureau's website at: <https://www.fiscal.treasury.gov/fs-services/gov/pmt/promptPayment/rates.htm>³

C. Interest calculations for Emergency Services on Contracted and Non-contracted Claims:

1. Medi-Cal and Healthy Kids

Late payment on a complete **claim for emergency services** and care, which is neither contested nor denied, shall automatically include the greater of either fifteen dollars (**\$15**) for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of **15 percent (15%) per annum** for the period of time that the payment is late.⁴

2. Medicare

Refer to the previous Section B. 2. Interest calculations for Non-Emergency Services on Contracted and Non-Contracted Claims, Medicare. These definitions and calculations are applicable to Emergency Services on Contracted and Non-contracted Medicare Claims.

D. Summary

If the claim is being adjusted/reprocessed **and** was ‘clean’/’complete’ at the time of the original submission, the claim **must** be processed with the ‘**oldest**’ (original) received date. Examples of a “clean” or “complete” claim that would apply interest using the ‘**oldest**’ (original) received date include: 1) wrong contract rate applied; 2) processed claim with the wrong member information; or 3) keying error, partial payment, etc.

For Medicare claims, interest **applies only to non-contracted providers**. The CMS Provider Dispute Resolution process also **only** applies to **non-contracted providers**. The formula [# of Delayed Days X total Claims Payment X (Interest rate/365⁵)] for calculating interest **is the same of all lines of business**.

E. Late Claim Determination of Interest Start Date– Medi-Cal and Healthy Kids Claims

Santa Clara Family Health Plan (SCFHP) will apply a strict 45-working day rule (or 63 calendar days) (less Federal Holidays, if any) to determine if a claim has been paid on time or is late

² Use 366 days during a Leap Year

³ The relevant interest rate is the rate on the day the agency began to owe interest – the day after the day the payment is was due.

⁴ California Health and Safety Code Section 1371.

⁵ Use 366 days within a Leap Year.

PROCEDURE

SCFHP will count 45-working days (or 63 calendar days) starting with the day following the day in which the claim is received from the provider (the date of receipt shall be counted as Day 0, and the following day as Day 1)

SCFHP is aware that some health plans have historically counted the “day of receipt” as part of their initial 45-working day count to determine if a claim was paid on time or was late. However, California law is clear that the (45-working day or 63 calendar days) count begins on the day following the date of receipt.

Example: Working Days and Interest Calculation

Non-Medicare Example for 45 day claims

For the purpose of calculating interest exclude the first day (day of receipt) and include the last day. The day of receipt is considered day zero, and the count begins the next day. Holidays not included in working days. Cal. Gov't Code § 6800; Cal. Civ. Code §§ 10 and 11; Cal. Civ. Proc. Code § 12a

To calculate working days the following methodology shall be used:

Received Date = Day 0

First Working Day After Receipt = Day 1

45 “working days” (including Day 1) = 45 Days (or 63 calendar days)

Therefore, for late claims, interest begins to accrue on the 1st calendar day after the 45th working day.

2. DEFINITIONS

“Complete claim” means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: “reasonably relevant information”.⁶

Medical Claim: CMS 1500 form (paper or electronic submission) including attachments and supplemental information or documentation, which provides: “reasonably relevant information” or “information necessary to determine payer liability.”

Hospital Claim: UB 04 (paper or electronic submission) including attachments and supplemental information or documentation, which provides: “reasonably relevant information” or “information necessary to determine payer liability.”

“Date of Receipt” means 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.⁷

“Date of Payment” means the *date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery*

⁶ California Code of Regulations section 1300.71.

⁷ California Code of Regulations section 1300.71.

PROCEDURE

service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in California Evidence Code section 641.

"Working Days" means Monday through Friday and excludes recognized federal holidays.⁸

Federal Holidays are listed below:

- New Year's Day,
- Martin Luther King Jr. day,
- Washington's Birthday
- Memorial Day
- Independence Day,
- Labor Day,
- Columbus Day,
- Veterans Day,
- Thanksgiving Day
- Christmas Day

"Calendar Days" means *all* calendar days *without* exclusion.

3. Approval/Revision History

Version Number	Change (Original/Reviewed/Revised)	First Level Approval	Second Level Approval
1	Original	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"><i>Arlene Bell</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature <i>Arlene Bell</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name <i>Interim Claim Director</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title <i>9/29/16</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"><i>David Cameron</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Signature <i>DAVID CAMERON</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Name <i>CFO</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Title <i>9-29-17</i></div> <div style="border-bottom: 1px solid black; padding-bottom: 5px;">Date</div>

⁸ California Code of Regulations section 1300.71.



Santa Clara
Family Health Plan

The Spirit of Care

**DMHC Routine Examination
Finding #6 – Stale-Dated Checks
Updated Policy**

CONFIDENTIAL

POLICY



Santa Clara
Family Health Plan

Policy Title:	State-Dated Checks Policy	Policy No.:	
Replaces Policy Title:		Replaces Policy No.:	
Issuing Department:	Finance	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Healthy Kids	<input checked="" type="checkbox"/> CMC

I. Purpose:

The purpose of this policy is to specify how Santa Clara Family Health Plan's (SCFHP) policy will ensure that outstanding amounts payable to providers and vendors are properly recorded in its financial statements and ultimately escheated to the State of California.

II. Policy:

On a monthly basis, SCFHP will routinely:

1. Review amounts outstanding per its bank reconciliations
2. Make reasonable and appropriate efforts to notify payees and resolve outstanding payments
3. Accrue appropriate amounts as liabilities in the financial statements for outstanding payments
4. Properly escheat balances to the State of California.

III. Responsibilities:

SCFHP's Controller is responsible for carrying out the terms of this policy as follows:

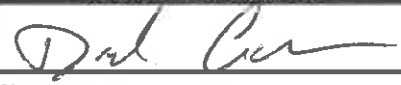
- Ensuring that bank reconciliations are prepared and reviewed monthly.
- Ensuring that regular efforts are made to contact providers and vendors for which payments have not been cashed/cleared
- Ensuring that all payments not clearing SCFHP's bank account after six months are reclassified as liabilities on its financial statements.
- Ensuring that outstanding payments are regularly escheated to California's State Controller's Office (SCO) per SCO requirements and SCFHP Escheatment Policy.

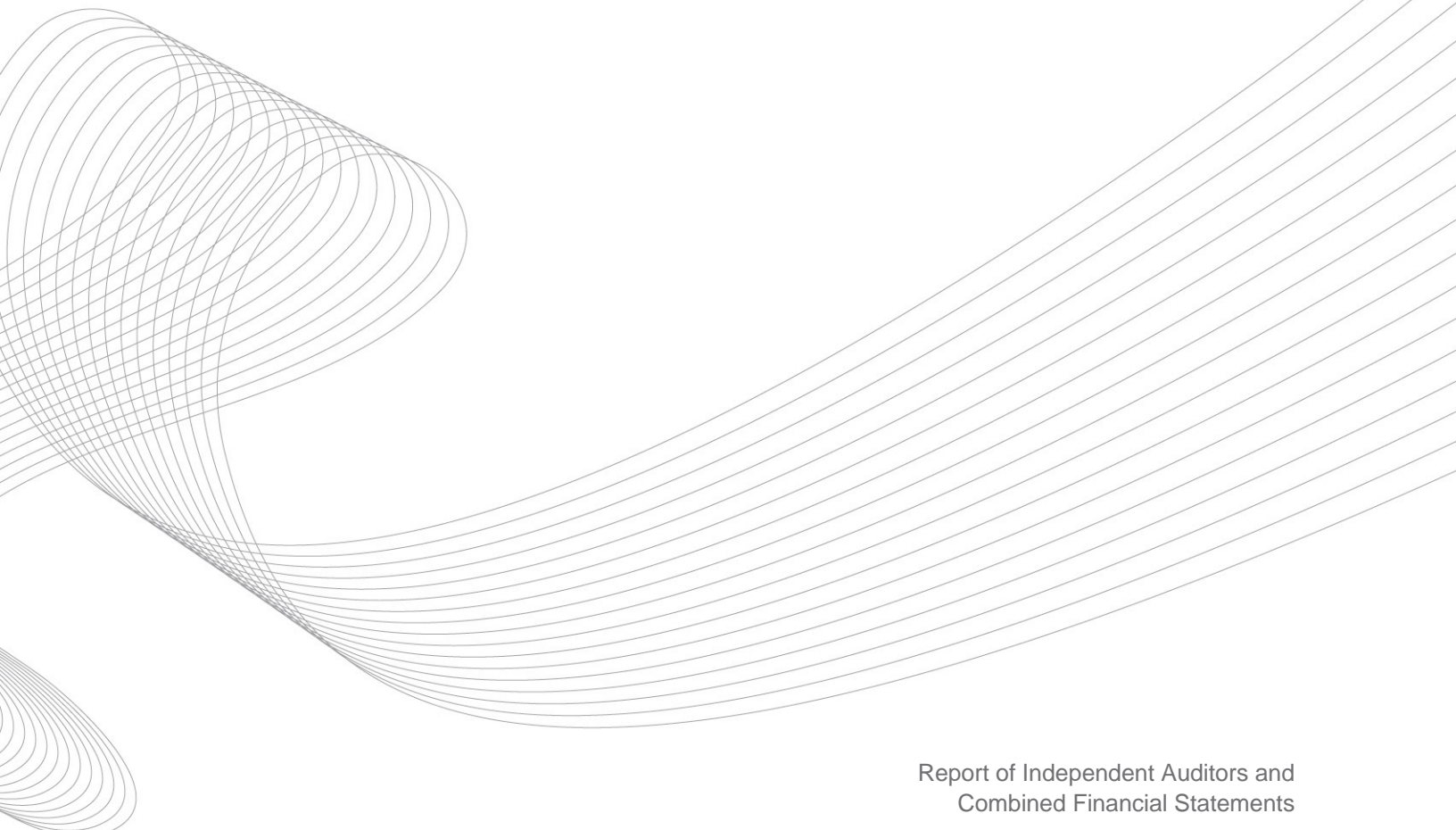
IV. References:

None

POLICY

V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature		Signature		
Name: Neal Jarecki		Name: Dave Cameron		
Title: Controller		Title CFO		
Date 9-28-16		Date 9-29-16		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Revised			



Report of Independent Auditors and
Combined Financial Statements

**Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
and Santa Clara Community
Health Authority**

June 30, 2016 and 2015

MOSS ADAMS LLP

Certified Public Accountants | Business Consultants

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MANAGEMENT'S DISCUSSION AND ANALYSIS

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
MANAGEMENT'S DISCUSSION AND ANALYSIS
June 30, 2016, 2015, and 2014**

INTRODUCTION:

In accordance with the Governmental Accounting Standards Board ("GASB") Codification Section 2200, Comprehensive Annual Financial Report, the management of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority, (the "JPA") (collectively, the "Health Authority") has prepared this discussion and analysis to provide readers and interested parties with an overview of the organizations' financial activities for the fiscal years ended June 30, 2016, 2015, and 2014. This discussion should be reviewed in conjunction with the Health Authority's combined financial statements and accompanying notes to enhance the reader's understanding of the Health Authority's financial performance.

ORGANIZATION:

Santa Clara County Health Authority is a licensed health maintenance organization that operates in Santa Clara County (the "County"). The County's Board of Supervisors established Santa Clara County Health Authority in August 1995 in accordance with the State of California Welfare and Institutions Code (the "Code") Section 14087.38. During 1997, the Health Authority obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975.

The JPA is a licensed health maintenance organization that operates in the County. The County's Board of Supervisors established the JPA in October 2005 in accordance with the State of California Welfare and Institutions Code Section 14087.54. During 2006, the JPA obtained licensure under the Knox-Keene Health Care Services Plan Act of 1975.

OVERVIEW OF FINANCIAL STATEMENTS:

The Health Authority's annual combined financial report consists of three statements – Statements of Net Position; Statements of Revenues, Expenses, and Changes in Net Position; and Statements of Cash Flows and accompanying notes. The statements report the following financial information:

- The combined Statements of Net Position present the Health Authority's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position.
- The combined Statements of Revenues, Expenses, and Changes in Net Position present the results of operations during the fiscal years and the resulting changes in net position.
- The combined Statements of Cash Flows identify sources and uses of cash from operating activities, investing activities, and other financing activities.

The following discussion and analysis addresses the Health Authority's overall program activities.

FINANCIAL HIGHLIGHTS:

- Total enrollment increased 10.4% to 272,667 members at June 30, 2016 from 246,940 members at June 30, 2015. Total enrollment increased 28.3% to 246,940 members at June 30, 2015 from 192,523 members at June 30, 2014.
- Net position increased by \$27,662,501 to \$100,293,455 for the fiscal year ended June 30, 2016 from \$72,630,954 for the fiscal year ended June 30, 2015 due to operating income of \$27,149,221 and non-operating income of \$513,280. Net position increased by \$31,758,374 to \$72,630,954 for the fiscal year ended June 30, 2015 from \$40,872,580 for the fiscal year ended June 30, 2014 due to operating income of \$37,140,604 and non-operating income of \$252,726.
- Total assets and deferred outflows of resources increased to \$576,527,455 as of June 30, 2016 from \$295,855,303 as of June 30, 2015. Total assets and deferred outflows of resources increased to \$295,855,303 as of June 30, 2015 from \$114,497,109 as of June 30, 2014.
- Total liabilities and deferred inflows of resources increased to \$476,234,000 at June 30, 2016 from \$223,224,349 at June 30, 2015. Total liabilities and deferred inflows of resources increased to \$223,224,349 at June 30, 2015 from \$73,624,529 at June 30, 2014.
- The current ratio (current assets divided by current liabilities) of 1.23 as of June 30, 2016 reflected a slight decrease from 1.37 at June 30, 2015. The current ratio (current assets divided by current liabilities) of 1.37 as of June 30, 2015 reflected a slight decrease from 1.50 at June 30, 2014.

**SANTA CLARA COUNTY HEALTH AUTHORITY
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SANTA CLARA COMMUNITY HEALTH AUTHORITY
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June 30, 2016, 2015, and 2014**

CONDENSED COMBINED STATEMENTS OF NET POSITION:

	June 30			2016 to 2015		2015 to 2014	
	2016	2015	2014	Amount	% Change	Amount	% Change
Assets:							
Current assets	\$ 569,709,852	\$ 289,667,319	\$ 110,647,818	\$ 280,042,533	96.7%	\$ 179,019,501	161.8%
Capital assets	4,941,914	4,515,303	3,543,941	426,611	9.4%	971,362	27.4%
Other assets	305,350	305,350	305,350	-	0.0%	-	0.0%
Total assets	574,957,116	294,487,972	114,497,109	280,469,144	95.2%	179,990,863	157.2%
Deferred outflows of resources	1,570,339	1,367,331	-	203,008	14.8%	1,367,331	100.0%
Total assets and deferred outflows of resources	\$ 576,527,455	\$ 295,855,303	\$ 114,497,109	\$ 280,672,152	94.9%	\$ 181,358,194	158.4%
Liabilities:							
Current liabilities	\$ 462,966,493	\$ 211,535,798	\$ 73,624,529	\$ 251,430,695	118.9%	\$ 137,911,269	187.3%
Noncurrent liabilities	10,937,886	9,795,917	-	1,141,969	11.7%	9,795,917	100.0%
Total liabilities	473,904,379	221,331,715	73,624,529	252,572,664	114.1%	147,707,186	200.6%
Deferred inflow of resources	2,329,621	1,892,634	-	436,987	23.1%	1,892,634	100.0%
Net position:							
Net investment in capital assets	4,941,914	4,515,303	3,543,941	426,611	9.4%	971,362	27.4%
Restricted	305,350	305,350	305,350	-	0.0%	-	0.0%
Unrestricted	95,046,191	67,810,301	37,023,289	27,235,890	40.2%	30,787,012	83.2%
Total net position	100,293,455	72,630,954	40,872,580	27,662,501	38.1%	31,758,374	77.7%
Total liabilities, deferred inflows of resources, and net position	\$ 576,527,455	\$ 295,855,303	\$ 114,497,109	\$ 280,672,152	94.9%	\$ 181,358,194	158.4%

Assets and Deferred Outflows of Resources

For the fiscal year ended June 30, 2016, assets increased \$280,469,144 or 95.2% due primarily to increases in cash and premiums receivable due largely from the State of California. During the same period, deferred outflows of resources increased \$203,008 or 14.8% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2015, assets increased \$179,990,863 or 157.2% due primarily to increases in cash and premiums receivable due largely from the State of California. During the same period, deferred outflows of resources increased \$1,367,331 or 100% due to the implementation of GASB 68 reporting requirements of employee retirement plans.

Liabilities and Deferred Inflows of Resources

For the fiscal year ended June 30, 2016, liabilities increased \$252,572,664 or 114.1% due primarily to amounts due to the State of California and increases in medical cost reserves. During the same period, deferred inflows of resources increased \$436,987 or 23.1% due to the timing of amounts attributable to employee retirement plans.

For the fiscal year ended June 30, 2015, liabilities increased \$147,707,186 or 200.6% due primarily to amounts due to the State of California and increases in medical cost reserves. During the same period, deferred inflows of resources increased \$1,892,634 or 100% due to the implementation of GASB 68 reporting requirements of employee retirement plans.

Tangible Net Equity

The Health Authority's is required to maintain a minimum level of tangible net equity ("TNE") per its contract with the Department of Health Care Services ("DHCS"). TNE is defined as the excess of total assets over total liabilities, excluding subordinated liabilities and intangible assets. The Health Authority's TNE was \$100,293,455, \$72,630,954 and \$40,872,580 at June 30, 2016, 2015 and 2014. The Health Authority exceeded the minimum required TNE levels at all times during the three fiscal years.

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CONDENSED COMBINED RESULTS OF OPERATIONS:

	Fiscal Year			2016 to 2015		2015 to 2014	
	2016	2015	2014	Amount	% Change	Amount	% Change
Year end membership:							
Medi-Cal	260,029	235,194	187,200	24,835	10.6%	47,994	25.6%
Medicare	8,203	7,187	-	1,016	14.1%	7,187	100.0%
Healthy Kids	4,435	4,559	5,323	(124)	-2.7%	(764)	-14.4%
Total year end membership	<u>272,667</u>	<u>246,940</u>	<u>192,523</u>	<u>25,727</u>	<u>10.4%</u>	<u>54,417</u>	<u>28.3%</u>
Annual member months:							
Medi-Cal	3,039,258	2,683,104	1,928,866	356,154	13.3%	754,238	39.1%
Medicare	101,943	39,516	-	62,427	158.0%	39,516	100.0%
Healthy Kids	52,025	57,356	63,893	(5,331)	-9.3%	(6,537)	-10.2%
Healthy Families	-	-	212	-	0.0%	(212)	-100.0%
Healthy Workers	-	-	3,395	-	0.0%	(3,395)	-100.0%
Total annual member months	<u>3,193,226</u>	<u>2,779,976</u>	<u>1,996,366</u>	<u>413,250</u>	<u>14.9%</u>	<u>783,610</u>	<u>39.3%</u>
Operating revenues:							
Capitation and premium revenue	\$ 1,213,865,945	\$ 902,348,543	\$ 438,857,677	\$ 311,517,402	34.5%	\$ 463,490,866	105.6%
Operating expenses:							
Medical expenses	\$ 1,114,554,803	\$ 784,111,433	\$ 392,114,308	\$ 330,443,370	42.1%	\$ 391,997,125	100.0%
Marketing, general, and administrative expenses	35,646,645	26,265,436	21,268,777	9,381,209	35.7%	4,996,659	23.5%
Depreciation	1,412,014	810,274	316,078	601,740	74.3%	494,196	156.4%
Premium tax	44,809,237	36,020,796	23,069,507	8,788,441	24.4%	12,951,289	56.1%
Premium deficiency	(9,705,975)	18,000,000	-	(27,705,975)	-153.9%	18,000,000	100.0%
Total operating expenses	<u>1,186,716,724</u>	<u>865,207,939</u>	<u>436,768,670</u>	<u>321,508,785</u>	<u>37.2%</u>	<u>428,439,269</u>	<u>133.3%</u>
Operating income	<u>27,149,221</u>	<u>37,140,604</u>	<u>2,089,007</u>	<u>(9,991,383)</u>	<u>-26.9%</u>	<u>35,051,597</u>	<u>-350.8%</u>
Nonoperating revenues:							
Gain on legal settlement	-	-	5,996,969	-	0.0%	(5,996,969)	-100.0%
Interest income	513,280	252,726	235,443	260,554	103.1%	17,283	7.3%
Total nonoperating revenues	<u>513,280</u>	<u>252,726</u>	<u>6,232,412</u>	<u>260,554</u>	<u>103.1%</u>	<u>(5,979,686)</u>	<u>-95.9%</u>
Changes in net position	27,662,501	37,393,330	8,321,419	(9,730,829)	-26.0%	29,071,911	349.4%
Net position, beginning of year	72,630,954	40,872,580	32,551,161	31,758,374	77.7%	8,321,419	25.6%
Cumulative effect of change in accounting principle	-	(5,634,956)	-	5,634,956	-100.0%	(5,634,956)	100.0%
Adjusted net position, beginning of year	<u>72,630,954</u>	<u>35,237,624</u>	<u>32,551,161</u>	<u>37,393,330</u>	<u>106.1%</u>	<u>2,686,463</u>	<u>100.0%</u>
Net position, end of year	<u>\$ 100,293,455</u>	<u>\$ 72,630,954</u>	<u>\$ 40,872,580</u>	<u>\$ 27,662,501</u>	<u>38.1%</u>	<u>\$ 31,758,374</u>	<u>77.7%</u>

Membership and Enrollment

During the fiscal year ended June 30, 2016, the Health Authority experienced a significant enrollment increase in the Medi-Cal line of business, largely due to the continued increases in the Medi-Cal expansion ("MCE") and Cal Medi-Connect ("CMC") members.

During the fiscal year ended June 30, 2015, the Health Authority experienced a significant enrollment increase in the Medi-Cal line of business, largely due to the continued increase in MCE members (a program within Medi-Cal that began January 1, 2014). The Health Authority also experienced an enrollment increase due to the launch of the CMC program.

Operating Revenue

During the fiscal year ended June 30, 2016, operating revenues increased by \$311,517,402 or 34.5% to \$1,213,865,945 versus the prior year operating revenue of \$902,348,543. Much of the increase was attributable to continued growth in the MCE and CMC membership coupled with certain CCI capitation rate increases.

During the fiscal year ended June 30, 2015, operating revenues increased by \$463,490,866 or 105.6% to \$902,348,543 versus the prior year operating revenue of \$438,857,677. Much of the increase was attributable to substantial growth in the MCE and CMC membership.

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Health Care Expenses

During the fiscal year ended June 30, 2016, health care expenses increased by \$330,443,370 or 42.1% to \$1,114,554,803 versus the prior year of \$784,111,433. Much of the increase was attributable to substantial growth in the MCE and CMC membership, particularly the mix of higher-cost members utilizing Medicaid Managed Long Term Services and Supports ("MLTSS").

During the fiscal year ended June 30, 2015, health care expenses increased by \$391,997,125 or 100% to \$784,111,433 versus the prior year expense of \$392,114,308. Much of the increase was attributable to substantial growth in the MCE and CMC membership and the inclusion of in-homes support services ("IHSS") expenses.

The Health Authority's medical loss ratio ("MLR"), or medical expenses as a percentage of premiums revenue, was 91.8%, 86.9% and 89.3% for the fiscal years ended June 30, 2016, 2015, and 2014, respectively.

Premium Deficiency Reserve

During the fiscal year ended June 30, 2016, management reduced its estimated premium deficiency reserve ("PDR") on the CMC contract to \$8,294,025 for the fiscal year 2017 and the first six months of fiscal year 2018. The Health Authority may receive future upward revenue adjustments in the form of revised capitation rates, shared risk corridor payments, and HCC risk adjustment true-up payments; however, management cannot quantify the likelihood of receiving these adjustments.

During the fiscal year ended June 30, 2015, management recorded an estimated PDR of \$18,000,000 on the CMC contract for the fiscal year 2016 and the first six months of fiscal year 2017.

General and Administrative Expenses

During the fiscal year ended June 30, 2016, administrative expenses increased by \$9,381,209 or 35.7% to \$35,646,645 versus the prior year expense of \$26,265,436. Much of the increase was attributable to increased personnel costs incurred to implement the CMC program launched in 2015.

During the fiscal year ended June 30, 2015, administrative expenses increased by \$4,996,659 or 23.5% to \$26,265,436 versus the prior year expense of \$21,268,777. Much of the increase was attributable to start-up costs for the new CMC program.

The Health Authority's administrative loss ratio ("ALR"), or marketing, general, and administrative expenses as a percentage of capitation and premium revenue (including depreciation expense), was 3.1%, 3.0% and 4.9% for the fiscal years ended June 30, 2016, 2015, and 2014, respectively.

CONDENSED COMBINED CASH FLOW INFORMATION:

The table below summarizes the major sources and uses of cash and cash equivalents for the fiscal years ended June 30, 2016, 2015, and 2014:

	As of June 30		2016 to 2015 Change		2015 to 2014 Change		
	2016	2015	2014	Amount	% Change	Amount	% Change
Cash flows from operating activities	\$ 36,812,249	\$ 75,873,209	\$ (22,985,325)	\$ (39,060,960)	-51.5%	\$ 98,858,534	-430.1%
Cash flows from capital and financing activities	(1,764,386)	(4,407,515)	(336,389)	2,643,129	-60.0%	(4,071,126)	1210.2%
Cash flows from investing activities	513,280	252,726	235,443	260,554	103.1%	17,283	7.3%
Net change in cash and cash equivalents	35,561,143	71,718,420	(23,086,271)	(36,157,277)	-50.4%	94,804,691	-410.7%
Cash and cash equivalents, beginning of year	110,215,576	38,497,156	61,583,427	71,718,420	186.3%	(23,086,271)	100.0%
Cash and cash equivalents, end of year	\$ 145,776,719	\$ 110,215,576	\$ 38,497,156	\$ 35,561,143	32.3%	\$ 71,718,420	186.3%

The Health Authority considers all highly liquid instruments with a maturity of three months or less to be cash and cash equivalents. The Health Authority invests excess cash in the Santa Clara County Investment Pool, which can be withdrawn on demand.

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CONDENSED CAPITAL ASSET INFORMATION:

The table below summarizes the major changes in capital assets for the fiscal years ended June 30, 2016, 2015 and 2014. Capital assets largely included furniture and fixtures, computer hardware and software, and leasehold improvements:

	Fiscal Year Ended June 30,			2016 to 2015 Change		2015 to 2014 Change	
	2016	2015	2014	Amount	% Change	Amount	% Change
Beginning balance, net	\$ 4,515,303	\$ 3,543,941	\$ 507,596	\$ 971,362	27.4%	\$ 3,036,345	598.2%
Additions	2,067,654	1,781,636	3,352,425	286,018	16.1%	(1,570,789)	-46.9%
Reductions/adjustments	(229,029)	-	-	(229,029)	100.0%	-	0.0%
Depreciation expense	(1,412,014)	(810,274)	(316,078)	(601,740)	74.3%	(494,196)	100.0%
Ending balance, net	\$ 4,941,914	\$ 4,515,303	\$ 3,543,943	\$ 426,611	9.4%	\$ 971,360	27.4%

KEY FACTORS INFLUENCING THE FISCAL YEAR 2016-2017 BUDGET:

The Health Authority's Governing Board formally approved a budget for the fiscal year ending June 30, 2017. The budget generally anticipates modest increases in enrollment and capitation rates with much of the Healthy Kids program enrollment folding into Medi-Cal. The capital budget includes a provision for an investment of approximately \$7 million for a combined claims management system.

REQUESTS FOR INFORMATION

This financial report is designed to provide a general overview of the Health Authority's finances for interested parties. Questions concerning any of the information provided in this report or requests for additional information should be addressed to Santa Clara Family Health Plan, 210 East Hacienda Avenue, Campbell, CA 95008 or call (408) 376-2000.

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority

Report on the Financial Statements

We have audited the accompanying combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively, the "Health Authority"), which comprise the combined statement of net position as of June 30, 2016, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatements.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined net position of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority as of June 30, 2016, and the results in its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

Prior Period Financial Statements

The combined financial statements of the Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively, the "Health Authority") as of and for the year ended June 30, 2015, were audited by other auditors whose report thereon dated December 16, 2015, expressed an unmodified opinion on those statements.

Other Matters

Required Supplementary Information

The accompanying Management's Discussion and Analysis on pages 1 through 5, schedule of proportionate share of the net pension liability, and supplementary schedule of contributions on pages 26 through 28 are not a required part of the combined financial statements but are supplementary information required by the Governmental Accounting Standards Board who considers them to be an essential part of financial reporting for placing the combined financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Health Plan's management. We have applied certain limited procedures in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the combined financial statements, and other knowledge we obtained during our audit of the combined financial statements. We do not express an opinion or provide an assurance on the supplementary information because limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Mass Adams LLP

San Francisco, California
October 27, 2016

COMBINED FINANCIAL STATEMENTS

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF NET POSITION
June 30, 2016 and 2015**

	<u>2016</u>	<u>2015</u>
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets		
Cash and cash equivalents	\$ 145,776,719	\$ 110,215,576
Premiums receivable	417,166,970	177,539,907
Due from Santa Clara Family Health Foundation	-	3,612
Prepays and other assets	6,766,163	1,908,224
Total current assets	569,709,852	289,667,319
Capital assets, net	4,941,914	4,515,303
Assets restricted as to use	305,350	305,350
Total assets	574,957,116	294,487,972
Deferred outflows of resources	1,570,339	1,367,331
Total deferred outflows of resources	1,570,339	1,367,331
Total assets and deferred outflows of resources	<u>\$ 576,527,455</u>	<u>\$ 295,855,303</u>
LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION		
Current liabilities		
Accounts payable and accrued liabilities	\$ 13,489,979	\$ 14,457,210
Amounts due to the State of California	117,992,329	31,082,780
In-home supportive services payable	238,387,141	69,537,810
Due to Santa Clara County Valley Health Plan and Kaiser	6,604,472	33,642,570
Medical incurred but not reported claims and medical claims payable	80,305,145	46,624,110
Provider incentives and other medical liabilities	3,812,902	3,103,264
Current premium deficiency reserves	2,374,525	13,088,054
Total current liabilities	462,966,493	211,535,798
Noncurrent liabilities		
Noncurrent premium deficiency reserves	5,919,500	4,911,946
Net pension liability	5,018,386	4,883,971
Total liabilities	473,904,379	221,331,715
Deferred inflows of resources	2,329,621	1,892,634
Total deferred inflows of resources	2,329,621	1,892,634
Net position		
Net investment in capital assets	4,941,914	4,515,303
Restricted	305,350	305,350
Unrestricted	95,046,191	67,810,301
Total net position	100,293,455	72,630,954
Total liabilities, deferred inflows of resources, and net position	<u>\$ 576,527,455</u>	<u>\$ 295,855,303</u>

See accompany notes.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION
For the Years Ended June 30, 2016 and 2015**

	<u>2016</u>	<u>2015</u>
Operating revenues		
Capitation and premium revenue	\$ 1,213,865,945	\$ 902,348,543
Total operating revenues	<u>1,213,865,945</u>	<u>902,348,543</u>
Operating expenses		
Medical expenses	1,114,554,803	784,111,433
Premium tax	44,809,237	36,020,796
Marketing, general, and administrative expenses	35,646,645	26,265,436
Depreciation	1,412,014	810,274
Premium deficiency	<u>(9,705,975)</u>	<u>18,000,000</u>
Total operating expenses	<u>1,186,716,724</u>	<u>865,207,939</u>
Operating income	27,149,221	37,140,604
Nonoperating revenues		
Interest income	<u>513,280</u>	<u>252,726</u>
Change in net position	27,662,501	37,393,330
Net position, beginning of year	<u>72,630,954</u>	<u>35,237,624</u>
Net position, end of year	<u>\$ 100,293,455</u>	<u>\$ 72,630,954</u>

See accompany notes.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
COMBINED STATEMENTS OF CASH FLOWS
For the Years Ended June 30, 2016 and 2015**

	<u>2016</u>	<u>2015</u>
Cash flows from operating activities		
Capitation and premiums received	\$ 974,238,882	\$ 845,025,076
Medical expenses paid	(896,962,223)	(687,049,316)
Marketing, general, and administrative expenses paid	(40,464,410)	(82,102,551)
Net cash provided by operating activities	<u>36,812,249</u>	<u>75,873,209</u>
Cash flows used in capital and financing activities		
Purchases of capital assets	(1,764,386)	(4,407,515)
Net cash used in capital and financing activities	<u>(1,764,386)</u>	<u>(4,407,515)</u>
Cash flows from investing activities		
Interest collection on investments	513,280	252,726
Net cash provided by investing activities	<u>513,280</u>	<u>252,726</u>
Net increase in cash and cash equivalents	35,561,143	71,718,420
Cash and cash equivalents, beginning of year	110,215,576	38,497,156
Cash and cash equivalents, end of year	<u>\$ 145,776,719</u>	<u>\$ 110,215,576</u>
Reconciliation of operating income to net cash provided by operating activities		
Operating income	\$ 27,149,221	\$ 37,140,604
Adjustments to reconcile operating (loss) income to net cash provided by operating activities		
Depreciation	1,412,014	810,274
Changes in operating assets and liabilities		
Premiums receivable	(239,627,063)	(112,653,429)
Due from Santa Clara Family Health Foundation	3,612	67,085
Prepays and other assets	(4,857,939)	5,285,263
Accounts payable and accrued liabilities	(1,041,470)	(16,718,369)
Amounts due to the State of California	86,909,549	26,587,505
In-home supportive services payable	168,849,331	69,537,810
Due to Santa Clara County Valley Health Plan and Kaiser	(27,038,098)	17,245,187
Net pension liability	368,394	(225,682)
Premium deficiency reserves	(9,705,975)	18,000,000
Medical incurred but not reported claims and medical claims payable	33,681,035	29,891,974
Provider incentives and other medical liabilities	709,638	904,987
Net cash provided by operating activities	<u>\$ 36,812,249</u>	<u>\$ 75,873,209</u>
Supplemental cash flow disclosure		
Cash paid during the year for premium tax	<u>\$ 42,995,251</u>	<u>\$ 28,675,372</u>
Supplemental disclosure of noncash item		
Payables for capital asset purchases	<u>\$ 303,268</u>	<u>\$ 435,155</u>

See accompany notes.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
NOTES TO COMBINED FINANCIAL STATEMENTS**

NOTE 1 - ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

History and organization - The accompanying combined financial statements include the Santa Clara County Health Authority and the Santa Clara Community Health Authority Joint Powers Authority ("JPA").

The Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and JPA (collectively, the "Health Authority") were established August 1, 1995 by the Santa Clara County Board of Supervisors pursuant to Section 14087.38 of the Welfare and Institutions Code. The Health Authority was created for the purpose of developing the Local Initiative Plan (the "Plan") for the expansion of Medi-Cal Managed Care, as presently regulated by the California State Department of Managed Health Care ("DMHC"). The Medi-Cal Managed Care Program offers no-cost health coverage to children, birth through age 18, pregnant women, and other low-income adults. During 1997, the Health Authority obtained licensure under the Knox-Keene Health Care Service Plan Act of 1975.

The JPA is a licensed health maintenance organization that operates in Santa Clara County (the "County"). The County's Board of Supervisors established the JPA in October 2005 in accordance with State of California Welfare and Institutions Code (the "Code") Section 14087.54. This legislation provides that the JPA is a public entity, separate and apart from the County, and is not considered to be an agency, division, or department of the County. Further, the JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. The JPA received its Knox-Keene license on May 11, 2006, and commenced operations on June 1, 2006.

The Health Authority has contracted with the California Department of Health Care Services ("DHCS") to receive funding to provide health care services to the Medi-Cal eligible County residents who are enrolled as members of the Health Authority ("DHCS contract"). The current DHCS contract is effective through December 31, 2016. The DHCS contract specifies capitation rates, which may be adjusted annually. DHCS revenue is paid monthly and is based upon contracted rates, and actual Medi-Cal enrollment. The Health Authority, in turn, has contracted with hospitals and physicians whereby capitation payments (agreed-upon monthly payments per member) and fee-for-service payments are made in return for contracted health care services for its members. Provider contracts are typically evergreen and contain annual rate change provisions, termination clauses, and risk-sharing provisions.

The Health Authority has also contracted with Centers for Medicare & Medicaid Services ("CMS") and the DHCS, effective January 1, 2015, to participate in Cal Medi-Connect, a demonstration project to integrate care for dual eligible beneficiaries. The Contract is for 3 one-year terms expiring on December 31, 2017. The Health Authority has the option to cancel this agreement prior to the end of each term.

Cal Medi-Connect is part of California's larger demonstration plan known as the Coordinated Care Initiative ("CCI"), which transforms the delivery of health care for seniors and people with disabilities. It integrates dual eligibles' care across all their entitlement benefits from Medicare, Medi-Cal, and other supportive services.

The Health Authority operates a Healthy Kids program to provide medical coverage to children of parents not otherwise eligible for either the Medi-Cal or Healthy Families programs. This program has been assigned to the JPA.

The DHCS oversaw the execution of Assembly Bill No. 1422 ("AB 1422") or Managed Care Organization ("MCO") premium tax. This program imposed an assessment on the Health Authority's capitation and premium revenue. DHCS used this assessment to obtain matching federal funds, which was used to sustain enrollment in the former Healthy Families program.

In June 2013, Senate Bill No. 78 ("SB 78") reauthorized the MCO premium tax through the State of California's fiscal year 2016. Beginning July 1, 2013 through June 30, 2016, the rate is equal to the state sales and use tax rate of 3.9375%. On March 1, 2016, SB X2-2 established a new MCO provider tax, to be administered by DHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by DHCS on licensed health care service plans, managed care plans contracted with DHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSF"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016-2017, 2017-2018, and 2018-2019 fiscal years, respectively, for Medi-Cal enrollees, AHCSF enrollees, and all other enrollees, as defined. The Health Authority paid \$42,995,251 and \$28,675,372 in MCO premium taxes during fiscal years 2016 and 2015, respectively. At June 30, 2016 and 2015, the Health Authority had payables due in the amount of \$10,779,014 and \$8,909,559, respectively, included in Amounts due to the State of California.

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Basis of accounting – The Health Authority is a governmental health insuring organization and, accordingly, follows principles, as prescribed by the Governmental Accounting Standards Board (“GASB”), the provisions of the American Institute of Certified Public Accountants Audit and Accounting Guide (“AICPA”), *Health Care Organizations*, and the California Code of Regulations, Title 2, Section 1131, State Controller’s Minimum Audit Requirements for California Special Districts and the State Controller’s Office prescribed reporting guidelines. The Health Authority utilizes the proprietary fund method of accounting under which the combined financial statements are prepared on the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred.

Pursuant to GASB Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Health Authority’s proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Use of estimates – The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Medical incurred but not reported claims and medical claims payable, premiums receivable, net pension liability, premium deficiency reserves, and useful lives of capital assets represent significant estimates. Actual results could differ from those estimates.

Risks and uncertainties – The Health Authority’s business could be impacted by continuing price pressure on new and renewal business, the Health Authority’s ability to effectively control health care costs, additional competitors entering the Health Authority’s markets, federal and state legislation in the area of health care reform, and governmental licensing regulations of MCOs and insurance companies. Changes in these areas could adversely impact the Health Authority’s operations in the future.

Cash and cash equivalents – The Health Authority considers all highly liquid instruments with a maturity of three months or less at the time of purchase to be cash equivalents. Cash and cash equivalents are carried at cost, which approximates fair value. At June 30, 2016 and 2015, the Health Authority’s cash deposits had carrying amounts of \$145,776,719 and \$110,215,576. The Health Authority’s bank balances, including interests in an investment pool were \$148,103,313 and \$110,132,822. The difference between carrying amounts and bank balances is due to interest receivable recorded as part of carrying amounts. Of the bank and investment pool balances at June 30, 2016 and 2015, \$147,353,313 and \$109,715,576, were not covered by federal depository insurance.

Amounts invested in the County Treasurer’s investment pool (the “Investment Pool”) are considered as cash and cash equivalents, as funds can be withdrawn by the Health Authority on demand. The County’s Investment Oversight Committee Board has oversight responsibility for the Investment Pool. The Investment Pool is not U.S. Securities and Exchange Commission registered, and based on the California statutes and the County’s investment policy, primarily invests in obligations of U.S. Treasury, certain federal agencies, bankers’ acceptances, commercial papers, certificates of deposit, repurchase agreements, and California State Treasurer’s Local Agency Investment Fund. The amounts invested in the Investment Pool are considered investments in an external investment pool and earn interest based on the blended rate of return earned by the entire portfolio in the pool. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties, other than in forced liquidation. The fair value of the Investment Pool is generally based on published market prices and quotations from major investment firms. As the Health Authority does not own identifiable investment securities of the pool but participates as a shareholder of the pool. These cash and cash equivalents are not individually identifiable and were not required to be categorized under GASB Codification Section C20, *Cash Deposits with Financial Institutions*, Section 150, *Investments* and Section 155, *Investments – Reverse Repurchase Agreements*. The fair value of the Health Authority’s share in the pool approximated the fair value of the position in the pool at June 30, 2016 and 2015.

Capital assets – Purchased capital assets are stated at cost. Depreciation is provided using the straight-line method over the estimated useful lives of the respective assets, generally three to five years. Leasehold improvements are amortized over the shorter of the remaining term of the lease or the useful life. The Health Authority capitalizes capital expenditures over \$1,000, which will have a useful life of three or more years.

The Health Authority evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

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Assets restricted as to use – Assets restricted as to use consist of bank certificates of deposit and are stated at fair value at June 30, 2016. Under the Knox-Keene licensure agreement, the Health Authority is required to maintain a minimum of \$300,000 in unrestricted deposits. In the event the Health Authority discontinues operations, these certificates of deposit are to be used for closing costs.

In Home Supportive Services (“IHSS”) payable – The Department of Health Care Services pays IHSS payments directly to the Santa Clara County’s Department of Social Services. As part of the Coordinated Care Initiative (“CCI”), the Health Authority assumes full risk for IHSS provider payments. These amounts are included in both premium revenue and medical expenses and an equivalent amount is recorded as premiums receivable and IHSS payable, respectively, in the Health Authority financials statements. Additionally, the Health Authority pays the MCO tax on the revenue and records it as premium tax.

Medical incurred but not reported claims and medical claims payable – The Health Authority contracts with various providers, including physicians and hospitals, to provide certain health care products and services to enrolled beneficiaries. The cost of the health care products and services provided or contracted for is accrued in the period in which it is provided to a member, based in part on actuarial estimates, including an accrual for medical services incurred but not as yet reported to the Health Authority. Estimates are monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions.

Provider incentives and other medical liabilities – The Health Authority has various incentive agreements with certain providers whereby the providers are reimbursed for efficient and quality services provided to certain enrolled beneficiaries. Under the agreements, health care costs (which include all fee-for-service claims and estimated medical incurred but not reported claims and medical claims payable) are allocated on a per member per month basis. Based on the terms of certain incentive agreements, a final reconciliation of surpluses are completed annually and paid within six months of the Health Authority’s fiscal year. Incentive payments are recorded in medical expenses in the accompanying combined financial statements.

Net pension liability – The Health Authority recognizes a net pension liability, which represents the proportionate share of the excess of the total pension liability over the fiduciary net position of the pension reflected in the actuarial report provided by the California Public Employees’ Retirement System (“CalPERS”). The net pension liability is measured as of the Health Authority’s prior fiscal year-end. Changes in the net pension liability are recorded in the period incurred as pension expense and as deferred inflows of resources or deferred outflows of resources depending on the nature of the change. The changes in net pension liability that are recorded as deferred inflows of resources or deferred outflows of resources are recognized in pension expense systematically over time.

For purposes of measuring the net pension liability, deferred outflows and inflows of resources related to pensions, pension expense, information about the fiduciary net position, and additions to deductions from the fiduciary net position have been determined on the same basis as they are reported by the CalPERS Financial Office. For this purpose, benefit payments (including refunds of employee contributions) are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

Net position – Net position is classified as net investment in capital assets, restricted net position, or unrestricted net position. Net investment in capital assets represents capital assets, net of accumulated depreciation, reduced by outstanding balances of bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets. Restricted net position is noncapital net position that must be used for a particular purpose, as specified by the state regulatory agency, grantors, or contributors external to the Health Authority. Unrestricted net position consists of net position that does not meet the definition of restricted or net investment in capital assets.

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Premium revenue – The Health Authority has agreements with the Medi-Cal Program in the state to provide certain health care products and services to enrolled Medi-Cal beneficiaries. The Health Authority receives monthly premium payments from the state based on the number of enrolled Medi-Cal beneficiaries, regardless of services actually performed. Premiums are due from the state monthly and are recognized as revenue during the period in which the Health Authority is obligated to provide services to members. A portion of revenues received from DHCS is subject to possible retroactive adjustments. Provisions have been made for estimated retroactive adjustments.

The Health Authority has an agreement with the County of Santa Clara to provide health care services to enrolled Healthy Kids beneficiaries. The Health Authority issues monthly invoices to the individual funding organizations for their respective portion of premium costs for all Healthy Kids enrollees. Premiums are due monthly and are recognized as revenue in the period the Health Authority is obligated to provide medical services. A nominal monthly premium is invoiced directly to the family of the Healthy Kids enrolled child and recognized as revenue in the service month.

For the years ended June 30, 2016 and 2015, premium revenues recorded from the state under the Medi-Cal Program totaled \$1,063,989,786 and \$845,804,124. Annual premium grants for the Healthy Kids Program totaled \$4,545,795 and \$4,994,395, and were funded by the following organizations: County of Santa Clara \$4,206,372 and \$4,083,244, the City of San Jose \$0 and \$550,056, City of Campbell \$0 and \$7,224, City of Sunnyvale \$0 and \$14,448, and monthly family premiums of \$335,927 and \$339,423.

The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015 to participate in the CMC program. For the years ended June 30, 2016 and 2015, premium revenues totaled \$31,800,109 and \$10,206,595, and \$113,530,255 and \$41,079,047 for the Medi-Cal and Medicare components of the CMC program, respectively. According to Chapter 33, Statutes of 2013 (SB 78, Committee on Budget and Fiscal Review), premium tax is imposed on only the revenues received by MCOs through their Medi-Cal managed care plans; consequently, the Medicare revenues are not subject to premium tax.

A special arrangement exists between DHCS and the Health Authority to provide health care services for patients being transferred from Agnews Developmental Center to community facilities. For the years ended June 30, 2016 and 2015, the Health Authority has recorded revenues related to the Agnews Program in the amount of \$0 and \$264,382, respectively.

Premium deficiency reserves – The Health Authority performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts.

The Health Authority entered into a three-way contract with CMS and the DHCS effective January 1, 2015 to participate in a demonstration project to integrate care for Dual Eligible beneficiaries. The Contract is for 3 one-year terms expiring on December 31, 2017. The Health Authority has the option to cancel this agreement prior to the end of each term. Management has estimated that it will incur losses on the contract. The premium deficiency reserves have been calculated to December 31, 2017 as this is the next date management could terminate the contract.

Accordingly, a premium deficiency reserve in the amount of \$8,294,025 and \$18,000,000 has been recorded at June 30, 2016 and 2015, respectively.

The Health Authority may receive future revenue adjustments in the form of shared risk corridor payments and CMS HCC risk adjustment true-ups; however, management has determined that it is too early in the program to estimate these adjustments.

Management has determined that no other premium deficiency reserves are needed at June 30, 2016 and 2015.

Concentration of credit risk – A majority of the Health Authority's revenues are derived from contracts with the Medi-Cal Program and Healthy Kids Program in the state. Loss of the contracts due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Authority. As of June 30, 2016, the Health Authority had premiums receivable of \$385,876,235, \$22,025,089, \$8,532,954, and \$732,692 due from the Medi-Cal Program, CMC program, Medicare and Healthy Kids Program, respectively. As of June 30, 2015, the Health Authority had premiums receivable of \$171,280,639, \$5,439,989, \$0 and \$819,279 due from the Medi-Cal Program, CMC program, Medicare, and Healthy Kids Program, respectively.

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Medical expenses – Hospital, physician, and other service costs are based on actual paid claims plus an estimate for accrued incurred but not reported claims. Claims are paid primarily on a fee-for-service basis. Many physicians belonging to medical groups and certain hospitals are compensated primarily on a capitation basis with provisions for additional incentive payments in certain circumstances.

Operating revenues and expenses – The Health Authority's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating expense is medical care cost. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Income taxes – The Health Authority falls under the purview of Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to federal income or state franchise taxes.

New accounting pronouncements – In February 2015, the GASB issued GASB Statement No. 72, *Fair Value Measurement and Application*, (“GASB 72”), which is effective for financial statements for periods beginning after June 15, 2015. GASB 72 addresses accounting and financial reporting issues related to fair value measurements. This Statement also provides guidance for determining a fair value measurement for financial reporting purposes and provides guidance for applying fair value to certain investments and disclosures related to all fair value measurements. The Health Authority has adopted GASB 72 as of July 1, 2015.

In June 2015, the GASB issued GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, (“GASB 75”), which replaces GASB Statement No. 45, and requires governments to report a liability on the face of the financial statements for the OPEB that they provide. It also requires more extensive disclosures about OPEB liabilities in the notes to the financial statements and RSI. The statement is effective for financial statements for periods beginning after June 15, 2017. The Health Authority is reviewing the impact of the adoption of GASB 75 for the fiscal year beginning July 1, 2017.

In June 2015, the GASB issued GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*, (“GASB 76”), which is effective for financial statements for periods beginning after June 15, 2015. GASB 76 supersedes the requirements of GASB Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*. GASB 76 reduces the Generally Accepted Accounting Principles (“GAAP”) hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP. The Health Authority has adopted GASB 76 as of July 1, 2015.

In March 2016, the GASB issued GASB Statement No. 82, *Pension Issues*, (“GASB 82”) which is effective for financial statements for periods beginning after June 15, 2017. GASB 82 improves financial reporting by enhancing consistency in the application of financial reporting requirements to certain pension issues. The Health Authority is reviewing the impact of the adoption of GASB 82 for the fiscal year ending 2018.

Reclassifications – Certain amounts in the 2015 combined financial statements have been reclassified to conform to the 2016 presentation. These reclassifications have no effect on the 2015 operating income or net position.

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NOTE 2 – CAPITAL ASSETS

Capital asset activity for the fiscal years ended June 30, 2016 and 2015 are as follows:

	2016				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Furniture and equipment	\$ 7,299,325	\$ 1,937,845	\$ -	\$ -	\$ 9,237,170
Leasehold improvements	534,349	129,809	-	-	664,158
Software work in progress	-	-	-	-	-
Software	4,045,499	-	(229,029)	-	3,816,470
Total capital assets	<u>11,879,173</u>	<u>2,067,654</u>	<u>(229,029)</u>	<u>-</u>	<u>13,717,798</u>
Less accumulated depreciation and amortization for:					
Furniture and equipment	6,576,686	590,791	-	-	7,167,477
Leasehold improvements	405,602	57,929	-	-	463,531
Software	381,582	763,294	-	-	1,144,876
Total accumulated depreciation	<u>7,363,870</u>	<u>1,412,014</u>	<u>-</u>	<u>-</u>	<u>8,775,884</u>
Capital assets, net	<u>\$ 4,515,303</u>	<u>\$ 655,640</u>	<u>\$ (229,029)</u>	<u>\$ -</u>	<u>\$ 4,941,914</u>
	2015				
	Beginning Balance	Additions	Reductions/ Adjustments	Transfers	Ending Balance
Furniture and equipment	\$ 6,624,287	\$ 672,154	\$ 2,884	\$ -	\$ 7,299,325
Leasehold improvements	412,095	125,017	(2,763)	-	534,349
Software work in progress	3,061,034	984,465	-	(4,045,499)	-
Software	-	-	-	4,045,499	4,045,499
Total capital assets	<u>10,097,416</u>	<u>1,781,636</u>	<u>121</u>	<u>-</u>	<u>11,879,173</u>
Less accumulated depreciation and amortization for:					
Furniture and equipment	6,170,484	405,180	1,022	-	6,576,686
Leasehold improvements	382,991	23,512	(901)	-	405,602
Software	-	381,582	-	-	381,582
Total accumulated depreciation	<u>6,553,475</u>	<u>810,274</u>	<u>121</u>	<u>-</u>	<u>7,363,870</u>
Capital assets, net	<u>\$ 3,543,941</u>	<u>\$ 971,362</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 4,515,303</u>

Depreciation expense totaled \$1,412,014 and \$810,274, at June 30, 2016 and 2015, respectively.

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NOTE 3 - RELATED-PARTY TRANSACTIONS

The Health Authority has a capitated contractual relationship with Santa Clara Valley Health Plan, a wholly owned health plan of the County of Santa Clara, to provide medical services to certain Health Authority enrollees. Because of continuing retroactive enrollment adjustments and capitation payment adjustments, periodic adjustments are recorded to reflect the outstanding amounts receivable from or payable to Santa Clara Valley Health Plan. The Health Authority accrued capitation payments, not including incentive payments, in the amounts of \$4,415,791 and \$11,230,305 for the Santa Clara Valley Health Plan as of June 30, 2016 and 2015, respectively, included in Due to Santa Clara County Valley Health Plan and Kaiser.

The Health Authority also has provider incentive and medical case management arrangements with Santa Clara Valley Health Plan. The Health Authority accrued provider incentive and medical case management payments in the amounts of \$0 and \$16,892,168 for the Santa Clara Valley Health Plan as of June 30, 2016 and 2015, respectively, included in Due to Santa Clara County Valley Health Plan and Kaiser.

The Health Authority recorded capitation payments of \$348,661,260 and \$347,573,494 to Santa Clara Valley Health Plan for the years ended June 30, 2016 and 2015, respectively.

NOTE 4 - MEDICAL INCURRED BUT NOT REPORTED CLAIMS AND MEDICAL CLAIMS PAYABLE

The Health Authority estimates medical incurred but not reported ("IBNR") claims and medical claims payable based on historical claims payment and other relevant information. Estimates are monitored and reviewed, and as settlements are made or estimates are adjusted, differences are reflected in current operations. Such estimates are subject to impact of changes in the regulatory environment. Activity for medical IBNR and medical claims payable as of June 30, 2016 and 2015 is summarized as follows:

	<u>2016</u>	<u>2015</u>
Beginning balance	\$ 46,624,110	\$ 16,732,136
Incurred related to:		
Current year	442,016,734	240,825,444
Prior year	7,496,623	(2,798,843)
Total incurred	<u>449,513,357</u>	<u>238,026,601</u>
Paid related to:		
Current year	368,658,197	194,088,479
Prior year	47,174,125	14,046,148
Total paid	<u>415,832,322</u>	<u>208,134,627</u>
Ending balance	<u>\$ 80,305,145</u>	<u>\$ 46,624,110</u>

NOTE 5 - DESIGNATED NET POSITION

Designated funds remain under the control of the board of directors, which may, at its discretion, later use the funds for other purposes. For the fiscal year ended June 30, 2016, no designation of unrestricted net position was made. In addition, during 2015, the designated unrestricted net position was reduced by an amount of \$298,599, in order to offset a net loss incurred by the Healthy Kids program, leaving a zero designated unrestricted net position balance at June 30, 2015.

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NOTE 6 - OPERATING LEASE OBLIGATIONS

The Health Authority leases its facilities under an operating lease that expires in August 2018. The Health Authority also has various equipment operating leases expiring in various years through June 2019.

Future minimum lease payments as of June 30, 2016 consist of the following:

<u>Years ending June 30,</u>	<u>Building</u>	<u>Equipment</u>	<u>Total</u>
2017	\$ 937,258	\$ 78,471	\$ 1,015,729
2018	963,033	78,471	1,041,504
2019	164,919	42,977	207,896
Total minimum lease payments	<u>\$ 2,065,210</u>	<u>\$ 199,919</u>	<u>\$ 2,265,129</u>

Rent expense for the years ended June 30, 2016 and 2015 was \$1,129,420 and \$1,168,927, respectively.

NOTE 7 - EMPLOYEE BENEFIT PLANS

IRC 401(a) and 457 Plans - The Health Authority has a defined-contribution plan and a deferred compensation plan under Sections 401(a) and 457, respectively, of the Internal Revenue Code (the Code). Under the 401(a) Plan, participants must contribute 6% of their gross compensation and the Health Authority must contribute 3% of the participants' gross compensation. The Health Authority contributes greater than 3% of gross compensation for senior staff level employees. In return, senior staff level employees contribute less than 6% of their gross compensation. Contributions by the Health Authority totaled \$360,755 and \$275,929 for the years ended June 30, 2016 and 2015, respectively. Under the 457 Plan, participants may contribute up to the maximum contribution allowed under the Code and the Health Authority makes no matching contributions.

These Plans are administered through a third-party administrator and is available to all employee groups. The Health Authority does not perform the investing function and has no fiduciary accountability for the plan. Thus, plan assets and any related liability to plan participants have been excluded from the Health Authority's combined financial statements.

California Public Employees' Retirement System

Plan description - The Health Authority participates in CalPERS, a cost sharing multiple-employer defined benefit-pension plan. CalPERS acts as a common investment and administrative agent for various local and state governmental agencies within the State of California. CalPERS provides retirement, disability, and death benefits based on the employees' years of service, age, and final compensation. CalPERS provides retirement benefits payable beginning at age 55 that are equal to 2% of the employee's final 3-year average compensation times the employee's years of service.

The State passed the California Employees' Pension Reform Act of 2013 ("PEPRA") which became effective on January 1, 2013. PEPRA changes include the classification of active employees into two distinct classifications: classic members and new members. Classic members represent active members hired before January 1, 2013, and retain the pension plan benefits in effect. This plan was closed to entrants on January 1, 2013 or after. New members are active members hired on or after January 1, 2013, and are subject to PEPRA. PEPRA offer a reduced benefit formula and increased retirement ages to new public employees, who first became PERS members on or after January 1, 2013. CalPERS provides retirement benefits payable beginning at age 62 that are equal to 2% of the employee's final 3-year average compensation times the employee's years of service. The provisions and all other requirements are established by State statute. CalPERS issues a stand-alone report that is available upon request at the following address: CalPERS Actuarial & Employer Service Division; P.O. Box 942709; Sacramento, California 94229-2709.

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Funding policy – The contribution requirements of the plan members and the Health Authority are established and may be amended by CalPERS. With the election to participate in CalPERS, participation in Social Security is discontinued, and contributions to CalPERS are in lieu of contributions to Social Security. The Health Authority is required to contribute an actuarially determined rate. The employer contribution rate was 8.00% and 11.03% of annual covered payroll for the years ended June 30, 2016 and 2015, respectively. All eligible participating employees are required to contribute 7% of their monthly salaries to CalPERS. The Health Authority deducts the contributions from employees' wages and remits to CalPERS on their behalf and for their account. Contributions to the pension plans from the Health Authority were \$910,906 and \$961,116 for the years ended June 30, 2016 and 2015, respectively.

For the PEPRA Miscellaneous Plan, the active employee contribution rate and the average employer's contribution rate was 6.24% and 6.25% of annual payroll for the years ended June 30, 2016 and 2015, respectively.

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pension – The net pension liability at June 30, 2016 is measured as of June 30, 2015, using an annual actuarial valuation as of June 30, 2014, rolled forward to June 30, 2015, using standard update procedures. The total pension liabilities in the June 30, 2014 actuarial valuations was based on the following actuarial methods and assumptions:

Actuarial cost method	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.65%
Inflation	2.75
Salary increases	Varies by Entry Age and Service
Investment rate of return	7.50% Net of Pension Plan Investment and Administrative Expenses; includes Inflation
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Post Retirement Benefit Increase:	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

The net pension liability at June 30, 2015 is measured as of June 30, 2014, using an annual actuarial valuation as of June 30, 2013, rolled forward to June 30, 2014, using standard update procedures. The total pension liabilities in the June 30, 2013 actuarial valuations was based on the following actuarial methods and assumptions:

Actuarial cost method	Entry Age Normal in accordance with the requirements of GASB Statement No. 68
Actuarial assumptions:	
Discount rate	7.50% Net of Administrative Expenses
Inflation	2.75
Salary increases	Varies by Entry Age and Service
Investment rate of return	7.50% Net of Pension Plan Investment and Administrative Expenses; includes Inflation
Mortality rate table	Derived using CalPERS' Membership Data for all Funds
Post Retirement Benefit Increase:	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

All other actuarial assumptions used in the June 30, 2014 and 2013 valuation were based on the results of an actuarial experience study for the fiscal years 1997 to 2011, including updates to salary increase, mortality, and retirement rates. The Experience Study report can be obtained at CalPERS' Web site under Forms and Publications.

Change of assumptions – GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* ("GASB 68"), paragraph 68 states that the long-term rate of return should be determined net of pension plan investment expense but without reduction for pension plan administrative expense. The discount rate of 7.65% used for the June 30, 2015 measurement date is without reduction of pension plan administrative expense. The discount rate of 7.50% used for the June 30, 2014 measurement date was net of administrative expenses.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
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NOTES TO COMBINED FINANCIAL STATEMENTS**

Discount rate – The discount rate used to measure the total pension liability at June 30, 2016 and 2015 was 7.65% and 7.50%, respectively, for the CalPERS plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.65% discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long-term expected discount rate of 7.65% will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report called “GASB Crossover Testing Report” that can be obtained from the CalPERS website.

GASB 68 requires that the long-term discount rate should be determined without reduction for pension plan administrative expense. The 7.50% investment return assumption used is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.65%. Using this lower discount rate has resulted in a slightly higher total pension asset and net pension asset. This difference was deemed immaterial to the CalPERS plan.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds’ asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation.

Asset Class	Current target allocation	Real return years 1-10 (a)	Real return years 11+ (b)
Global equity	51.0%	5.25%	5.71%
Global fixed income	19.0%	99.00%	2.43%
Inflation sensitive	6.0%	45.00%	3.36%
Private equity	10.0%	6.83%	6.95%
Real estate	10.0%	4.50%	5.13%
Infrastructure and forestland	2.0%	4.50%	5.09%
Liquidity	2.0%	-0.55%	-1.05%

(a) An expected inflation rate of 2.5% was used for this period.

(b) An expected inflation rate of 3.0% was used for this period.

**SANTA CLARA COUNTY HEALTH AUTHORITY
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NOTES TO COMBINED FINANCIAL STATEMENTS**

Sensitivity of the employer's proportionate share of the net pension liability to changes in the discount rate - The following presents the Health Authority's net pension liability as of the measurement date, calculated using the discount rate of 7.50%, as well as what the net pension liability would be if it were calculated using a discount rate that is 1% point lower (6.50%) or 1% point higher (8.50%) than the current rate:

	June 30, 2016		
	Current		
	1% Decrease (6.5%)	discount rate (7.5%)	1% Increase (8.5%)
Health Authority's net pension liability	\$ 8,416,183	\$ 5,018,386	\$ 2,213,109

	June 30, 2015		
	Current		
	1% Decrease (6.5%)	discount rate (7.5%)	1% Increase (8.5%)
Health Authority's net pension liability	\$ 8,701,727	\$ 4,883,971	\$ 1,715,597

At June 30, 2016, the Health Authority reported an asset of \$2,128 for new members and a liability of \$5,020,514 for classic members for its proportionate share of the net pension liability. At June 30, 2015, the Health Authority reported a liability of \$161 for new members and \$4,883,810 for classic members for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2014, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2013. The Health Authority's proportion of the net pension liability was based on the CalPERS cost-sharing allocation methodology. This process is described in the CalPERS Public Agency Cost-Sharing Allocation Methodology Report that can be obtained at CalPERS' Web site under the GASB 68 section.

Health Authority's proportion for the miscellaneous plan was 0.18300% and 0.07849% at June 30, 2016 and 2015, respectively. For the PEPRA Miscellaneous Plan, the Health Authority's proportion was 0.00008% and 0.00000% at June 30, 2016 and 2015, respectively.

For the years ended June 30, 2016 and 2015, the Health Authority recognized pension expense of \$1,221,463 and \$735,434, respectively. Pension expense represents the change in the net pension liability during the measurement period, adjusted for actual contributions and the deferred recognition of changes in investment gain/loss, actuarial gain/loss, actuarial assumptions or method, and plan benefits.

For the years ended June 30, 2016, the Health Authority had \$1,570,339 of deferred outflows of resources and \$2,329,621 of deferred inflows of resources related to pensions from the following sources:

	2016	
	Deferred outflows of resources	Deferred inflows of resources
Change in employers' proportionate share	\$ 79,389	\$ -
Experience	62,191	-
Differences between employer's actual contributions and its proportionate share of total employer contributions	17,510	-
Net differences between projected and actual earnings on pension plan investments	1,411,249	(1,741,234)
Assumptions	-	(588,387)
	\$ 1,570,339	\$ (2,329,621)

**SANTA CLARA COUNTY HEALTH AUTHORITY
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NOTES TO COMBINED FINANCIAL STATEMENTS**

For the years ended June 30, 2015, the Health Authority had \$1,367,331 of deferred outflows of resources and \$1,892,634 of deferred inflows of resources related to pensions from the following sources:

	2015	
	Deferred outflows of resources	Deferred inflows of resources
Change in employers' proportionate share Experience	\$ 14,041	\$ (251,394)
Differences between employer's actual contributions and its proportionate share of total employer contributions	-	-
Net differences between projected and actual earnings on pension plan investments	392,174	-
Assumptions	-	(1,641,240)
Contributions subsequent to the measurement date	961,116	-
	<u>\$ 1,367,331</u>	<u>\$ (1,892,634)</u>

Deferred outflows of resources and deferred inflows of resources above represent the unamortized portion of changes to net pension liability to be recognized in future periods in a systematic manner.

Deferred outflows of resources of \$910,906 and \$961,116 resulting from contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the years ending June 30, 2016 and 2015, respectively.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ended June 30.

2016	\$ (407,595)
2017	(390,642)
2018	(303,062)
2019	342,017
	<u>\$ (759,282)</u>

NOTE 8 – POSTRETIREMENT HEALTH BENEFITS

Plan description – The Health Authority participates in the California Employers' Retiree Benefit Trust ("CERBT"), a single employer agent plan as administered by CalPERS to prefund its postemployment healthcare benefits. The Health Authority's OPEB Plan provides healthcare benefits to eligible employees and their surviving spouses. Retired employees who retire directly from the health plan are eligible to receive contributions from Santa Clara Family Health Plan toward their monthly Public Employees' Medical and Hospital Care Act ("PEMHCA") (health plans offered by CalPERS) if they meet certain age and service eligibility requirements as outlined in the plan document and as approved by the board of directors of the Health Authority. All employees who attain age 50 with a minimum of 5 years of CalPERS service and employed by the Health Authority at the time of retirement are eligible. Copies of PERS' annual financial report may be obtained from their executive office at 400 Q Street, Sacramento, California 95811. A separate report for the County's plan in CERBT is not available.

**SANTA CLARA COUNTY HEALTH AUTHORITY
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NOTES TO COMBINED FINANCIAL STATEMENTS**

Funding policy – The Health Authority pays for 90% of the cost of retiree medical plan premiums, including the cost for spouse and dependent coverage. Retirees are required to pay the other 10%. The Health Authority contracts with CalPERS for health plan coverage. The Health Authority contribution is also capped at 90% of Blue Shield Access+, Bay Area Region premium (basic and supplemental rates for non-Medicare and Medicare retirees, respectively) for retirees who elect PERS Care (“PPO”) or out of state coverage. Upon the death of the retiree, the Health Authority will continue the contributions described to surviving spouse's lifetime or until any surviving minor dependents reach age 26.

The Health Authority must contribute the minimum required amount of \$5,000 or the annual required contribution (“ARC”), whichever is lower. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities over a period not to exceed 30 years. The contribution requirements of the Health Authority are established and may be amended by the CERBT.

Actuarial methods and assumptions – Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Actuarially determined amounts are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The required schedule of funding progress, presented as required supplementary information following the notes to the combined financial statements, presents multiyear trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits. Projections of benefits for financial reporting purposes are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

The actuarial cost method used for determining the benefit obligations is the Projected Unit Credit Cost Method. Under this method, the actuarial present value of projected benefits is the value of benefits expected to be paid for current actives and retirees and is calculated based on census data and the various assumptions noted below. The actuarial value of assets is equal to the market value of assets as of June 30, 2016. The unfunded actuarial accrued liability is being amortized as a level dollar amount over 30 years on an open basis (i.e., rolling 30 years).

Demographic assumptions used in the valuations include withdrawal probabilities of miscellaneous employees terminating within one year for an employee with five years of service ranging from 0.97% to 7.02% for entering ages from 50 to 30 years, respectively; probability of retirement within one year for an active employee with 15 years of service ranging from 100% to 0% for ages 75 to 50, respectively; disability probabilities ranging from 0.21% to 0.02% and 0.23% to 0.01%, for males and females aged 50 to 25 years, respectively; mortality rates based on statistics taken from the California PERS most recent pension valuation projected to year 2028 with scale BB; election coverage by 100% of new retirees; spouse coverage by 35% of new retirees at retirement; female spouses are assumed to be three years younger than male spouses. For current retirees, actual age data was used. In addition, medical PMPM costs for fiscal year 2016 were adjusted by age groups, retirees, spouses, and gender. The average age of the covered active employees was 44.15 with an average service of 4.79 at the valuation date. The average age of the current retirees was 66.67 at the valuation date. The valuation also included a measurement of an implicit subsidy for community rated health plans.

Economic assumptions include discount rate of 7.00%, which is based on the investments held in the OPEB trust and includes a 2.50% long-term inflation assumption.

The assumed health care cost trend rates used in the calculations were 4.25% for 2017, graded to 4.25% for year 2088 and beyond and 3.50% for 2017, graded to 4.50% for year 2075 and beyond for ages pre-65 and post-65, respectively.

**SANTA CLARA COUNTY HEALTH AUTHORITY
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NOTES TO COMBINED FINANCIAL STATEMENTS**

Annual OPEB cost – The following table sets forth the actuarial calculation of the annual required contribution and net OPEB obligation for the fiscal years ended June 30, 2016 and 2015:

	<u>2016</u>	<u>2015</u>
Determination of annual required contribution:		
Normal cost at fiscal year-end	\$ 607,107	\$ 695,345
Amortization of unfunded actuarial accrued liability	<u>347,048</u>	<u>404,909</u>
Annual required contribution	<u>\$ 954,155</u>	<u>\$ 1,100,254</u>
Determination of net OPEB obligation:		
Annual required contribution	\$ 954,155	\$ 1,100,254
Interest on prior year net OPEB obligation (asset)	-	-
Adjustment to ARC	<u>-</u>	<u>-</u>
Annual OPEB cost	<u>954,155</u>	<u>1,100,254</u>
Benefit payments made directly by the health Authority	499,704	364,921
Implicit Subsidies attributed to Pay-Go benefit payments	-	99,915
Contributions made to CERBT	<u>454,451</u>	<u>635,418</u>
Total contributions made	<u>954,155</u>	<u>1,100,254</u>
Net OPEB asset	-	-
Net OPEB obligation (asset) - beginning of fiscal year	<u>(3)</u>	<u>(3)</u>
Net OPEB obligation (asset) - end of fiscal year	<u>\$ (3)</u>	<u>\$ (3)</u>

The following table summarizes the contributions to the post retirements health benefits plan for the years ended:

<u>Fiscal year ended</u>	<u>Annual OPEB cost</u>	<u>Net OPEB obligation</u>	<u>Percentage of OPEB cost contributed</u>
June 30, 2014	\$ 743,289	\$ (3)	100%
June 30, 2015	\$ 1,100,254	\$ (3)	100%
June 30, 2016	\$ 954,155	\$ (3)	100%

Funding status and funding progress – As of June 30, 2016 and 2015, the most recent actuarial valuation date, the funded status of the plan was as follows:

	<u>2016</u>	<u>2015</u>
Actuarial accrued liability (AAL)	\$ 8,959,169	\$ 8,998,672
Actuarial value of plan assets	<u>5,188,446</u>	<u>4,692,134</u>
Unfunded actuarial accrued liability (UAAL)	<u>\$ 3,770,723</u>	<u>\$ 4,306,538</u>
Funded ratio (actuarial value of plan assets/AAL)	57.9%	52.1%
Covered payroll (active plan members)	\$ 13,266,167	\$ 10,307,059
UAAL as a percentage of covered payroll	28.4%	41.8%

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
NOTES TO COMBINED FINANCIAL STATEMENTS**

As of June 30, 2016, the most recent actuarial valuation date, the plan was 57.9% funded. The actuarial accrued liability for benefits was \$8,959,169 and the actuarial value of assets was \$5,188,446, resulting in an unfunded accrued liability of \$3,770,723. Unfunded actuarial accrued liability is amortized over 30 years and is included in the annual required contribution.

NOTE 9 – MEDICAL STOP LOSS INSURANCE

The Health Authority has entered into certain stop-loss agreements with third parties in order to limit its losses on individual claims. Under the terms of these agreements, the third parties will reimburse the Health Authority certain proportions of the cost of each member's annual hospital services excluding those that are capitated, in excess of specified deductibles, up to a maximum of \$1,500,000 per member per contract year. Insurance premiums are recorded as medical expenses and recoveries are recorded as a reduction of these expenses. Stop-loss recoveries exceeded premiums by \$2,138,132 and \$174,899 in 2016 and 2015, respectively.

NOTE 10 – TANGIBLE NET EQUITY

As a limited license plan under Knox-Keene Health Care Services Plan Act of 1975 (the Act), the Health Authority is required to maintain a minimum level of tangible net equity. The required tangible net equity level was \$32,375,000 and \$19,411,000 at June 30, 2016 and 2015, respectively. The Health Authority's tangible net equity was \$100,293,455 and \$72,630,954 at June 30, 2016 and 2015, respectively.

NOTE 11 – RISK MANAGEMENT

The Health Authority is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Health Authority carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Health Authority's commercial coverage.

NOTE 12 – COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the Health Authority is a party to claims and legal actions by enrollees, providers, and others. The Health Authority's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, Health Authority management is of the opinion that any liability that may ultimately result from claims or legal actions will not have a material effect on the financial position or results of operations of the Health Authority.

NOTE 13 – HEALTH CARE REFORM

In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. health-care system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2014. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2014 for low-income families, children, pregnant women, seniors, and persons with disabilities. For the years ended June 30, 2016 and 2015, the Health Authority served an average of 79,905 and 54,382 Medi-Cal Expansion members per month, which increased revenues by approximately \$368 million and \$332 million, respectively.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
NOTES TO COMBINED FINANCIAL STATEMENTS**

NOTE 14 - SUBSEQUENT EVENTS

Subsequent events are events or transactions that occur after the statement of net position date but before financial statements are issued. The Health Authority recognizes in the combined financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the statement of net position, including the estimates inherent in the process of preparing the combined financial statements. The Health Authority's combined financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the statement of net position but arose after the statement of net position date and before combined financial statements are issued.

The Health Authority has evaluated subsequent events through October 27, 2016, the date at which the combined financial statements were available to be issued, and determined that there are no other items to be disclosed.

SUPPLEMENTARY INFORMATION



**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
SUPPLEMENTAL POST EMPLOYMENT HEALTH BENEFITS INFORMATION**

Benefits are funded by the health plan on a pay-as-you go basis. As of June 30, 2016 and 2015, 155 and 127 active employees and 51 and 49 retirees, respectively, were eligible to participate in the plan.

The following table shows a schedule of funded status and progress:

<u>Actuarial Valuation Date</u>	<u>Actuarial Value of Assets (a)</u>	<u>Actuarial Accrued Liability (AAL) (b)</u>	<u>Unfunded Actuarial Accrued Liability (UAAL) (a-b)</u>	<u>Funded Ratio (a/b)</u>	<u>Covered Payroll (c)</u>	<u>UAAL as a Percentage of Covered Payroll ((a-b)/c)</u>
June 30, 2014	\$ 4,054,959	\$ 9,342,541	\$ (5,287,582)	43.40%	\$ 9,586,094	-55.16%
June 30, 2015	\$ 4,692,134	\$ 8,998,672	\$ (4,306,538)	52.14%	\$ 10,307,509	-41.78%
June 30, 2016	\$ 5,188,446	\$ 8,959,169	\$ (3,770,723)	57.91%	\$ 13,266,167	-28.42%

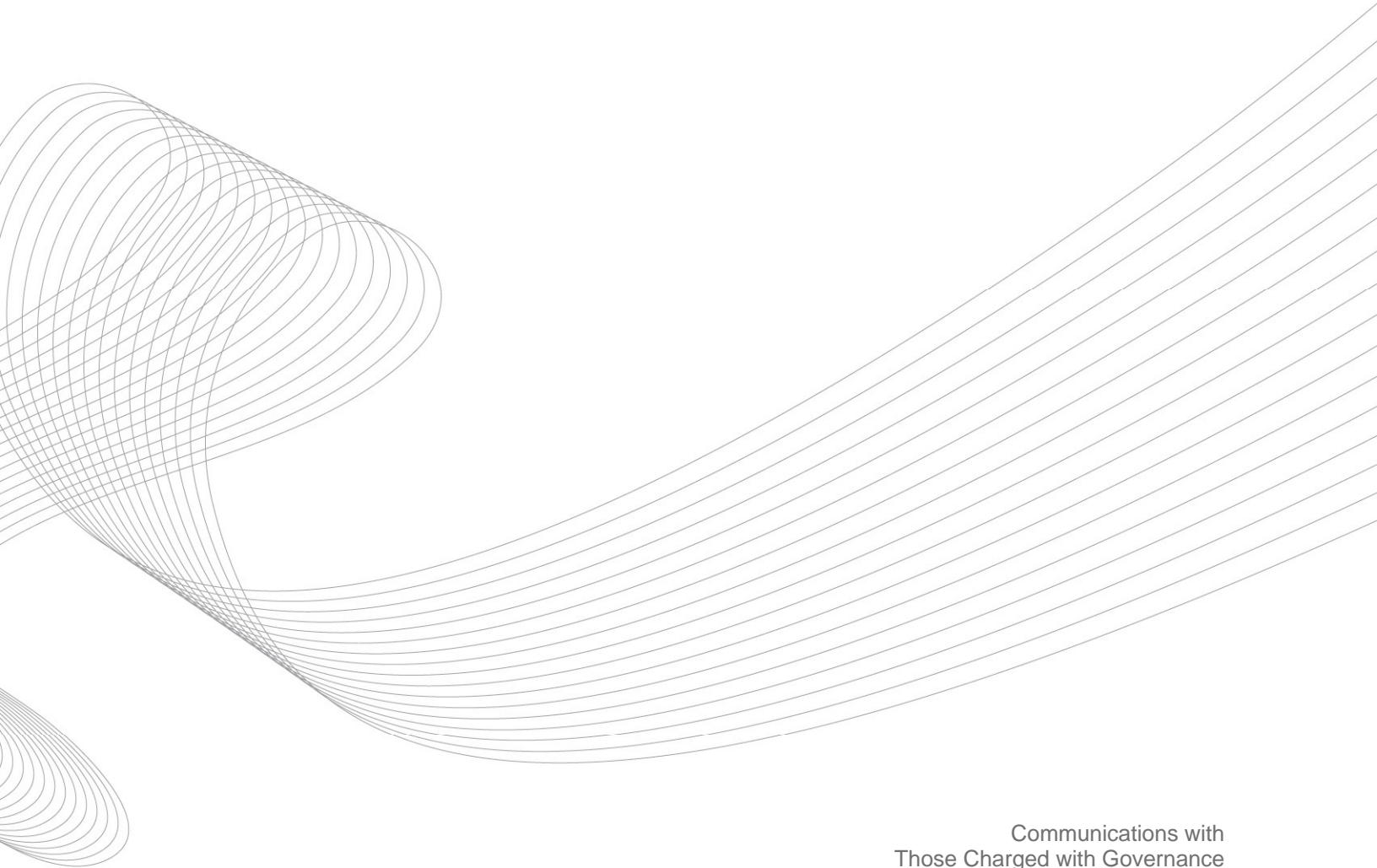
The actuarial cost method used for determining the benefit obligations is the “projected unit credit cost method.” Under this method, the actuarial present value of projected benefits is the value of benefits expected to be paid for current active members and retirees and is calculated based on assumptions discussed above and underlying census data.

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
SCHEDULE OF PROPORTIONATE SHARE OF THE NET PENSION LIABILITY**

	<u>2016</u>	<u>2015</u>
Proportion of the net pension liability	0.07311%	0.07849%
Proportionate share of the net pension liability	\$ 5,018,386	\$ 4,883,971
Covered - employee payroll	\$ 7,427,745	\$ 8,850,000
Proportionate share of the net pension liability as percentage of covered-employee payroll	67.56%	55.19%
Proportionate share of plan's fiduciary net position as a percentage of the plan's total pension liability	83.63%	83.03%
Proportionate share of aggregate employer contributions	\$ 887,143	\$ 646,110

**SANTA CLARA COUNTY HEALTH AUTHORITY
(DBA SANTA CLARA FAMILY HEALTH PLAN) AND
SANTA CLARA COMMUNITY HEALTH AUTHORITY
SCHEDULE OF CONTRIBUTIONS**

	<u>2016</u>	<u>2015</u>
Measurement period	2014-2015	2013-2014
Actuarially determined contribution	\$ 910,906	\$ 886,335
Contributions in relation to the actuarially determined contribution	<u>(910,906)</u>	<u>(886,335)</u>
Contribution deficiency (excess)	<u>\$ -</u>	<u>\$ -</u>
Covered-employee payroll	\$ 7,427,745	\$ 8,850,000
Contributions as a percentage of covered-employee payroll	12.26%	10.02%



Communications with
Those Charged with Governance

**Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
and Santa Clara Community
Health Authority**

June 30, 2016

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COMMUNICATIONS WITH THOSE CHARGED WITH GOVERNANCE

To the Board of Directors
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority

We have audited the combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively the "Health Authority"), as of and for the year ended June 30, 2016, and have issued our report thereon dated October 27, 2016. Professional standards require that we provide you with the following information related to our audit.

OUR RESPONSIBILITY UNDER AUDITING STANDARDS GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA

As stated in our engagement letter dated June 6, 2016, our responsibility, as described by professional standards, is to form and express an opinion about whether the combined financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the combined financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free from material misstatement. An audit of combined financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Authority's internal control over financial reporting. Accordingly, we considered the Health Authority's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the combined financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

PLANNED SCOPE AND TIMING OF THE AUDIT

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated June 6, 2016.

SIGNIFICANT AUDIT FINDINGS AND ISSUES

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Health Authority are described in Note 1 to the combined financial statements. During the year, management adopted Governmental Accounting Standards Board ("GASB") Statement No. 72, *Fair Value Measurements and Application* ("GASB 72") and No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments* ("GASB 76"). There have been no other new accounting policies adopted and there were no changes in the application of existing policies during 2016. We noted no transactions entered into by the Health Authority during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the combined financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the combined financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the combined financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the combined financial statements were:

- Management recorded an estimated liability for incurred but unpaid claims expense. The estimated liability for unpaid claims is based on management's estimate of historical claims experience and known activity subsequent to year-end. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.
- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon an historical experience methodology. We have an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.
- Management's estimate of the net pension liability is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.
- Management recorded an estimated liability for the medical loss ratio requirement for Medi-Cal Expansion. The estimated liability is based on management's estimate of revenues and allowable medical expenses related to Medi-Cal Expansion. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.

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- Management recorded an estimated liability for premium deficiency reserve. The estimated liability is based on management's analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. We have gained an understanding of management's estimate methodology, and have examined the documentation supporting these methodologies and formulas. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.
- The useful lives of fixed assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the combined financial statements taken as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the Health Authority's financial statements relate to medical claims payable, net pension, and capitation and premium revenues.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the combined financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the attached management representation letter dated October 27, 2016.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Health Authority's combined financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Health Authority that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Health Authority within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Health Authority's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Governors of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority and its management, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
October 27, 2016



Santa Clara
Family Health Plan

October 27, 2016

Moss Adams LLP
101 Second Street, Suite 900
San Francisco, CA 94105

We are providing this letter in connection with your audit of the combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively the "Health Authority"), which comprise the combined statement of net position as of June 30, 2016, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the combined financial statements for the purpose of expressing an opinion as to whether the combined financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than \$1,075,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the combined financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter,

Combined Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated June 6, 2016, for the preparation and fair presentation of the combined financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the combined financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.



8. The following, if any, have been properly recorded or disclosed in the combined financial statements:
 - a. Related-party transactions, including sales, purchases, loans, transfers, leasing arrangements, and guarantees, and amounts receivable from or payable to related parties.
 - b. Guarantees, whether written or oral, under which the Health Authority is contingently liable.
 - c. Significant estimates and material concentrations known to management that are required to be disclosed in accordance with the Government Accounting Standards Board ("GASB") Codification Section C50, *Claims and Judgments* [Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.]
9. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the combined financial statements. We understand that *near term* means the period within one year of the date of the combined financial statements. In addition, we have no knowledge of concentrations existing at the date of the combined financial statements that make the Health Authority vulnerable to the risk of severe impact that have not been properly disclosed in the combined financial statements. We understand that concentrations include individual or group concentrations of payors, members, suppliers, lenders, products, services, sources of labor or materials, licenses or other rights, or operating areas or markets. We further understand that *severe impact* means a significant financially disruptive effect on the normal functioning of the Health Authority.

Information Provided

10. We have provided you with:
 - a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the combined financial statements such as records, documentation and other matters;
 - b. Minutes of the meetings of Board of Governors, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;
 - c. Additional information that you have requested from us for the purpose of the audit;
 - d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
11. We acknowledge our responsibility for the design and implementation of programs and controls to prevent and detect fraud. We understand the term "fraud" includes misstatements arising from fraudulent financial reporting and misstatements arising from misappropriation of assets. Misstatements arising from fraudulent financial reporting are intentional misstatements, or omissions of amounts or disclosures in the combined financial statements to deceive financial statement users. Misstatements arising from misappropriation of assets involve the theft of an entity's assets where the effect of the theft causes the condensed interim financial information not to be presented in conformity with accounting principles generally accepted in the United States of America.
12. All transactions have been properly recorded in the accounting records and are reflected in the combined financial statements.
13. We have disclosed to you the results of our assessment of the risk that the combined financial statements may be materially misstated as a result of fraud.
14. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—
 - a. Board of Governors,
 - b. Management,
 - c. Employees who have significant roles in internal control, or



- d. Others when the fraud could have a material effect on the combined financial statements.
15. There are no—
- a. There are no violations or possible violations of laws or regulations that exist, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the combined financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the combined financial statements. This is including, but not limited to, the antikickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.
 - b. Possible illegal acts brought to the attention of management.
 - c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.
 - d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.
16. We have no knowledge of any allegations of fraud or suspected fraud, affecting the Health Authority's combined financial statements communicated by employees, former employees, analysts, regulators or others.
17. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing combined financial statements.
18. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the combined financial statements and we have not consulted legal counsel concerning litigation, claims, or assessments.
19. We have disclosed to you, if any, the identity of the Health Authority's related parties and all the related party relationships and transactions of which we are aware.
20. The Health Authority has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.
21. There are no estimates that may be subject to a material change in the near term that have not been properly disclosed in the combined financial statements. We understand that near term means the period within one year of the date of the combined financial statements. In addition, we have no knowledge of concentrations existing at the date of the combined financial statements that make the Health Authority vulnerable to the risk of severe impact that have not been properly disclosed in the combined financial statements. We understand that concentrations include individual or group concentrations of payors, members, suppliers, lenders, products, services, sources of labor or materials, licenses or other rights, or operating areas or markets. We further understand that severe impact means a significant financially disruptive effect on the normal functioning of the Health Authority.
22. The Health Authority has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the combined financial statements.
23. The Health Authority has complied with all aspects of contractual agreements that would have a material effect on the combined financial statements in the event of noncompliance.
24. Capitation and premium revenue and noncapital grants and contributions as disclosed in Note 1 of the combined financial statements are fairly stated in accordance with U.S. GAAP.
25. We have disclosed to you any change in the Health Authority's internal control over financial reporting that occurred during the Health Authority's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Health Authority's internal control over financial reporting
26. The liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation, has been determined using appropriate



estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of June 30, 2016. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.

27. We agree with the findings of our specialists in evaluating the liabilities for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims expenses and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the combined financial statements and underlying accounting records. We did not give or cause any instructions to be given to specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.
28. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.
29. All reinsurance transactions entered into by the Health Authority are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Health Authority's reinsurance arrangements meet the risk transfer provisions of GASB Codification Section Po20, *Public Entity Risk Pools*, or are accounted for as deposits.
30. We believe that the actuarial assumptions and methods used to measure postretirement liabilities and costs for financial accounting purposes are appropriate in the circumstances.
31. The Health Authority was in compliance with the requirements of licensure under the Knox-Keene Health Care Service Health Authority act of 1975 at June 30, 2016.
32. Risk sharing, provider incentive, withhold, capitation and other arrangements with providers wherein the Health Authority is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the combined financial statements at net realizable value, giving consideration to all amounts due under arrangements. We believe the estimated risk sharing liability is fairly stated as of June 30, 2016.
33. The Health Authority has appropriately reconciled its books and records (e.g., general ledger accounts) underlying the combined financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the combined financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a balance sheet account, which should have been written off to an income statement account and vice versa.
34. In regard to your assistance with drafting the combined financial statements, we have:
 - a. Made all management decisions and performed all management functions.
 - b. Designated an individual with suitable skill, knowledge, or experience to oversee the services.
 - c. Evaluated the adequacy and results of the services performed.
 - d. Accepted responsibility for the results of the services.
 - e. Established and maintained internal controls, including monitoring of ongoing activities.




35. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Health Authority's audit.
36. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Health Authority; a significant customer may be unable to purchase from the Health Authority; or a significant service provider may be unable to provide services to the Health Authority, in each case because of their respective inability to comply with HIPAA.
37. To our knowledge, there are no instances where any officer or employee of the Health Authority has an interest in a company with which the Health Authority does business that would be considered a "conflict of interest." Such an interest would be contrary to the Health Authority's policy.
38. We acknowledge our responsibility for presenting the Management's Discussion and Analysis required by GASB Codification 62 paragraph 565 in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis is measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.
39. We acknowledge our responsibility for presenting the schedule of changes in net pension liability and related ratios and schedule of contributions required by GASB 68 in accordance with accounting principles generally accepted in the United States of America and we believe the schedules are presented in accordance with the prescribed guidelines.
40. Pending changes in the organizational structure, financing arrangements, or other matters, if any, that could have a material effect on the combined financial statements of the entity are properly disclosed.
41. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe a premium deficiency reserve of \$8,294,025 is necessary at June 30, 2016.
42. We believe that the actuarial assumptions and methods used to measure net pension liability for financial accounting purposes are appropriate in the circumstances.
43. We have reviewed and evaluated the impact of adopting GASB 72, Fair Value Measurement and Application, and GASB 76, The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments, as discussed in Note 1. The Health Authority has determined that adopting GASB 72 and GASB 76 had no material impact to the combined financial position and the combined results of operations as of and for the year ended June 30, 2016.
44. We have not completed the process of evaluation the impact that will result from adopting GASB 75, Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions, and GASB 82, Pension Issues, as discussed in Note 1. The Health Authority is therefore unable to disclose the impact that adopting GASB 75 and GASB 82 will have on its combined financial position and the combined results of operations when such statements are adopted.
45. We were in compliance with our tangible net equity regulatory requirement at June 30, 2016.

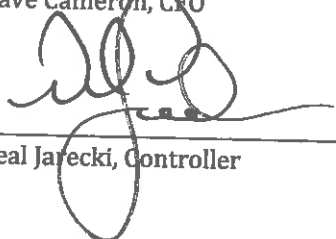


46. The liability calculation for the required 85% medical loss ratio for the Medi-Cal Expansion population uses appropriate claims and encounters data and allowable medical expenses, and is calculated in accordance with our Medi-Cal contract. The estimated liability is to the best of our knowledge and belief as of June 30, 2016.
47. We have disclosed to you all of the matters of which we are aware that are relevant to the Health Authority's ability to continue as a going concern, including all significant conditions and events, and mitigating factors and the Health Authority's plans to be able to continue operations on an ongoing basis.
48. We confirm we are subject to the audit requirements of the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts and the State Controller's Office prescribed reporting guidelines. We confirm that the fiscal year 2015-2016 Special Districts Financial Transactions Report for the Santa Clara Community Health Authority has not been filed as of the date of this letter. Santa Clara Community Health Authority has no activity for fiscal year 2015-2016 and no activity will be reported in the Special Districts Financial Transactions Report. The deadline for the Special District Financial Transaction Report for fiscal year 2015-2016 is due 7 months after the fiscal year end June 30, 2016.

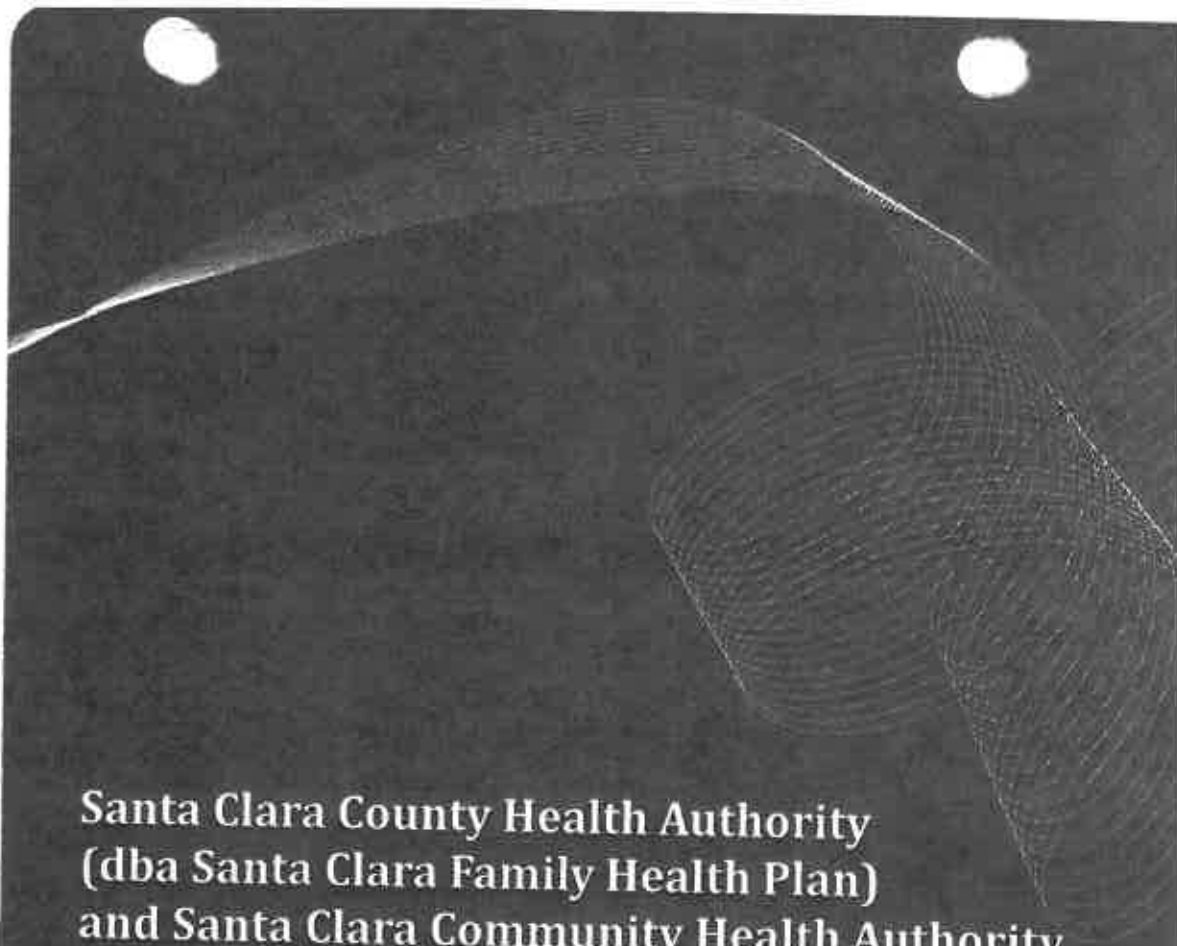
To the best of our knowledge and belief, no events have occurred subsequent to the combined statements of net position date and through the date of this letter that would require adjustment to or disclosure in the aforementioned combined financial statements.

 10/25/16

Dave Cameron, CEO

 10/27/16

Neal Jarecki, Controller



**Santa Clara County Health Authority
(dba Santa Clara Family Health Plan)
and Santa Clara Community Health Authority
Report of Independent Auditors**

Chris Pritchard
Health Care Services Partner

Rianne Suico
Health Care Services Senior Manager

MOSS ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS

Unmodified Opinion

Combined financial statements are fairly presented in accordance with generally accepted accounting principles.



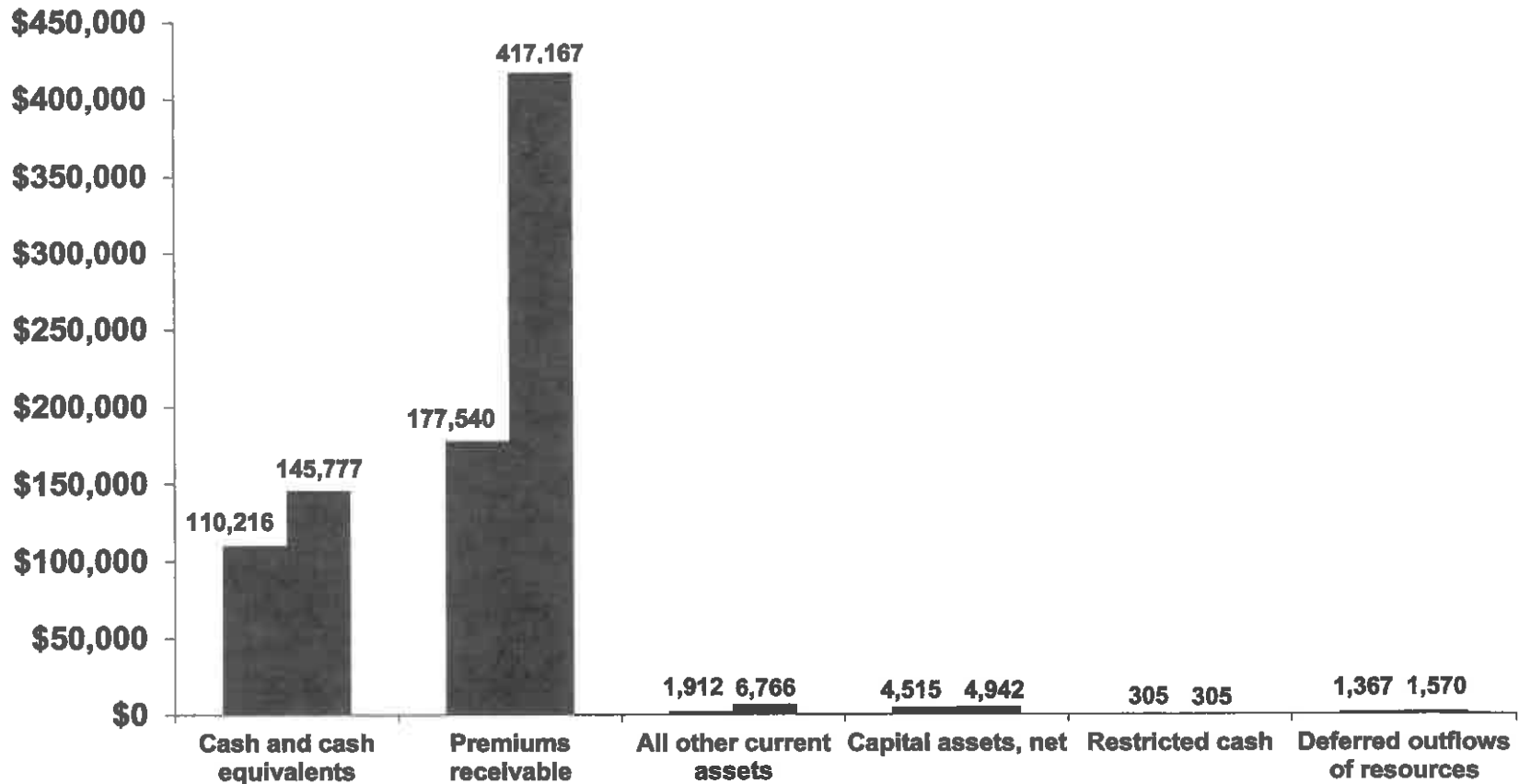


COMBINED STATEMENTS OF NET POSITION

ASSET COMPOSITION

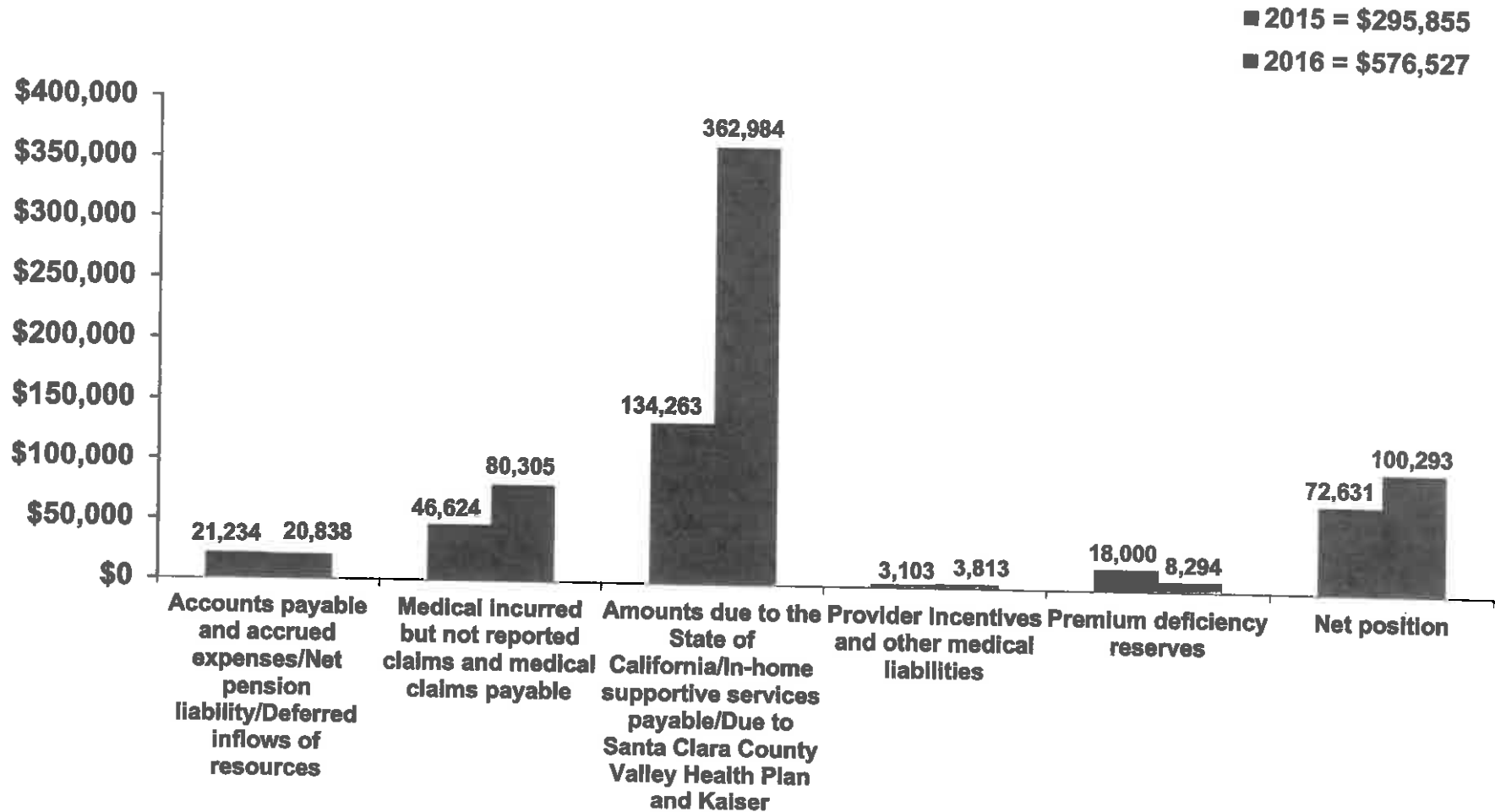
(IN THOUSANDS)

■ 2015 = \$295,855
 ■ 2016 = \$576,527



LIABILITIES AND NET POSITION BALANCE

(IN THOUSANDS)





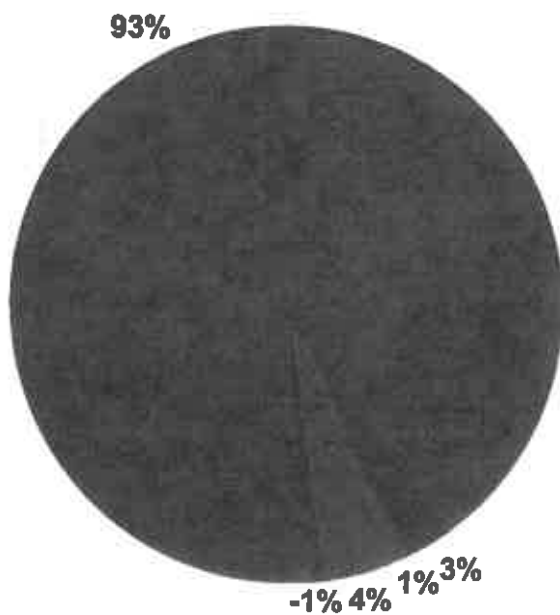
OPERATIONS



OPERATING EXPENSES

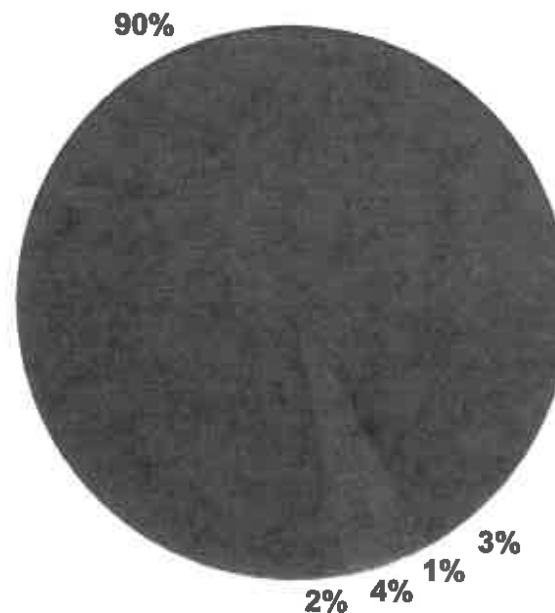
(IN THOUSANDS)

June 30, 2016
\$1,186,717

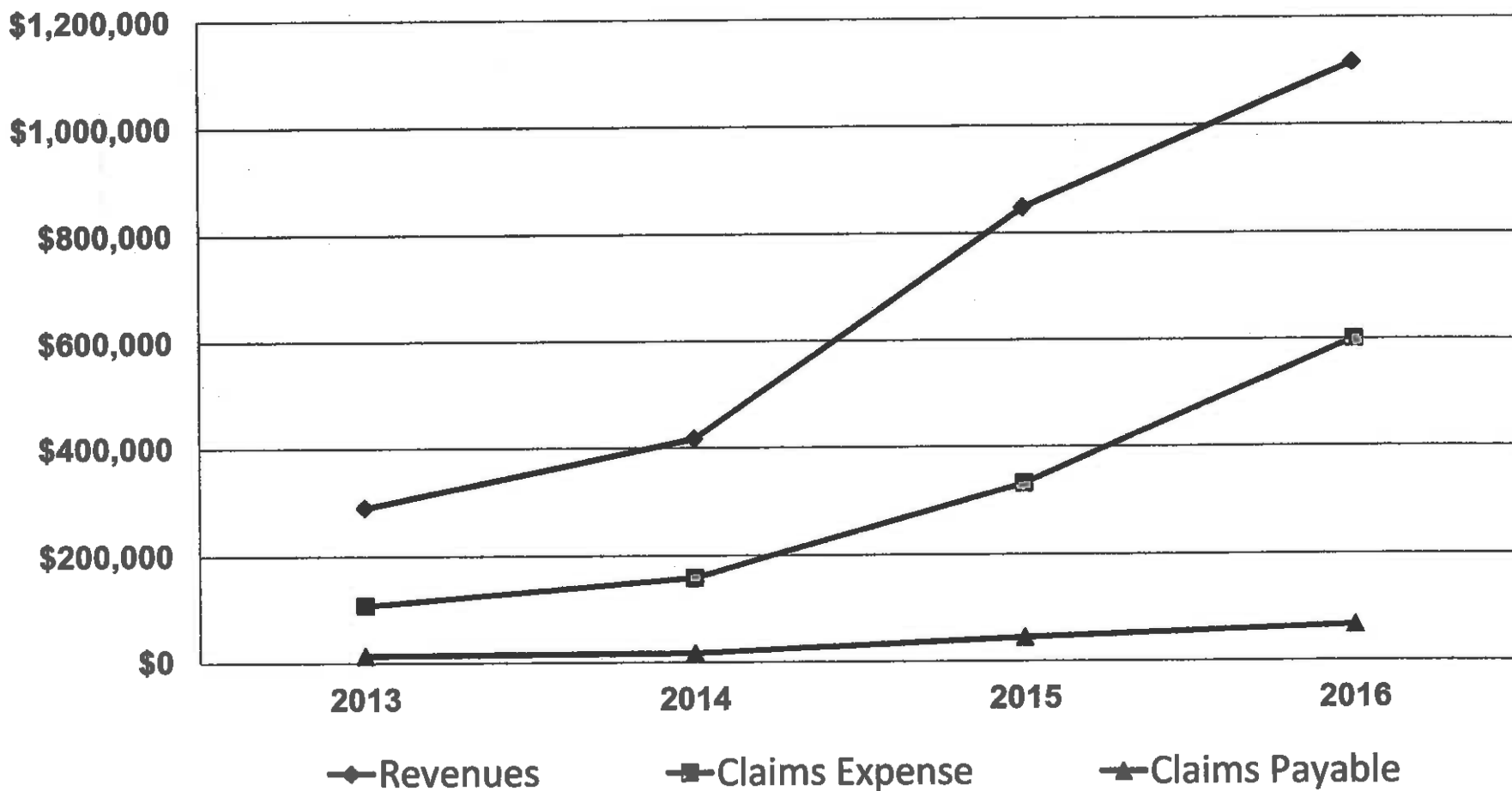


- Medical expenses
- Marketing, general, and administrative expenses
- Depreciation
- Premium tax
- Premium deficiency

June 30, 2015
\$865,208



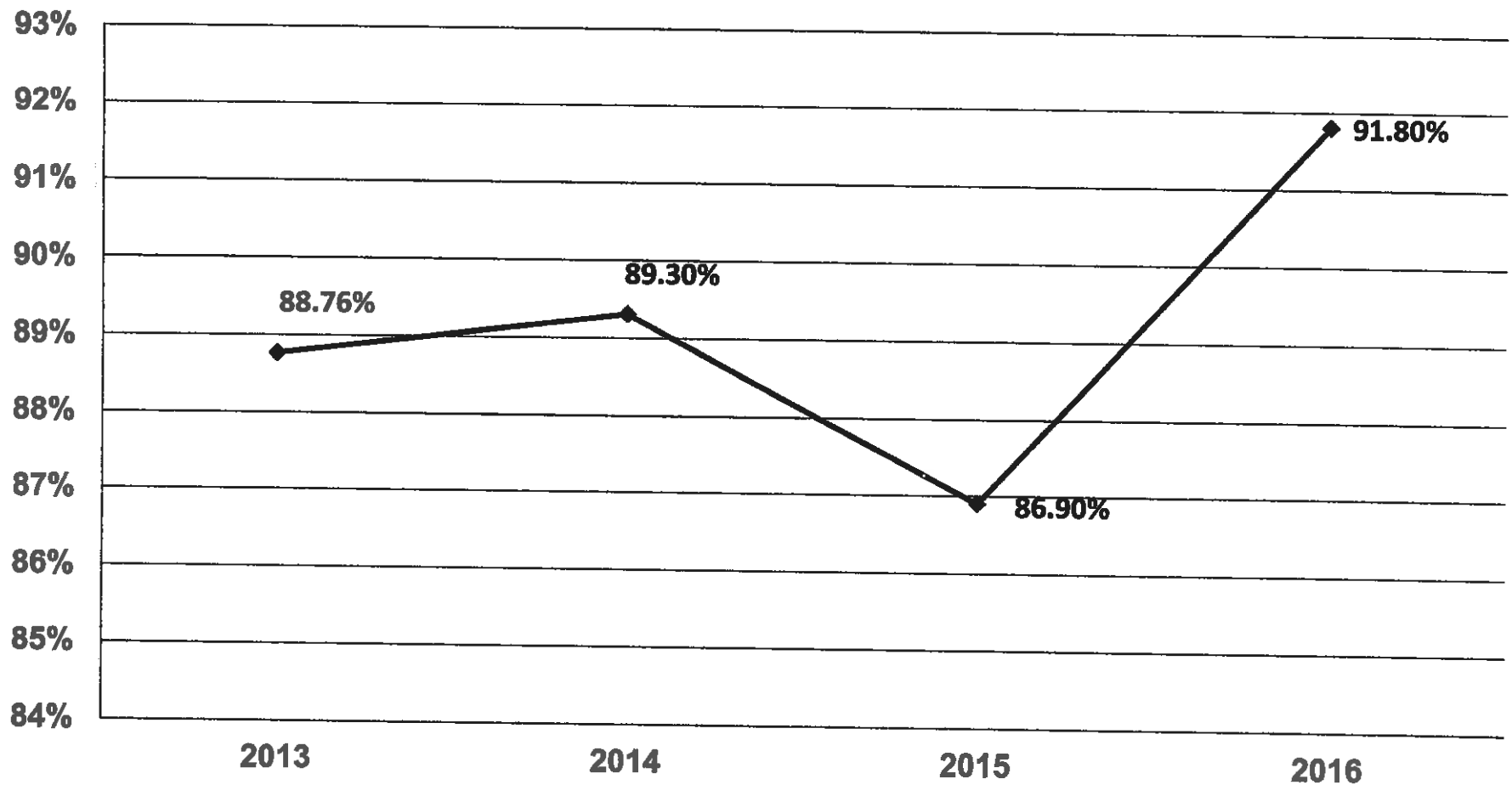
REVENUES, CLAIMS EXPENSE, AND CLAIMS PAYABLE (IN THOUSANDS)



Source: Annual Department of Managed Health Care Filing



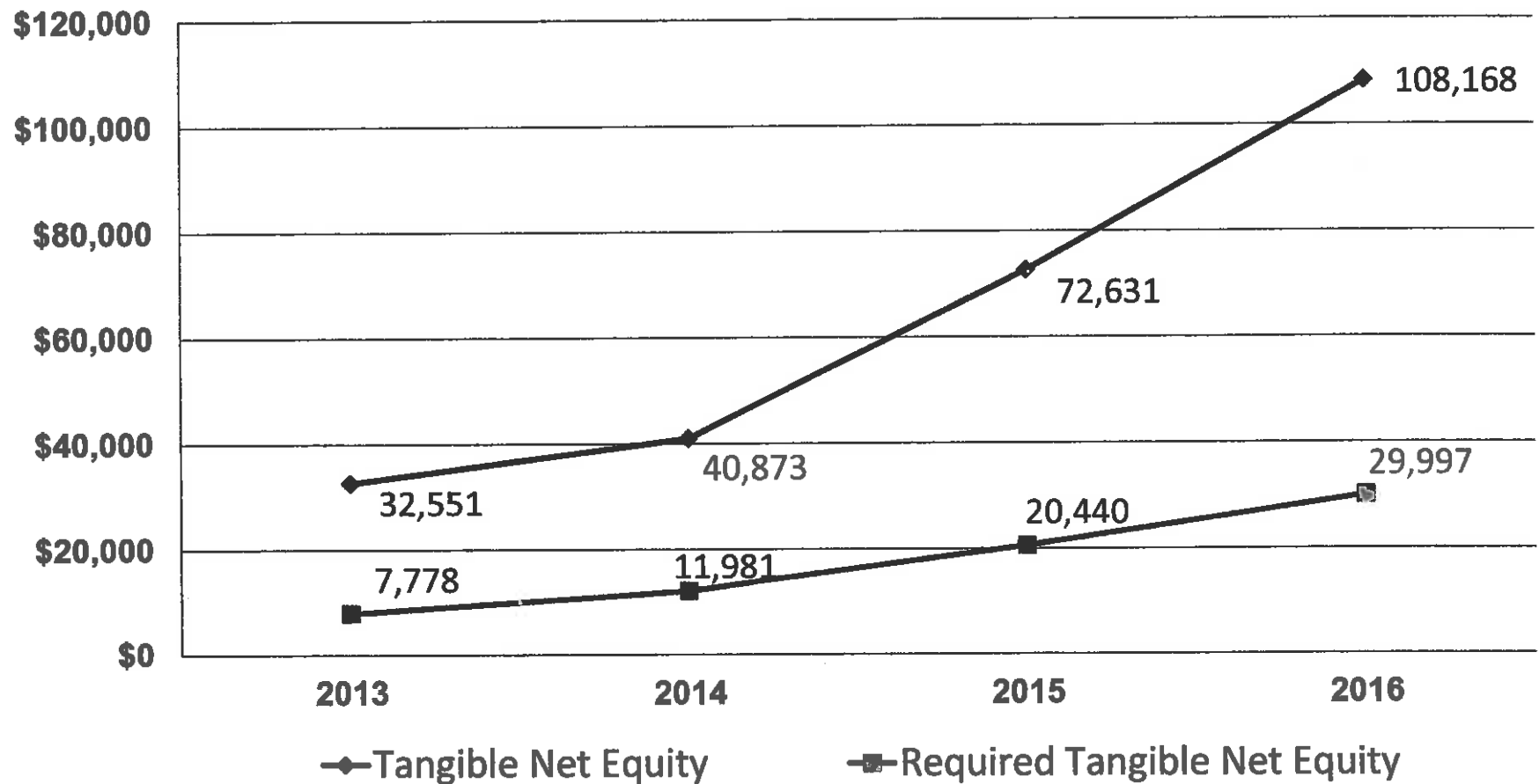
TREND OF MEDICAL LOSS RATIO FOR ALL LINES OF BUSINESS



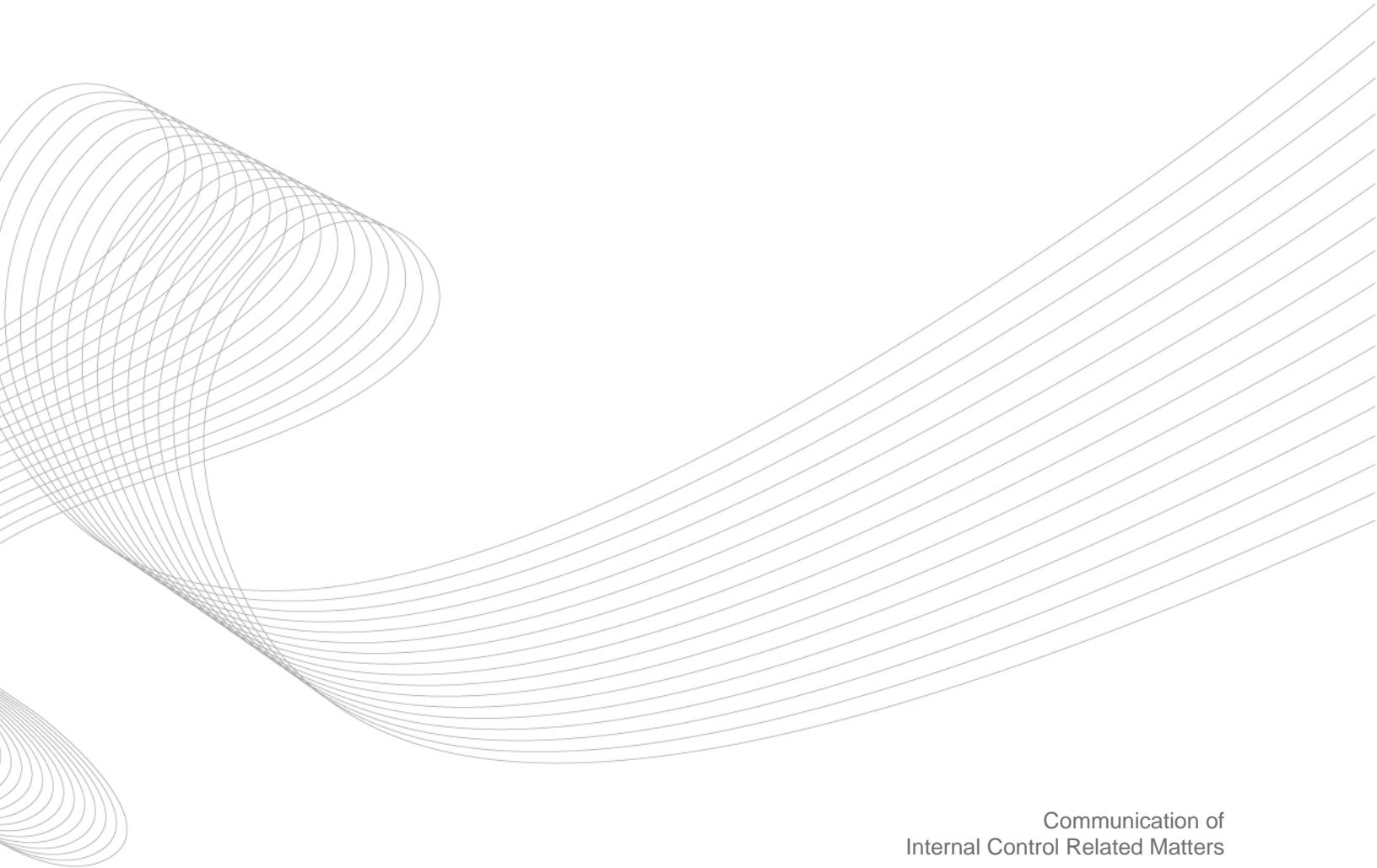
Source: Medical loss ratio calculated using internal reports.

TANGIBLE NET EQUITY

(IN THOUSANDS)



Source: Annual Department of Managed Health Care Filing



Communication of
Internal Control Related Matters

**Santa Clara County Health Authority
(dba Santa Clara Family Health Plan
and Santa Clara Community
Health Authority**

June 30, 2016

MOSS-ADAMS_{LLP}

Certified Public Accountants | Business Consultants

COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS

To the Board of Directors
Santa Clara County Health Authority
(dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority

In planning and performing our audit of the combined financial statements of Santa Clara County Health Authority (dba Santa Clara Family Health Plan) and Santa Clara Community Health Authority (collectively, the "Health Authority"), as of and for the year ended June 30, 2016, in accordance with auditing standards generally accepted in the United States of America, we considered the Health Authority's internal control over financial reporting (internal control) as a basis for designing our audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health Authority's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health Authority's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

We did note the following items that management might consider as best practice recommendations. We believe the following operational or administrative recommendation may be of a potential benefit to the Health Authority:

Formalized Written Policies and Procedures

Observation: We observed there are insufficient written policies and procedures surrounding the significant business cycles, such as financial closing and reporting, cash management, expenditures, payroll, claims, capitation revenue, and capitation expense.

Recommendation: We recommend that management develop formalized written policies and procedures for these significant business cycles.

Management's Response: The Health Authority's CFO and Controller will conduct a comprehensive review of all Finance functions, develop all needed policy and procedure documentation, ensure that the policies & procedures are routinely followed, and ensure that regular completion is documented.

“Super-User” Access Rights

Observation: We observed that the Accounting Manager has “super-user” access rights within the accounting and payroll systems. This could potentially affect proper access rights and segregation of duties of others.

Recommendation: We recommend that management ensure that no employee has “super-user” access rights within the accounting and payroll systems and that each employee has the appropriate user access rights for the employee’s position.

Management’s Response: Management concurs with this recommendation. The Health Authority’s Controller will conduct a comprehensive review of access rights granted to all Finance staff and will work with the Health Authority’s Information Technology staff to ensure that access is appropriately limited to the minimum level required.

Reports Of Cybersecurity Attacks

Observation: We observed there is no formalized policy surrounding management receiving and reviewing regular reports that communicate the frequency and number of attempted cybersecurity attacks on the Health Authority’s IT network.

Recommendation: One of the key performance indicators for how well an organization's current cybersecurity strategy is working is the number of thwarted breach attempts and attacks on the organization's network. Regular reporting on the number of attacks and the number of nullified attacks helps management determine the effectiveness of the defense measures implemented, as well as determine if additional measures are needed given the volume of continuing and varied attacks. We recommend that management develop a formalized policy for IT management to provide visibility to the Health Authority's management of the number of attacks it sustains over various timeframes (e.g., daily, weekly) and the success at defeating them. This reporting could be in the form of verbal reports during regularly scheduled management meetings or via a dashboard on the Health Authority's intranet site that is available to all employees to view if interested.

Management’s Response: The Health Authority’s CIO & Information Technology staff will implement regular reporting to Executive Leadership of cybersecurity threats.

Documentation of Review of AP Reconciliations

Observation: We observed that there is no documentation of review of AP reconciliations to ensure proper review and approval of monthly AP reconciliations had occurred.

Recommendation: We recommend management document review of the AP reconciliations.

Management’s Response: The Health Authority’s CFO and Controller will conduct a comprehensive review of all Finance functions, develop all needed policy and procedure documentation, ensure that the policies & procedures are routinely followed, and ensure that regular completion is documented.

Review and Documentation of Review of Journal Entries

Observation: We observed that there is a lack of consistency in documentation of review of journal entries to ensure that adequate review and approval of journal entries with proper supporting documentation had occurred.

Recommendation: We recommend that management develop a process to ensure that all journal entries are reviewed and to ensure there is consistent documentation of the review.

Management's Response: The Health Authority's CFO and Controller will conduct a comprehensive review of all Finance functions, develop all needed policy and procedure documentation, ensure that the policies & procedures are routinely followed, and ensure that regular completion is documented.

Board Review and Approval of Significant Contracts

Observation: We observed there is no formal review and approval by the Board for significant contracts.

Recommendation: We recommend that management develop a formal documented policy and procedure with consideration of dollar thresholds for significant contracts that would require review and approval by executive management and/or the Board.

Management's Response: The Health Authority's CFO and Controller will conduct a comprehensive review of all Finance functions, develop all needed policy and procedure documentation, ensure that the policies & procedures are routinely followed, and ensure that regular completion is documented.

Management's written responses to the operational or administrative recommendations noted in our audit were not subjected to the auditing procedures applied in the audit of the combined financial statements and, accordingly, we express no opinion on them.

This communication is intended solely for the information and use of management, the Board of Directors, and others within the Health Authority and is not intended to be, and should not be used by anyone other than these specified parties.



San Francisco, California
October 27, 2016



Santa Clara
Family Health Plan

Case Management Application Executive Committee

October 27, 2016



Case Management

- Case management is currently on the Altruista product:
 - Limited functionality and capacity for expansion to SPD
 - Hosted, web-based solution (limits SCFHP's ability to internally configure and develop the system)
 - Cost of ownership more than a new solution
- Regulatory requirements for Cal MediConnect (CMC)
 - Implementing mandated business processes and delivering regulatory reports for our CMC line of business has been challenging on Altruista



Compliance

- Implementing a new case management system will help to ensure compliance with the following regulations regarding case management:
 - Dual Plan Letter (DPL) 15-005: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
 - Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements
 - SCFHP's Three-Way Contract with CMS and DHCS
 - NCQA Health Plan Standards and Guidelines
 - SCFHP 2017 Model of Care



Request for Quote (RFQ)

- Four vendors participated in the RFQ process: Casenet, TriZetto, ZeOmega, and Essette
- Three vendors were invited to demo: Essette, TriZetto and Casenet
- Finalist selected based on combination of highest functionality, meeting compliance, and best price



Executive Committee

Proposed Action:

Augment the fiscal year 2016 - 2017 capital budget and authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected case management system vendor in an amount not to exceed \$550K for licensing and implementation.





August 2016 Financial Summary

SCCHA Executive Committee Meeting
October 27, 2016



Fiscal Year 2016-17 Highlights

- **Net Surplus** — Aug \$1.3m surplus and YTD \$1.4m surplus (\$0.6m unfavorable to budget)
- **Enrollment** — Aug 2016 membership: 280,382 (2.2% favorable to budget) and Aug YTD: 556,691 member months (1.6% favorable to budget and 10.3% higher than Aug YTD last year)
 - Continued growth in Adult and Aged Medi-Cal membership. CMC membership has been trending downward.
- **Revenue** — over budget by \$6.5 m (+3.4%)
 - Increase is due to higher than budgeted members year to date, which was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.
- **Medical Expenses** — over budget by \$7.0m (-3.9%)
 - Increase is due to higher than budgeted member months resulting in higher capitation costs and also due to higher hospital and LTC expenses, which are partially offset by lower Professional FFS, Outpatient, and Pharmacy expenses.
- **Administrative Expenses** — over budget by \$50k (-0.7%)
 - Increase is due to open positions being filled by consulting/temporary resources and the overall vacancy rate being lower than budget. Some of this increase was offset by lower information service expenses and legal expenses.
- **Other Expenses** — over budget by \$18k due to lower interest income than budget
- **Balance Sheet**
 - Cash position increased due to the receipt of Medicare RAF receivable and an overall increase in the payables.
 - Receivables for CCI rate recast continued to increase (partially offset by Medi-Cal Expansion rate overpayments).
 - TNE of \$101.7M or 314% of Required TNE of \$32.4m per DMHC (\$11.6 million below the SCFHP low-end Equity Target and \$35.3 million above the low-end Liquidity Target).
 - Capital Expenses increased by \$1.1 million due to capitalization of work-in-progress expenses of the Trizetto project.



Consolidated Performance

August 2016 and Year to Date

	Month of August	FYTD through August
Revenue	\$98.9 million	\$196.5 million
Medical Costs	\$94.1 million	\$187.7 million
Medical Loss Ratio	95.2%	95.6%
Administrative Costs	\$3.4 million (3.5%)	\$7.1 million (3.6%)
Other Income/ Expense	(\$59,477)	(\$189,760)
Net Surplus (Loss)	\$1,263,850	\$1,412,292
Cash on Hand		\$161.7 million
Receivables		\$472.5 million
Current Liabilities		\$531 million
Tangible Net Equity		\$101.7 million
Pct. Of Min. Requirement		314%



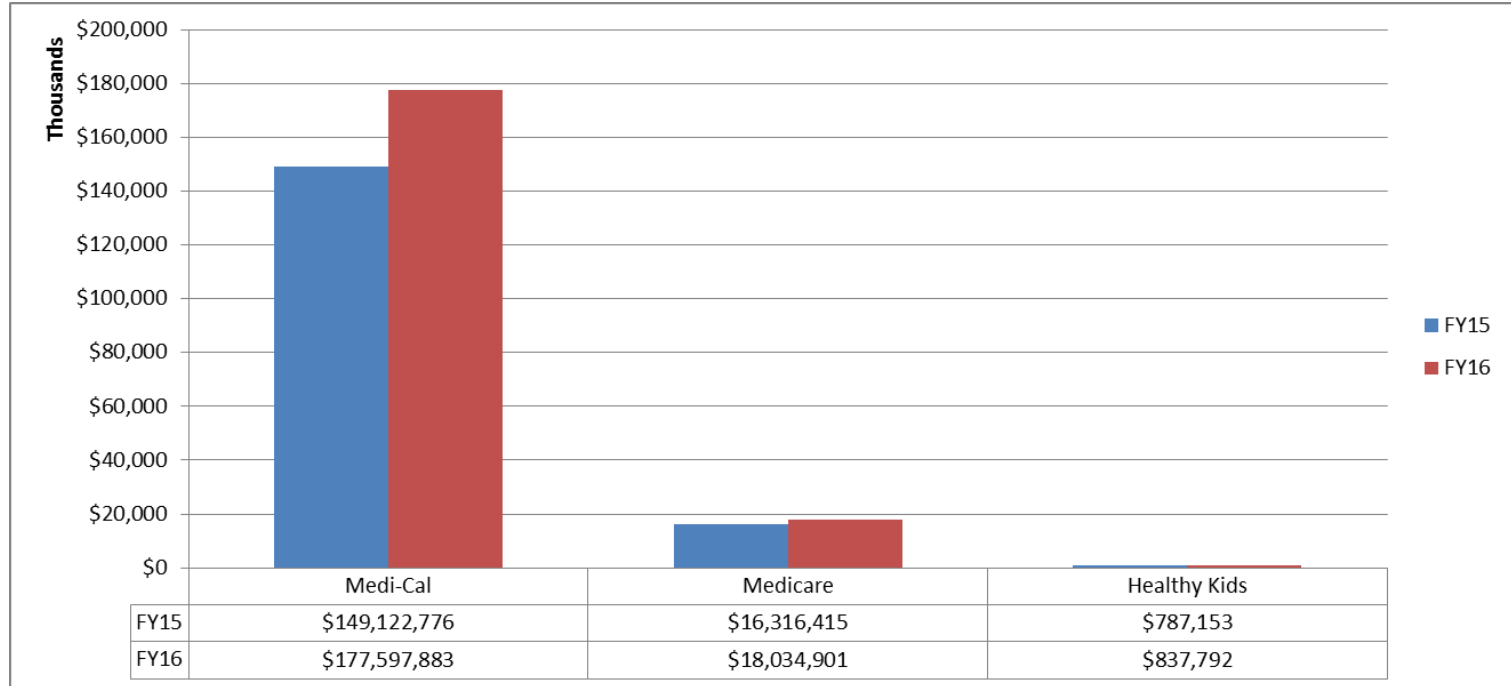
Consolidated Performance

Summary Operating Results - Actual vs. Budget
For the Current Month & Fiscal Year to Date - Aug 2016
 Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 98,884,096	\$ 94,946,833	\$ 3,937,263	4.1%	Revenue	\$ 196,470,576	\$ 189,934,575	\$ 6,536,001	3.4%
94,130,661	90,332,021	(3,798,639)	-4.2%	Medical Expense	187,734,794	180,709,502	(7,025,292)	-3.9%
4,753,435	4,614,811	138,624	3.0%	Gross Margin	8,735,782	9,225,073	(489,291)	-5.3%
3,430,108	3,490,164	60,055	1.7%	Administrative Expense	7,133,730	7,083,344	(50,387)	-0.7%
1,323,326	1,124,647	198,679	17.7%	Net Operating Income	1,602,052	2,141,730	(539,677)	-25.2%
(59,477)	(85,842)	26,366	30.7%	Non-Operating Income/Exp	(189,760)	(171,685)	(18,076)	-10.5%
\$ 1,263,850	\$ 1,038,805	\$ 225,045	21.7%	Net Surplus/ (Loss)	\$ 1,412,292	\$ 1,970,045	\$ (557,753)	-28.3%



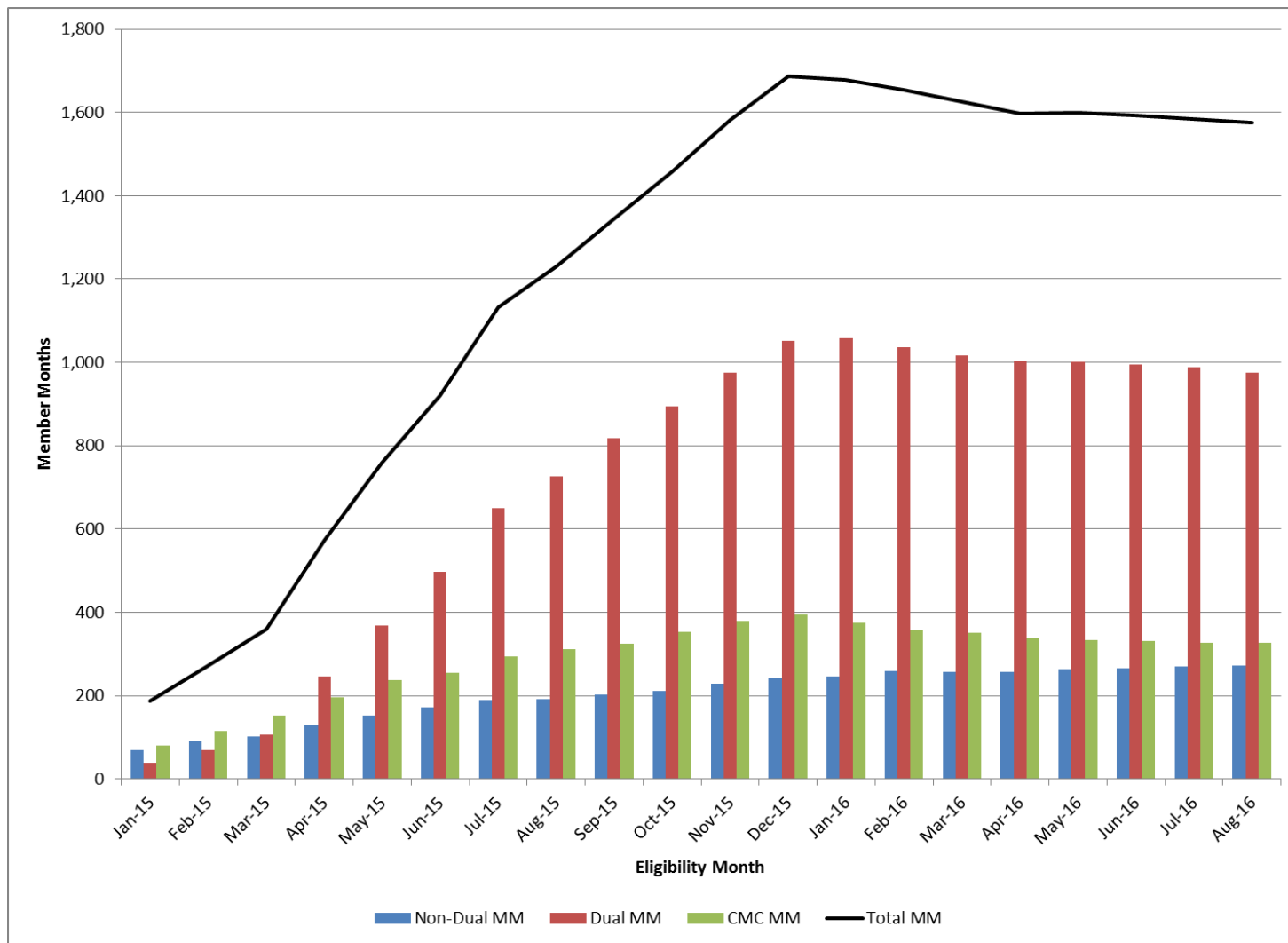
Year Over Year Revenue Trend



Medi-Cal revenue increased by 19% and Medicare revenue increased by 11%.



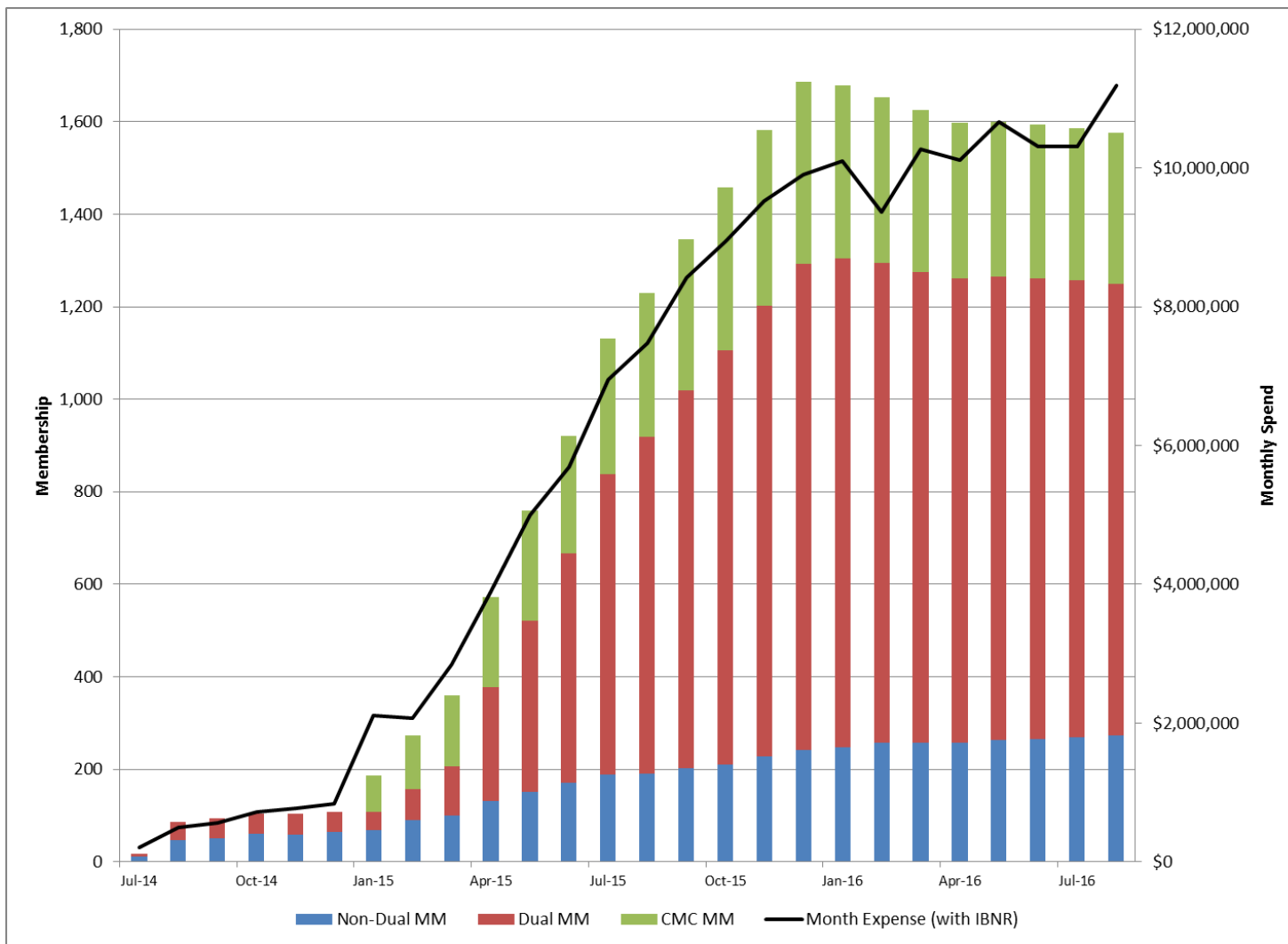
Long Term Care Membership Medi-Cal and CMC





Medi-Cal Long Term Care Experience

Jul 2014 – Aug 2016





Enrollment Summary August and YTD

Santa Clara Family Health Plan Enrollment Summary
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For the Month of Aug 2016

Two Months Ending Aug 2016

	<u>Actual</u> <u>Budget</u> <u>Variance</u>			<u>Actual</u> <u>Budget</u> <u>Variance</u>			<u>Prior Year</u>	<u>Change</u>
							<u>Actual</u>	<u>vs. FY16</u>
Medi-Cal	268,133	262,043	2.3%	531,954	523,133	1.7%	480,469	10.7%
Healthy Kids	4,224	4,326	(2.3%)	8,604	8,791	(2.1%)	9,094	(5.4%)
Medicare	8,025	7,878	1.9%	16,133	15,906	1.4%	15,241	5.9%
Total	280,382	274,246	2.2%	556,691	547,831	1.6%	504,804	10.3%



Enrollment by Network - YTD

Santa Clara Health Authority
Aug 2016

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	24,949	9%	254	6%	8,025	100%	33,228	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	143,116	53%	2,678	63%	-	0%	145,794	52%
Palo Alto Medical Foundation	7,596	3%	38	1%	-	0%	7,634	3%
Physicians Medical Group	48,577	18%	1,081	26%	-	0%	49,658	18%
Premier Care	16,529	6%	173	4%	-	0%	16,702	6%
Kaiser	27,366	10%	-	0%	-	0%	27,366	10%
Total	268,133	100%	4,224	100%	8,025	100%	280,382	100%
Enrollment at June 30, 2016	260,029		4,435		8,203		272,667	
Net Change from Beginning of FY17	3.1%		-4.8%		-2.2%		2.8%	

Membership has increased 2.8% since the beginning of the Fiscal Year, primarily due to growth in Adult and Aged Medi-Cal membership.



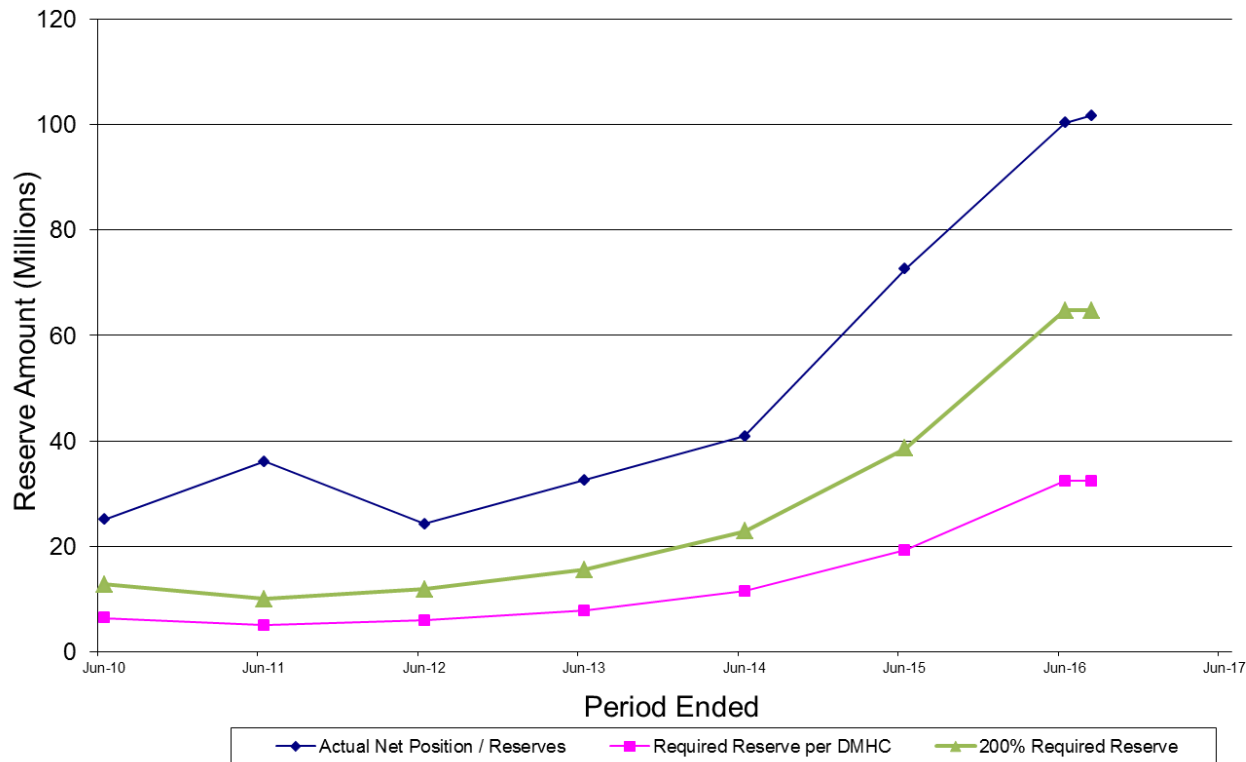
Enrollment by Aid Category

		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,261	11,123	11,106	11,066	10,998	10,954	10,895	10,843	10,812	10,912
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38
	Long Term Care	194	194	205	212	230	249	248	259	258	257	264	266	270	275
Total Non-Duals		221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708
DUAL	Aged	10,003	10,678	11,583	12,426	13,381	14,035	14,074	14,246	14,328	14,301	14,415	14,496	14,524	14,521
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843
	Long Term Care	644	722	814	904	982	1,064	1,058	1,038	1,019	1,006	1,003	998	992	980
	Total Duals		16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366
Total Medi-Cal		238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135
Healthy Kids		4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,527	9,305	8,784	8,528	8,377	8,151	8,033	7,871	7,781	7,697
	CMC - Long Term Care	294	312	325	352	379	394	375	358	351	337	334	332	327	328
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025
Total Enrollment		250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384



Tangible Net Equity at August 31, 2016

TNE is \$101.7 million or 314% of the Required TNE of \$32.4m per the Department of Managed Health Care (DMHC). The Plans reserves are roughly \$11.6 million below the SCFHP low end TNE target and \$35.3 million above the SCFHP low end liquidity target.





Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Two Months Ended August 2016
(Unaudited)

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

Summary of Financial Results

For the month of August 2016, SCFHP recorded a net surplus of \$1.3 million compared to a budgeted net surplus of \$1.0 million resulting in a favorable variance from budget of \$0.2 million. For year to date August 2016, SCFHP recorded a net surplus of \$1.4 million compared to a budgeted net surplus of \$2.0 million resulting in an unfavorable variance from budget of \$0.6 million. The table below summarizes the components of the overall variance from budget.

Summary Operating Results – Actual vs. Budget
For the Current Month & Fiscal Year to Date – Aug 2016
Favorable/ (Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 98,884,096	\$ 94,946,833	\$ 3,937,263	4.1%	Revenue	\$ 196,470,576	\$ 189,934,575	\$ 6,536,001	3.4%
94,130,661	90,332,021	(3,798,639)	-4.2%	Medical Expense	187,734,794	180,709,502	(7,025,292)	-3.9%
4,753,435	4,614,811	138,624	3.0%	Gross Margin	8,735,782	9,225,073	(489,291)	-5.3%
3,430,108	3,490,164	60,055	1.7%	Administrative Expense	7,133,730	7,083,344	(50,387)	-0.7%
1,323,326	1,124,647	198,679	17.7%	Net Operating Income	1,602,052	2,141,730	(539,677)	-25.2%
(59,477)	(85,842)	26,366	30.7%	Non-Operating Income/Exp	(189,760)	(171,685)	(18,076)	-10.5%
\$ 1,263,850	\$ 1,038,805	\$ 225,045	21.7%	Net Surplus/ (Loss)	\$ 1,412,292	\$ 1,970,045	\$ (557,753)	-28.3%

Member Months

For the month of August 2016, overall member months were higher than budget by 6,136 (+2.2%). For year to date August 2016, overall member months were higher than budget by 8,860 (+1.6%).

In the two months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 3.1%, membership in the Healthy Kids program decreased by 4.8%, and membership in the CMC program decreased by 2.2%.

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

Revenue

The Health Plan recorded net revenue of \$98.9 million for the month of August 2016, compared to budgeted revenue of \$94.9 million, resulting in a favorable variance from budget of \$3.9 million, or 4.1%. For year to date August 2016, the Plan recorded net revenue of \$196.5 million, compared to budgeted revenue of \$189.9 million, resulting in a favorable variance from budget of \$6.5 million, or 3.4%. The favorable variance was largely due to higher than budgeted members year to date. The Plan also received additional retroactivity related revenue. These positive variances were partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher PMPM reflecting the higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.

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

Medical Expenses

For the month of August 2016, medical expense was \$94.1 million compared to budget of \$90.3 million, resulting in an unfavorable budget variance of \$3.8 million, or -4.2%. For year to date August 2016, medical expense was \$187.7 million compared to budget of \$180.7 million, resulting in an unfavorable budget variance of \$7.0 million, or -3.9%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by lower Professional FFS, Outpatient services, and Pharmacy expenses.

Administrative Expenses

Overall administrative costs were under budget by \$60 thousand (+1.7%) for the month of August 2016, and over budget by \$50 thousand (-0.7%) for year to date August 2016. Personnel costs were over budget due to open positions being filled by consulting and temporary staffing resources as well as the overall vacancy rate being lower than budget. Some of this unfavorability was offset by lower information service expenses and legal expenses.

Overall administrative expenses were 3.6% of revenues for year to date August 2016.

Balance Sheet (Page 6)

Current assets at August 31, 2016 totaled \$638.9 million compared to current liabilities of \$531.0 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 as of August 31, 2016. Working capital increased by \$0.8 million for the two months year to date ended August 31, 2016.

Cash as of August 31, 2016, increased by \$15.6 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by \$55.3 million during the same two months period ended August 31, 2016. The cash position increased largely due to the receipt of Medicare RAF receivable and an overall increase in the payables.

Liabilities increased by a net amount of \$68.2 million during the two months ended August 2016. Liabilities increased primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State and an increase in IHSS/MCO payables.

Capital Expenses increased by \$1.1 million for the two months ended August 31, 2016. Most of these expenses represent the capitalized portion of the claims system (Trizetto) upgrade project.

Reserves Analysis

Tangible Net Equity (TNE) was \$101.7 million at August 31, 2016 or 314% of the minimum Required TNE per the Department of Managed Health Care (DMHC) of \$32.4 million. A chart showing TNE trends is shown on page 14 of this report.

At the September 2016 Board of Director's meeting, a policy was adopted for targeting the organization's capital reserves to include a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

As of August 31, 2016, the Plan's TNE was \$11.6 million below the low-end Equity Target and \$35.3 million above the low-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	\$101,705,748
Current Required TNE	\$32,375,000
Excess TNE	\$69,330,748
Required TNE Percentage	314%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	\$113,312,500
500% of Required TNE (high end)	\$161,875,000
TNE Above/(Below) SCFHP Low End Target	(\$11,606,752)
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	\$ 161,669,825
Less: Pass-Through Liabilities (Non State of CA *)	(6,829,475)
Net Cash Available to SCFHP	\$154,840,350
SCFHP Target Liquidity: **	
45 days of Total Operating Expenses	(\$119,497,435)
60 days of Total Operating Expenses	(\$159,329,914)
Liquidity Above/(Below) SCFHP Low End Target	\$35,342,915

* Supplemental Information: Pass-Throughs from State of CA	
Receivables Due to SCFHP	468,400,108
Payables Due from SCFHP	(426,217,982)
Net Receivable/(Payable)	\$42,182,125

** Excludes IHSS

**Santa Clara County Health Authority
Balance Sheet**

	<u>AUG 16</u>	<u>JUL 16</u>	<u>JUN 16</u>	<u>JUN 15</u>
Assets				
Current Assets				
Cash and Marketable Securities	\$ 161,669,825	\$ 156,693,435	\$ 146,082,070	\$ 110,520,927
Premiums Receivable	472,494,829	447,225,673	417,166,973	177,531,031
Due from Santa Clara Family Health Foundation - net				3,612
Prepaid Expenses and Other Current Assets	<u>4,697,053</u>	<u>6,340,911</u>	<u>6,766,163</u>	<u>1,917,101</u>
Total Current Assets	638,861,708	610,260,019	570,015,205	289,972,670
Long Term Assets				
Equipment	14,779,896	13,769,810	13,717,799	11,879,173
Less: Accumulated Depreciation	<u>(9,089,501)</u>	<u>(8,936,053)</u>	<u>(8,775,886)</u>	<u>(7,363,871)</u>
Total Long Term Assets	<u>5,690,395</u>	<u>4,833,757</u>	<u>4,941,913</u>	<u>4,515,302</u>
Total Assets	<u>\$ 644,552,103</u>	<u>\$ 615,093,776</u>	<u>\$ 574,957,118</u>	<u>\$ 294,487,972</u>
Deferred Outflow of Resources	<u>\$ 1,570,339</u>	<u>\$ 1,570,339</u>	<u>1,570,339</u>	<u>1,367,331</u>
Total Deferred Outflows and Assets	<u>646,122,442</u>	<u>616,664,115</u>	<u>576,527,457</u>	<u>295,855,303</u>
Liabilities and Net Position				
Current Liabilities				
Trade Payables	\$ 3,886,568	\$ 3,645,802	\$ 4,824,017	\$ 3,547,100
Deferred Rent	134,106	138,257	142,408	167,134
Employee Benefits	941,677	1,015,476	1,013,759	973,066
Retirement Obligation per GASB 45	101,185	50,592		
Advance Premium - Healthy Kids	48,742	66,827	65,758	65,828
Liability for ACA 1202	5,503,396	5,503,396	5,503,985	5,069,225
Payable to Hospitals (SB90)	55,140	55,140	55,140	55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,306,473	1,289,030	1,717,483	4,615,251
Due to Santa Clara County Valley Health Plan and Kaiser	8,007,431	7,293,954	6,604,472	12,550,402
MCO Tax Payable - State Board of Equalization	22,948,187	18,556,017	10,779,014	8,909,559
Due to DHCS	134,655,041	120,850,476	107,213,315	22,173,221
Liability for In Home Support Services (IHSS)	268,614,754	253,234,802	238,387,141	69,537,810
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	13,088,054
Medical Cost Reserves	<u>82,457,496</u>	<u>88,840,951</u>	<u>84,321,012</u>	<u>70,819,543</u>
Total Current Liabilities	530,999,187	502,879,710	462,966,494	211,535,798
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	4,911,946
Net Pension Liability GASB 68	5,168,386	5,093,386	5,018,386	4,883,971
Total Liabilities	<u>542,087,073</u>	<u>513,892,596</u>	<u>473,904,380</u>	<u>221,331,715</u>
Deferred Inflow of Resources	<u>2,329,621</u>	<u>2,329,621</u>	<u>2,329,621</u>	<u>1,892,634</u>
Net Position / Reserves				
Invested in Capital Assets	5,690,395	4,833,757	4,941,913	4,515,302
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	94,297,711	95,154,349	67,383,691	30,416,972
Current YTD Income (Loss)	<u>1,412,292</u>	<u>148,442</u>	<u>27,662,502</u>	<u>37,393,330</u>
Net Position / Reserves	<u>101,705,748</u>	<u>100,441,898</u>	<u>100,293,456</u>	<u>72,630,954</u>
Total Liabilities, Deferred Inflows, and Net Assets	<u>\$ 646,122,442</u>	<u>\$ 616,664,115</u>	<u>\$ 576,527,457</u>	<u>\$ 295,855,303</u>
Solvency Ratios:				
Working Capital	\$ 107,862,521	\$ 107,380,309	\$ 107,048,711	\$ 78,436,872
Working Capital Ratio	1.2	1.2	1.2	1.4
Average Days Cash on Hand	51	50	47	55

Santa Clara County Health Authority
Income Statement for the Two Months Ending Aug 31, 2016

	For the Month of Aug 2016					For Two Months Ending Aug 31, 2016				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	\$ 89,787,769	90.8%	\$ 86,126,352	90.7%	\$ 3,661,417	\$ 177,597,883	90.4%	\$ 172,120,986	90.6%	\$ 5,476,896
HEALTHY KIDS	\$ 423,382	0.4%	\$ 381,365	0.4%	\$ 42,017	\$ 837,792	0.4%	\$ 774,673	0.4%	\$ 63,120
MEDICARE	\$ 8,672,945	8.8%	\$ 8,439,116	8.9%	\$ 233,829	\$ 18,034,901	9.2%	\$ 17,038,916	9.0%	\$ 995,985
TOTAL REVENUE	<u>\$ 98,884,096</u>	<u>100.0%</u>	<u>\$ 94,946,833</u>	<u>100.0%</u>	<u>\$ 3,937,263</u>	<u>\$ 196,470,576</u>	<u>100.0%</u>	<u>\$ 189,934,575</u>	<u>100.0%</u>	<u>\$ 6,536,001</u>
MEDICAL EXPENSES										
MEDI-CAL	\$ 83,717,073	84.7%	\$ 82,124,226	86.5%	\$ (1,592,847)	\$ 166,770,649	84.9%	\$ 164,132,788	86.4%	\$ (2,637,861)
HEALTHY KIDS	\$ 366,182	0.4%	\$ 367,761	0.4%	\$ 1,579	\$ 700,825	0.4%	\$ 747,424	0.4%	\$ 46,599
MEDICARE	\$ 10,047,406	10.2%	\$ 7,840,035	8.3%	\$ (2,207,370)	\$ 20,263,321	10.3%	\$ 15,829,290	8.3%	\$ (4,434,030)
TOTAL MEDICAL EXPENSES	<u>\$ 94,130,661</u>	<u>95.2%</u>	<u>\$ 90,332,021</u>	<u>95.1%</u>	<u>\$ (3,798,639)</u>	<u>\$ 187,734,794</u>	<u>95.6%</u>	<u>\$ 180,709,502</u>	<u>95.1%</u>	<u>\$ (7,025,292)</u>
MEDICAL OPERATING MARGIN	\$ 4,753,435	4.8%	\$ 4,614,811	4.9%	\$ 138,624	\$ 8,735,782	4.4%	\$ 9,225,073	4.9%	\$ (489,291)
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	\$ 1,743,779	1.8%	\$ 1,631,081	1.7%	\$ (112,698)	\$ 3,384,587	1.7%	\$ 3,097,500	1.6%	\$ (287,087)
RENTS AND UTILITIES	\$ 106,389	0.1%	\$ 113,523	0.1%	\$ 7,134	\$ 213,934	0.1%	\$ 225,464	0.1%	\$ 11,531
PRINTING AND ADVERTISING	\$ 151,216	0.2%	\$ 169,108	0.2%	\$ 17,892	\$ 175,188	0.1%	\$ 212,967	0.1%	\$ 37,779
INFORMATION SYSTEMS	\$ 106,724	0.1%	\$ 227,062	0.2%	\$ 120,338	\$ 312,113	0.2%	\$ 508,424	0.3%	\$ 196,311
PROF FEES / CONSULTING / TEMP STAFFING	\$ 841,245	0.9%	\$ 908,042	1.0%	\$ 66,797	\$ 1,812,858	0.9%	\$ 1,835,860	1.0%	\$ 23,002
DEPRECIATION / INSURANCE / EQUIPMENT	\$ 176,516	0.2%	\$ 175,470	0.2%	\$ (1,047)	\$ 379,852	0.2%	\$ 351,339	0.2%	\$ (28,513)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	\$ 227,036	0.2%	\$ 183,180	0.2%	\$ (43,856)	\$ 708,505	0.4%	\$ 686,359	0.4%	\$ (22,146)
MEETINGS / TRAVEL / DUES	\$ 64,544	0.1%	\$ 78,419	0.1%	\$ 13,875	\$ 128,933	0.1%	\$ 156,371	0.1%	\$ 27,438
OTHER	\$ 12,660	0.0%	\$ 4,280	0.0%	\$ (8,381)	\$ 17,760	0.0%	\$ 9,059	0.0%	\$ (8,701)
TOTAL ADMINISTRATIVE EXPENSES	<u>\$ 3,430,108</u>	<u>3.5%</u>	<u>\$ 3,490,164</u>	<u>3.7%</u>	<u>\$ 60,055</u>	<u>\$ 7,133,730</u>	<u>3.6%</u>	<u>\$ 7,083,344</u>	<u>3.7%</u>	<u>\$ (50,387)</u>
OPERATING SURPLUS (LOSS)	\$ 1,323,326	1.3%	\$ 1,124,647	1.2%	\$ 198,679	\$ 1,602,052	0.8%	\$ 2,141,730	1.1%	\$ (539,677)
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	\$ (50,592)	-0.1%	\$ (50,592)	-0.1%	\$ -	\$ (101,185)	-0.1%	\$ (101,185)	-0.1%	\$ -
GASB 68 - UNFUNDED PENSION LIABILITY	\$ (75,000)	-0.1%	\$ (75,000)	-0.1%	\$ -	\$ (150,000)	-0.1%	\$ (150,000)	-0.1%	\$ -
INTEREST & OTHER INCOME	\$ 66,115	0.1%	\$ 39,750	0.0%	\$ 26,366	\$ 61,424	0.0%	\$ 79,500	0.0%	\$ (18,076)
NET SURPLUS (LOSS) FINAL	<u>\$ 1,263,850</u>	<u>1.3%</u>	<u>\$ 1,038,805</u>	<u>1.1%</u>	<u>\$ 225,045</u>	<u>\$ 1,412,292</u>	<u>0.7%</u>	<u>\$ 1,970,045</u>	<u>1.0%</u>	<u>\$ (557,753)</u>

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

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 1,743,779	\$ 1,631,081	\$ (112,698)	-6.9%	Personnel	\$ 3,384,587	\$ 3,097,500	\$ (287,087)	-9.3%
1,686,330	1,859,083	172,754	9.3%	Non-Personnel	3,749,143	3,985,844	\$ 236,700	5.9%
3,430,108	3,490,164	60,055	1.7%	Total Administrative Expense	7,133,730	7,083,344	(50,387)	-0.7%

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

Two Months Ended Aug 31, 2016

	Medi-Cal	CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)				
REVENUE	172,947,190	22,685,594	\$837,792	\$196,470,576
MEDICAL EXPENSES	161,493,631	25,540,339	700,825	\$187,734,794
(MLR)	93.4%	112.6%	83.7%	95.6%
GROSS MARGIN	11,453,559	(2,854,745)	136,968	8,735,782
ADMINISTRATIVE EXPENSES <i>(% MM allocation except CMC)</i>	6,209,594	823,700	100,436	7,133,730
OPERATING INCOME/(LOSS)	5,243,966	(3,678,445)	36,532	1,602,052
OTHER INCOME/(EXPENSE) <i>(% of Revenue Allocation)</i>	(167,040)	(21,911)	(809)	(189,760)
NET INCOME/ (LOSS)	\$5,076,925	(\$3,700,356)	\$35,722	\$1,412,292
PMPM (ALLOCATED BASIS)				
REVENUE	\$325.12	\$1,406.16	\$97.37	\$352.93
MEDICAL EXPENSES	303.59	1,583.11	81.45	337.23
GROSS MARGIN	21.53	(176.95)	15.92	15.69
ADMINISTRATIVE EXPENSES	11.67	51.06	11.67	12.81
OPERATING INCOME/(LOSS)	9.86	(228.01)	4.25	2.88
OTHER INCOME/ (EXPENSE)	(0.31)	(1.36)	(0.09)	(0.34)
NET INCOME/ (LOSS)	\$9.54	(\$229.37)	\$4.15	\$2.54
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	531,954	16,133	8,604	556,691
Member MONTHS by LOB	95.6%	2.9%	1.6%	100%
Revenue by LOB	88.0%	11.5%	0.4%	100%

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

Cash flows from operating activities	
Premiums received	\$ 180,753,618
Medical expenses paid	\$ (157,967,737)
Administrative expenses paid	\$ (6,197,453)
Net cash from operating activities	\$ 16,588,429
Cash flows from capital and related financing activities	
Purchases of capital assets	\$ (1,062,097)
Cash flows from investing activities	
Interest income and other income, net	\$ 61,424
Net (Decrease) increase in cash and cash equivalents	\$ 15,587,755
Cash and cash equivalents, beginning of year	\$ 146,082,070
Cash and cash equivalents at Aug 31, 2016	\$ 161,669,825
Reconciliation of operating income to net cash from operating activities	
Operating income (loss)	\$ 1,350,868
Adjustments to reconcile operating income to net cash from operating activities	
Depreciation	\$ 313,616
Changes in operating assets and liabilities	
Premiums receivable	\$ (55,327,857)
Due from Santa Clara Family Health Foundation	\$ -
Prepays and other assets	\$ 2,069,109
Deferred outflow of resources	\$ -
Accounts payable and accrued liabilities	\$ (1,345,263)
State payable	\$ 39,610,899
Santa Clara Valley Health Plan payable	\$ 1,402,959
Net Pension Liability	\$ 150,000
Medical cost reserves and PDR	\$ (1,863,515)
Deferred inflow of resources	\$ -
Total adjustments	\$ 15,237,561
Net cash from operating activities	\$ 16,588,429

Santa Clara Family Health Plan Enrollment Summary

For the Month of Aug 2016

Two Months Ending Aug 2016

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Prior Year Actual</u>	<u>Change FY17 vs. FY16</u>
Medi-Cal	268,133	262,043	2.3%	531,954	523,133	1.7%	480,469	10.7%
Healthy Kids	4,224	4,326	(2.3%)	8,604	8,791	(2.1%)	9,094	(5.4%)
Medicare	8,025	7,878	1.9%	16,133	15,906	1.4%	15,241	5.9%
Total	280,382	274,246	2.2%	556,691	547,831	1.6%	504,804	10.3%

Santa Clara Health Authority
Aug 2016

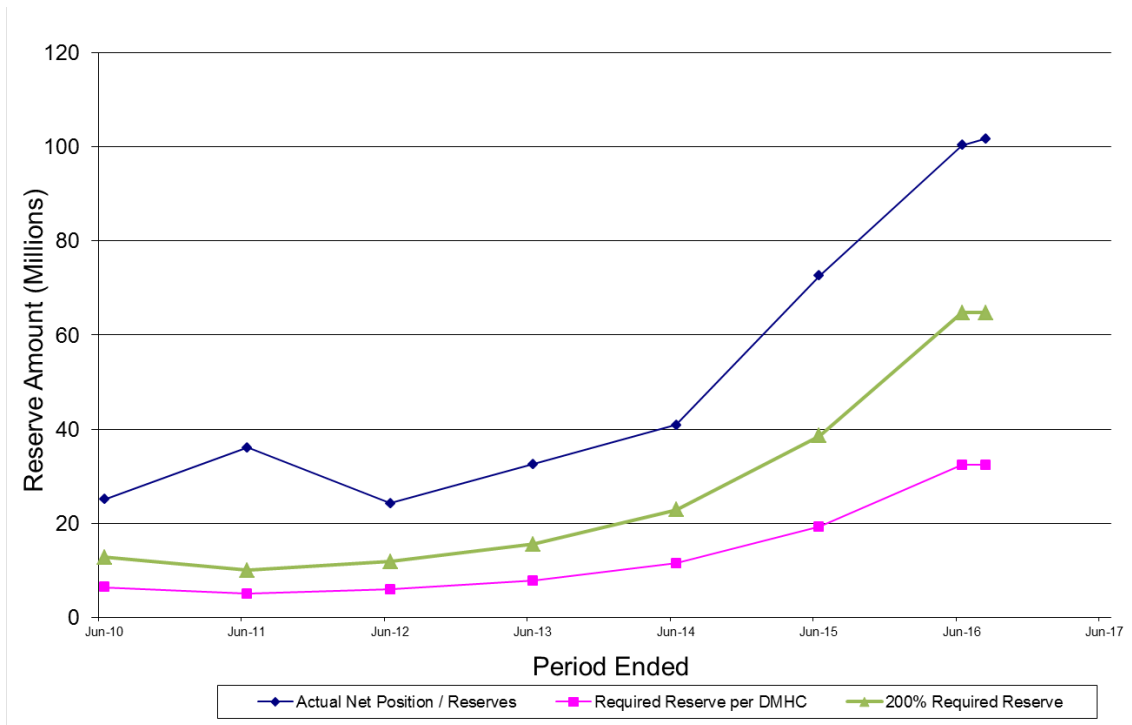
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	24,949	9%	254	6%	8,025	100%	33,228	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	143,116	53%	2,678	63%	-	0%	145,794	52%
Palo Alto Medical Foundation	7,596	3%	38	1%	-	0%	7,634	3%
Physicians Medical Group	48,577	18%	1,081	26%	-	0%	49,658	18%
Premier Care	16,529	6%	173	4%	-	0%	16,702	6%
Kaiser	27,366	10%	-	0%	-	0%	27,366	10%
Total	268,133	100%	4,224	100%	8,025	100%	280,382	100%
Enrollment at June 30, 2016	260,029		4,435		8,203		272,667	
Net Change from Beginning of FY17	3.1%		-4.8%		-2.2%		2.8%	

Santa Clara Family Health Plan Enrollment by Aid-Category

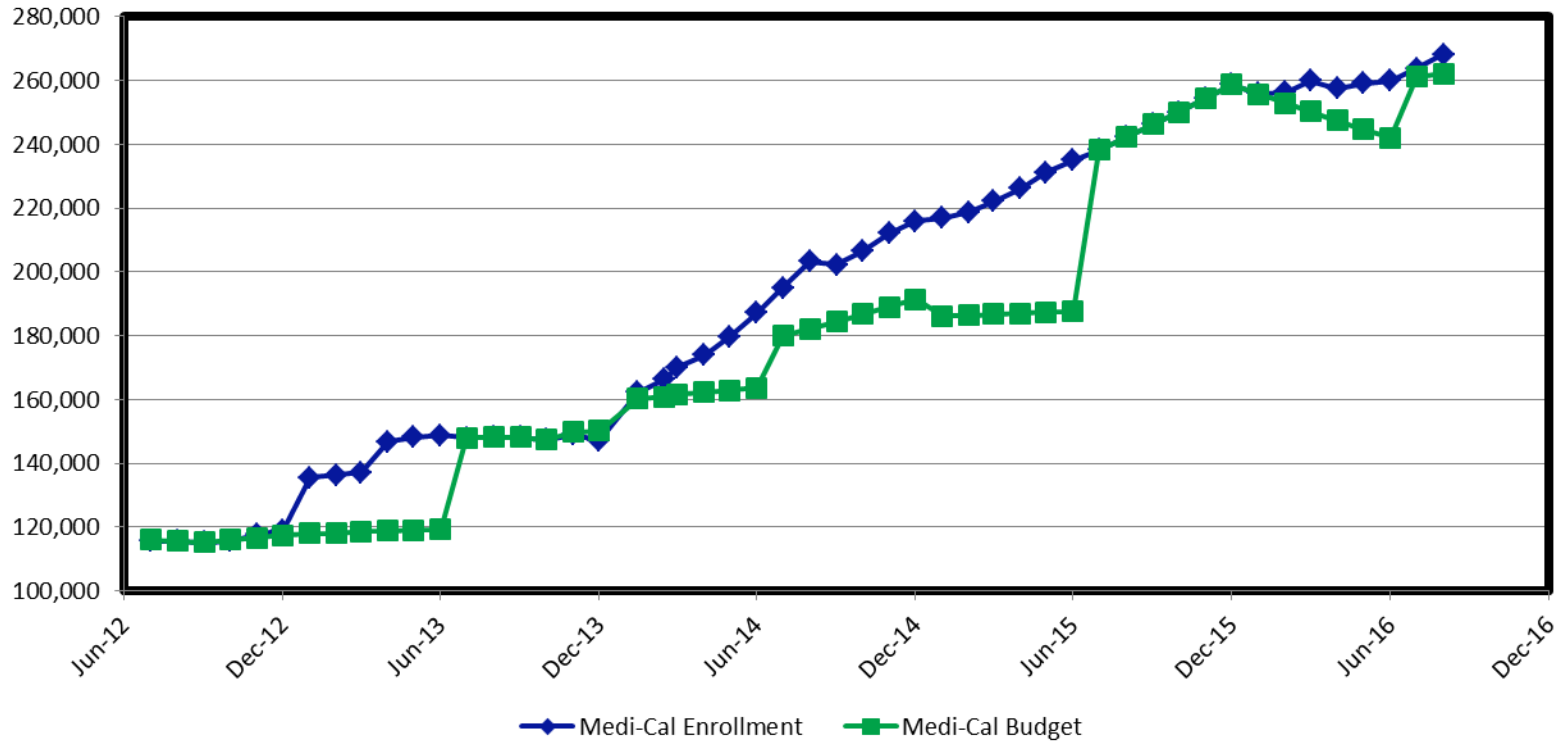
		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,261	11,123	11,106	11,066	10,998	10,954	10,895	10,843	10,812	10,912
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38
	Long Term Care	194	194	205	212	230	249	248	259	258	257	264	266	270	275
Total Non-Duals		221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708
DUAL	Aged	10,003	10,678	11,583	12,426	13,381	14,035	14,074	14,246	14,328	14,301	14,415	14,496	14,524	14,521
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843
	Long Term Care	644	722	814	904	982	1,064	1,058	1,038	1,019	1,006	1,003	998	992	980
Total Duals		16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427
Total Medi-Cal		238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135
Healthy Kids		4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,527	9,305	8,784	8,528	8,377	8,151	8,033	7,871	7,781	7,697
	CMC - Long Term Care	294	312	325	352	379	394	375	358	351	337	334	332	327	328
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025
Total Enrollment		250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384

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

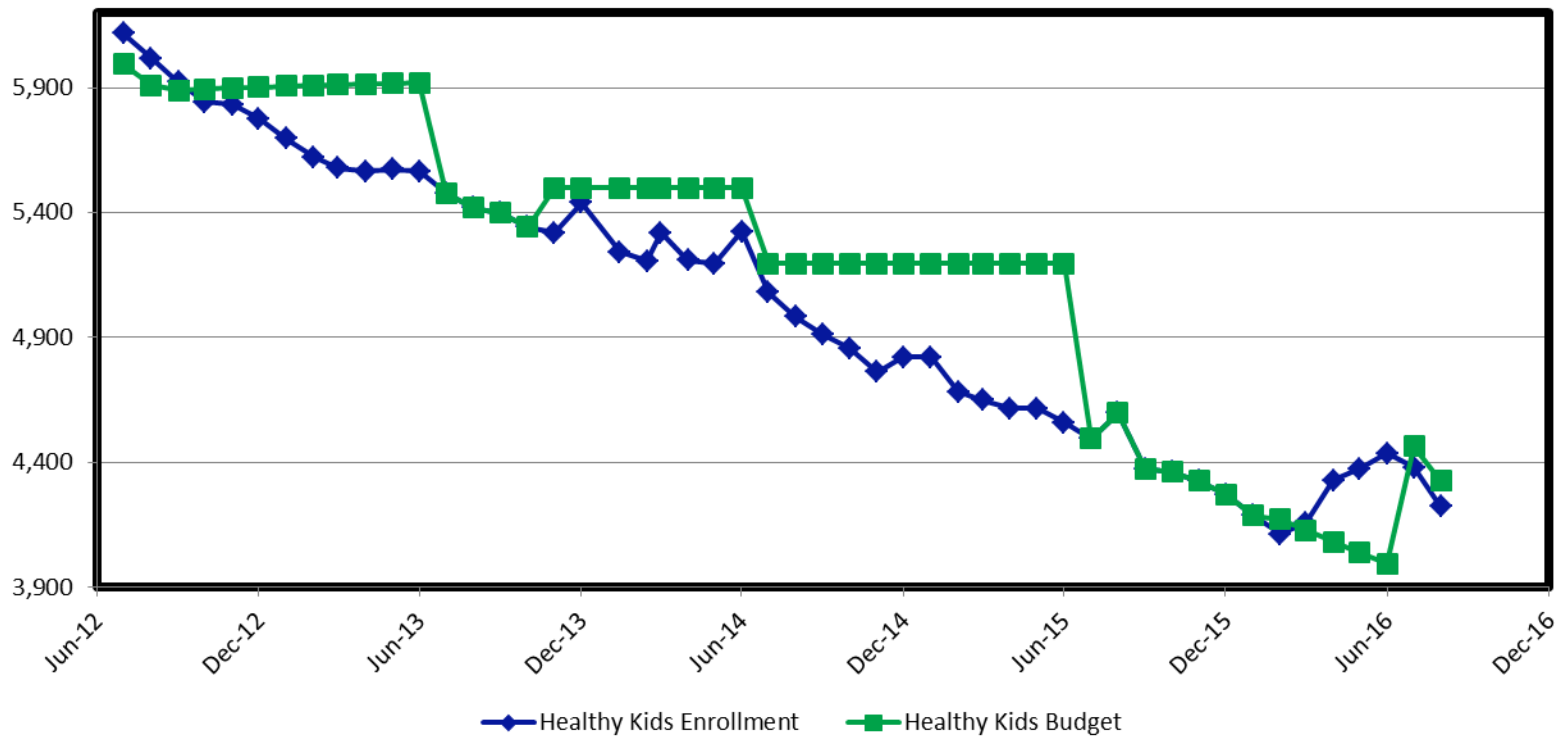
	<u>6/30/2010</u>	<u>6/30/2011</u>	<u>6/30/2012</u>	<u>6/30/2013</u>	<u>6/30/2014</u>	<u>6/30/2015</u>	<u>6/30/2016</u>	<u>8/31/2016</u>
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	101,705,748
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	32,375,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	64,750,000
	3.930	7.225	4.102	4.185	3.575	3.769	3.098	3.141



SCFHP Medi-Cal Enrollment as of Aug 2016



SCFHP Healthy Kids Enrollment as of Aug 2016





Santa Clara
Family Health Plan

The Spirit of Care

Financial Statements
For Three Months Ended September 2016
(Unaudited)

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

Summary of Financial Results

For the month of September 2016, SCFHP recorded a net surplus of \$2.2 million compared to a budgeted net surplus of \$1.3 million resulting in a favorable variance from budget of \$0.9 million. For year to date September 2016, SCFHP recorded a net surplus of \$3.7 million compared to a budgeted net surplus of \$3.3 million resulting in a favorable variance from budget of \$0.3 million. The table below summarizes the components of the overall variance from budget.

Summary Operating Results – Actual vs. Budget
For the Current Month & Fiscal Year to Date – Sep 2016
Favorable/ (Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 99,699,958	\$ 94,932,637	\$ 4,767,321	5.0%	Revenue	\$ 296,170,535	\$ 284,867,212	\$ 11,303,322	4.0%
93,691,322	90,335,894	(3,355,428)	-3.7%	Medical Expense	281,426,116	271,045,396	(10,380,720)	-3.8%
6,008,637	4,596,743	1,411,893	30.7%	Gross Margin	14,744,419	13,821,816	922,603	6.7%
3,667,488	3,167,079	(500,409)	-15.8%	Administrative Expense	10,801,218	10,250,422	(550,796)	-5.4%
2,341,149	1,429,665	911,484	63.8%	Net Operating Income	3,943,201	3,571,394	371,807	10.4%
(98,666)	(85,842)	(12,823)	-14.9%	Non-Operating Income/Exp	(288,426)	(257,527)	(30,899)	-12.0%
\$ 2,242,483	\$ 1,343,822	\$ 898,661	66.9%	Net Surplus/ (Loss)	\$ 3,654,775	\$ 3,313,867	\$ 340,908	10.3%

Member Months

For the month of September 2016, overall member months were higher than budget by 5,761 (+2.1%). For year to date September 2016, overall member months were higher than budget by 14,625 (+1.8%).

In the three months since the end of the prior fiscal year, 6/30/2016, membership in Medi-Cal increased by 3.6%, membership in the Healthy Kids program decreased by 33.2%, and membership in the CMC program decreased by 3.6%.

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

Revenue

The Health Plan recorded net revenue of \$99.7 million for the month of September 2016, compared to budgeted revenue of \$94.9 million, resulting in a favorable variance from budget of \$4.8 million, or 5.0%. For year to date September 2016, the Plan recorded net revenue of \$296.2 million, compared to budgeted revenue of \$284.9 million, resulting in a favorable variance from budget of \$11.3 million, or 4.0%. The favorable variance was largely due to higher than budgeted members year to date. This positive variance was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher PMPM reflecting the higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.

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

Medical Expenses

For the month of September 2016, medical expense was \$93.7 million compared to budget of \$90.3 million, resulting in an unfavorable budget variance of \$3.4 million, or -3.7%. For year to date September 2016, medical expense was \$281.4 million compared to budget of \$271.0 million, resulting in an unfavorable budget variance of \$10.4 million, or -3.8%. The unfavorable variance was largely due to higher than budgeted member months, which led to higher capitation costs. Increased hospital and LTC expenses also contributed to the unfavorable variance. Some of this unfavorability was offset by lower Professional FFS, Outpatient services, and Pharmacy expenses. Additionally, the Plan reserved \$3.5 million for risk sharing expenses.

Administrative Expenses

Overall administrative costs were over budget by \$0.5 million (-15.8%) for the month of September 2016, and over budget by \$0.6 million (-5.4%) for year to date September 2016. Personnel costs were over budget due to open positions being filled by consulting and temporary staffing resources as well as the overall vacancy rate being lower than budget. Some of this unfavorability was offset by lower information service expenses and legal expenses.

Overall administrative expenses were 3.6% of revenues for year to date September 2016.

Balance Sheet (Page 6)

Current assets at September 30, 2016 totaled \$693.3 million compared to current liabilities of \$583.0 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.2 as of September 30, 2016. Working capital increased by \$3.2 million for the three months year to date ended September 30, 2016.

Cash as of September 30, 2016, increased by \$37.0 million compared to the cash balance as of year-end June 30, 2016. Net receivables increased by \$88.4 million during the same three months period ended September 30, 2016. The cash position increased largely due to the receipt of Medicare RAF receivable and an overall increase in the payables.

Liabilities increased by a net amount of \$120.3 million during the three months ended September 2016. Liabilities increased primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State and an increase in IHSS/MCO payables.

Capital Expenses increased by \$1.1 million for the three months ended September 30, 2016. Most of these expenses represent the capitalized portion of the claims system (Trizetto) upgrade project.

Reserves Analysis

Tangible Net Equity (TNE) was \$103.9 million at September 30, 2016 or 321% of the minimum Required TNE per the Department of Managed Health Care (DMHC) of \$32.4 million. A chart showing TNE trends is shown on page 14 of this report.

At the September 2016 Board of Director's meeting, a policy was adopted for targeting the organization's capital reserves to include a) an Equity Target of 350-500% of DMHC required TNE percentage and b) a Liquidity Target of 45-60 days of total operating expenses in available cash.

As of September 30, 2016, the Plan's TNE was \$9.4 million below the low-end Equity Target and \$55.7 million above the low-end Liquidity Target (see calculations below).

Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	\$103,948,231
Current Required TNE	\$32,375,000
Excess TNE	\$71,573,231
Required TNE Percentage	321%
SCFHP Target TNE Range:	
350% of Required TNE (low end)	\$113,312,500
500% of Required TNE (high end)	\$161,875,000
TNE Above/(Below) SCFHP Low End Target	(\$9,364,269)
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	\$183,080,604
Less: Pass-Through Liabilities (Non State of CA *)	(\$6,828,916)
Net Cash Available to SCFHP	\$176,251,689
SCFHP Target Liquidity: **	
45 days of Total Operating Expenses	(\$120,572,029)
60 days of Total Operating Expenses	(\$160,762,706)
Liquidity Above/(Below) SCFHP Low End Target	\$55,679,659

* Supplemental Information: Pass-Throughs from State of CA	
Receivables Due to SCFHP	\$501,573,523
Payables Due from SCFHP	(\$463,168,695)
Net Receivable/(Payable)	\$38,404,828

** Excludes IHSS

**Santa Clara County Health Authority
Balance Sheet**

	<u>SEP 16</u>	<u>AUG 16</u>	<u>JUL 16</u>	<u>JUN 16</u>
Assets				
Current Assets				
Cash and Marketable Securities	\$ 183,080,604	\$ 161,669,825	\$ 156,693,435	\$ 146,082,070
Premiums Receivable	505,588,385	472,494,829	447,225,673	417,166,973
Due from Santa Clara Family Health Foundation - net				
Prepaid Expenses and Other Current Assets	<u>4,612,601</u>	<u>4,697,053</u>	<u>6,340,911</u>	<u>6,766,163</u>
Total Current Assets	693,281,590	638,861,708	610,260,019	570,015,205
Long Term Assets				
Equipment	14,853,860	14,779,896	13,769,810	13,717,799
Less: Accumulated Depreciation	<u>(9,244,180)</u>	<u>(9,089,501)</u>	<u>(8,936,053)</u>	<u>(8,775,886)</u>
Total Long Term Assets	<u>5,609,680</u>	<u>5,690,395</u>	<u>4,833,757</u>	<u>4,941,913</u>
Total Assets	<u>\$ 698,891,270</u>	<u>\$ 644,552,103</u>	<u>\$ 615,093,776</u>	<u>\$ 574,957,118</u>
Deferred Outflow of Resources	<u>\$ 1,570,339</u>	<u>\$ 1,570,339</u>	<u>1,570,339</u>	<u>1,570,339</u>
Total Deferred Outflows and Assets	<u>700,461,609</u>	<u>646,122,442</u>	<u>616,664,115</u>	<u>576,527,457</u>
Liabilities and Net Position				
Current Liabilities				
Trade Payables	\$ 3,728,676	\$ 3,886,568	\$ 3,645,802	\$ 4,824,017
Deferred Rent	129,955	134,106	138,257	142,408
Employee Benefits	984,344	941,677	1,015,476	1,013,759
Retirement Obligation per GASB 45	151,777	101,185	50,592	
Advance Premium - Healthy Kids	42,072	48,742	66,827	65,758
Deferred Revenue - Medicare	8,677,372			
Liability for ACA 1202	5,503,396	5,503,396	5,503,396	5,503,985
Payable to Hospitals (SB90)	55,140	55,140	55,140	55,140
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,305,914	1,306,473	1,289,030	1,717,483
Due to Santa Clara County Valley Health Plan and Kaiser	8,104,013	8,007,431	7,293,954	6,604,472
MCO Tax Payable - State Board of Equalization	30,597,915	22,948,187	18,556,017	10,779,014
Due to DHCS	148,459,120	134,655,041	120,850,476	107,213,315
Liability for In Home Support Services (IHSS)	284,111,659	268,614,754	253,234,802	238,387,141
Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	88,830,528	82,457,496	88,840,951	84,321,012
Total Current Liabilities	583,020,871	530,999,187	502,879,710	462,966,494
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	5,243,386	5,168,386	5,093,386	5,018,386
Total Liabilities	<u>594,183,757</u>	<u>542,087,073</u>	<u>513,892,596</u>	<u>473,904,380</u>
Deferred Inflow of Resources	<u>2,329,621</u>	<u>2,329,621</u>	<u>2,329,621</u>	<u>2,329,621</u>
Net Position / Reserves				
Invested in Capital Assets	5,609,680	5,690,395	4,833,757	4,941,913
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	94,378,426	94,297,711	95,154,349	67,383,691
Current YTD Income (Loss)	<u>3,654,775</u>	<u>1,412,292</u>	<u>148,442</u>	<u>27,662,502</u>
Net Position / Reserves	<u>103,948,231</u>	<u>101,705,748</u>	<u>100,441,898</u>	<u>100,293,456</u>
Total Liabilities, Deferred Inflows, and Net Assets	<u>\$ 700,461,609</u>	<u>\$ 646,122,442</u>	<u>\$ 616,664,115</u>	<u>\$ 576,527,457</u>
Solvency Ratios:				
Working Capital	\$ 110,260,719	\$ 107,862,521	\$ 107,380,309	\$ 107,048,711
Working Capital Ratio	1.2	1.2	1.2	1.2

Santa Clara County Health Authority
Income Statement for the Three Months Ending Sep 30, 2016

	For the Month of Sep 2016					For Two Months Ending Sep 30, 2016				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	\$ 90,582,683	90.9%	\$ 86,370,689	91.0%	\$ 4,211,994	\$ 268,180,566	90.5%	\$ 258,491,675	90.7%	\$ 9,688,891
HEALTHY KIDS	\$ 302,185	0.3%	\$ 256,735	0.3%	\$ 45,450	\$ 1,139,977	0.4%	\$ 1,031,408	0.4%	\$ 108,570
MEDICARE	\$ 8,815,090	8.8%	\$ 8,305,213	8.7%	\$ 509,877	\$ 26,849,991	9.1%	\$ 25,344,129	8.9%	\$ 1,505,862
TOTAL REVENUE	<u>\$ 99,699,958</u>	<u>100.0%</u>	<u>\$ 94,932,637</u>	<u>100.0%</u>	<u>\$ 4,767,321</u>	<u>\$ 296,170,535</u>	<u>100.0%</u>	<u>\$ 284,867,212</u>	<u>100.0%</u>	<u>\$ 11,303,322</u>
MEDICAL EXPENSES										
MEDI-CAL	\$ 83,932,870	84.2%	\$ 82,372,325	86.8%	\$ (1,560,545)	\$ 250,703,518	84.6%	\$ 246,505,113	86.5%	\$ (4,198,405)
HEALTHY KIDS	\$ 252,325	0.3%	\$ 247,884	0.3%	\$ (4,441)	\$ 953,150	0.3%	\$ 995,308	0.3%	\$ 42,158
MEDICARE	\$ 9,506,127	9.5%	\$ 7,715,685	8.1%	\$ (1,790,442)	\$ 29,769,448	10.1%	\$ 23,544,975	8.3%	\$ (6,224,472)
TOTAL MEDICAL EXPENSES	<u>\$ 93,691,322</u>	<u>94.0%</u>	<u>\$ 90,335,894</u>	<u>95.2%</u>	<u>\$ (3,355,428)</u>	<u>\$ 281,426,116</u>	<u>95.0%</u>	<u>\$ 271,045,396</u>	<u>95.1%</u>	<u>\$ (10,380,720)</u>
MEDICAL OPERATING MARGIN	\$ 6,008,637	6.0%	\$ 4,596,743	4.8%	\$ 1,411,893	\$ 14,744,419	5.0%	\$ 13,821,816	4.9%	\$ 922,603
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	\$ 1,830,757	1.8%	\$ 1,568,750	1.7%	\$ (262,007)	\$ 5,215,344	1.8%	\$ 4,666,250	1.6%	\$ (549,094)
RENTS AND UTILITIES	\$ 106,615	0.1%	\$ 127,065	0.1%	\$ 20,450	\$ 320,549	0.1%	\$ 352,529	0.1%	\$ 31,980
PRINTING AND ADVERTISING	\$ (43)	0.0%	\$ 54,108	0.1%	\$ 54,152	\$ 175,144	0.1%	\$ 267,075	0.1%	\$ 91,931
INFORMATION SYSTEMS	\$ 184,126	0.2%	\$ 245,612	0.3%	\$ 61,486	\$ 496,239	0.2%	\$ 754,035	0.3%	\$ 257,796
PROF FEES / CONSULTING / TEMP STAFFING	\$ 1,144,565	1.1%	\$ 797,430	0.8%	\$ (347,135)	\$ 2,957,424	1.0%	\$ 2,633,290	0.9%	\$ (324,133)
DEPRECIATION / INSURANCE / EQUIPMENT	\$ 182,023	0.2%	\$ 174,652	0.2%	\$ (7,371)	\$ 561,875	0.2%	\$ 525,991	0.2%	\$ (35,884)
OFFICE SUPPLIES / POSTAGE / TELEPHONE	\$ 134,931	0.1%	\$ 89,180	0.1%	\$ (45,752)	\$ 843,437	0.3%	\$ 775,539	0.3%	\$ (67,898)
MEETINGS / TRAVEL / DUES	\$ 69,445	0.1%	\$ 95,002	0.1%	\$ 25,558	\$ 198,378	0.1%	\$ 251,374	0.1%	\$ 52,996
OTHER	\$ 15,068	0.0%	\$ 15,280	0.0%	\$ 211	\$ 32,829	0.0%	\$ 24,339	0.0%	\$ (8,490)
TOTAL ADMINISTRATIVE EXPENSES	<u>\$ 3,667,488</u>	<u>3.7%</u>	<u>\$ 3,167,079</u>	<u>3.3%</u>	<u>\$ (500,409)</u>	<u>\$ 10,801,218</u>	<u>3.6%</u>	<u>\$ 10,250,422</u>	<u>3.6%</u>	<u>\$ (550,796)</u>
OPERATING SURPLUS (LOSS)	\$ 2,341,149	2.3%	\$ 1,429,665	1.5%	\$ 911,484	\$ 3,943,201	1.3%	\$ 3,571,394	1.3%	\$ 371,807
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	\$ (50,592)	-0.1%	\$ (50,592)	-0.1%	\$ -	\$ (151,777)	-0.1%	\$ (151,777)	-0.1%	\$ -
GASB 68 - UNFUNDED PENSION LIABILITY	\$ (75,000)	-0.1%	\$ (75,000)	-0.1%	\$ -	\$ (225,000)	-0.1%	\$ (225,000)	-0.1%	\$ -
INTEREST & OTHER INCOME	\$ 26,927	0.0%	\$ 39,750	0.0%	\$ (12,823)	\$ 88,351	0.0%	\$ 119,250	0.0%	\$ (30,899)
NET SURPLUS (LOSS) FINAL	<u>\$ 2,242,483</u>	<u>2.2%</u>	<u>\$ 1,343,822</u>	<u>1.4%</u>	<u>\$ 898,661</u>	<u>\$ 3,654,775</u>	<u>1.2%</u>	<u>\$ 3,313,867</u>	<u>1.2%</u>	<u>\$ 340,908</u>

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

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 1,830,757	\$ 1,568,750	\$ (262,007)	-16.7%	Personnel	\$ 5,215,344	\$ 4,666,250	\$ (549,094)	-11.8%
1,836,731	1,598,329	(238,402)	-14.9%	Non-Personnel	5,585,874	5,584,172	\$ (1,702)	0.0%
3,667,488	3,167,079	(500,409)	-15.8%	Total Administrative Expense	10,801,218	10,250,422	(550,796)	-5.4%

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

Three Months Ended Sep 30, 2016

	Medi-Cal	CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)				
REVENUE	261,248,766	33,781,791	\$1,139,977	\$296,170,535
MEDICAL EXPENSES	242,527,125	37,945,841	953,150	\$281,426,116
(MLR)	92.8%	112.3%	83.6%	95.0%
GROSS MARGIN	18,721,641	(4,164,050)	186,828	14,744,419
ADMINISTRATIVE EXPENSES <i>(% MM allocation except CMC)</i>	9,433,081	1,232,008	136,129	10,801,218
OPERATING INCOME/(LOSS)	9,288,561	(5,396,058)	50,698	3,943,201
OTHER INCOME/(EXPENSE) <i>(% of Revenue Allocation)</i>	(254,417)	(32,898)	(1,110)	(288,426)
NET INCOME/ (LOSS)	\$9,034,143	(\$5,428,957)	\$49,588	\$3,654,775
PMPM (ALLOCATED BASIS)				
REVENUE	\$325.96	\$1,405.12	\$98.56	\$353.82
MEDICAL EXPENSES	302.60	1,578.31	82.41	336.20
GROSS MARGIN	23.36	(173.20)	16.15	17.61
ADMINISTRATIVE EXPENSES	11.77	51.24	11.77	12.90
OPERATING INCOME/(LOSS)	11.59	(224.44)	4.38	4.71
OTHER INCOME/ (EXPENSE)	(0.32)	(1.37)	(0.10)	(0.34)
NET INCOME/ (LOSS)	\$11.27	(\$225.81)	\$4.29	\$4.37
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	801,467	24,042	11,566	837,075
Member MONTHS by LOB	95.7%	2.9%	1.4%	100%
Revenue by LOB	88.2%	11.4%	0.4%	100%

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

Cash flows from operating activities		
Premiums received	\$	268,813,828
Medical expenses paid	\$	(229,692,541)
Administrative expenses paid	\$	<u>(1,075,043)</u>
Net cash from operating activities	\$	38,046,245
 Cash flows from capital and related financing activities		
Purchases of capital assets	\$	(1,136,061)
 Cash flows from investing activities		
Interest income and other income, net	\$	<u>88,351</u>
 Net (Decrease) increase in cash and cash equivalents	\$	<u>36,998,534</u>
 Cash and cash equivalents, beginning of year	\$	<u>146,082,070</u>
 Cash and cash equivalents at Sep 30, 2016	\$	<u><u>183,080,604</u></u>
 Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	\$	3,566,424
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	\$	468,294
Changes in operating assets and liabilities		
Premiums receivable	\$	(88,421,413)
Due from Santa Clara Family Health Foundation	\$	-
Prepays and other assets	\$	2,153,562
Deferred outflow of resources	\$	-
Accounts payable and accrued liabilities	\$	7,256,096
State payable	\$	61,064,706
Santa Clara Valley Health Plan and Kaiser payable	\$	1,499,541
Net Pension Liability	\$	225,000
Medical cost reserves and PDR	\$	4,509,516
Deferred inflow of resources	\$	<u>-</u>
Total adjustments	\$	<u>34,479,820</u>
Net cash from operating activities	\$	<u><u>38,046,245</u></u>

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Sep 2016			Three Months Ending Sep 2016				
	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Prior Year Actual</u>	<u>FY17 vs. FY16</u>
Medi-Cal	269,509	263,950	2.1%	801,467	787,084	1.8%	726,628	10.3%
Healthy Kids	2,962	2,916	1.6%	11,566	11,707	(1.2%)	13,469	(14.1%)
Medicare	7,909	7,753	2.0%	24,042	23,659	1.6%	23,153	3.8%
Total	280,380	274,619	2.1%	837,075	822,450	1.8%	763,250	9.7%

Santa Clara Health Authority
Sep 2016

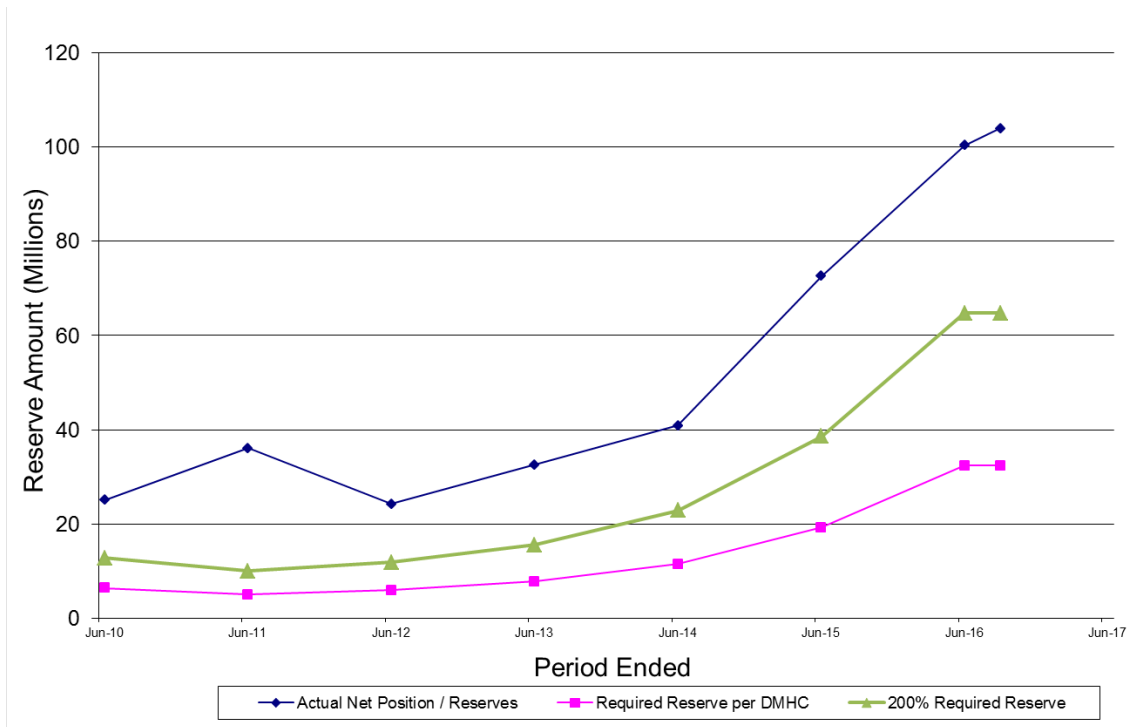
Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	25,518	9%	217	7%	7,909	100%	33,644	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	143,711	53%	1,726	58%	-	0%	145,437	52%
Palo Alto Medical Foundation	7,585	3%	38	1%	-	0%	7,623	3%
Physicians Medical Group	48,706	18%	818	28%	-	0%	49,524	18%
Premier Care	16,641	6%	163	6%	-	0%	16,804	6%
Kaiser	27,348	10%	-	0%	-	0%	27,348	10%
Total	269,509	100%	2,962	100%	7,909	100%	280,380	100%
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	3.6%		-33.2%		-3.6%		2.8%	

Santa Clara Family Health Plan Enrollment by Aid-Category

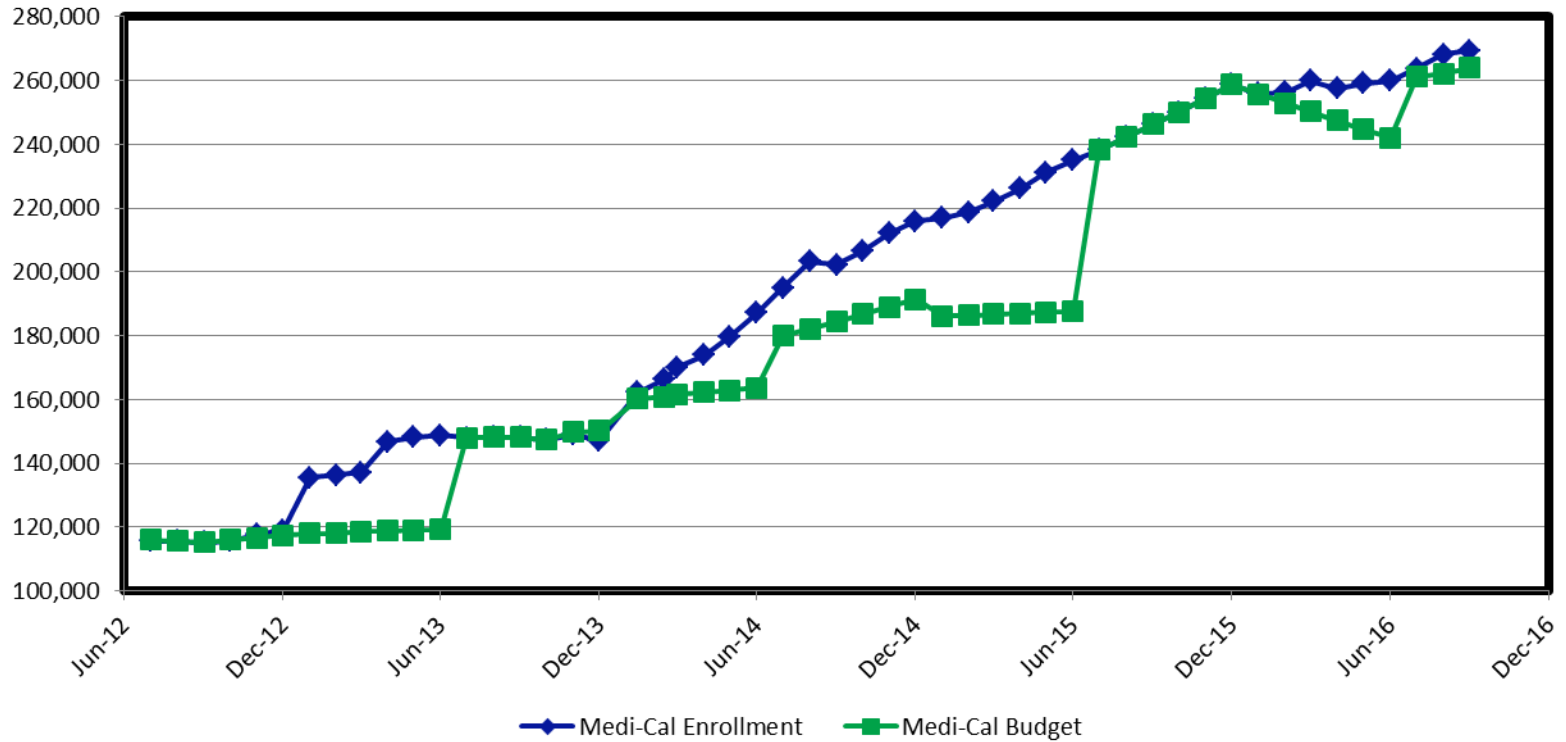
		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200	31,372
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150	10,138
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,261	11,123	11,106	11,066	10,998	10,954	10,895	10,843	10,812	10,912	11,026
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572	83,721
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38
	Long Term Care	194	194	205	212	230	249	248	259	258	257	264	266	270	275	277
Total Non-Duals		221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928
DUAL	Aged	10,003	10,678	11,583	12,426	13,381	14,035	14,074	14,246	14,328	14,301	14,415	14,496	14,524	14,521	14,729
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083	6,027
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843	1,856
	Long Term Care	644	722	814	904	982	1,064	1,058	1,038	1,019	1,006	1,003	998	992	980	969
	Total Duals		16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427
Total Medi-Cal		238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509
Healthy Kids		4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,527	9,305	8,784	8,528	8,377	8,151	8,033	7,871	7,781	7,697	7,585
	CMC - Long Term Care	294	312	325	352	379	394	375	358	351	337	334	332	327	328	324
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909
Total Enrollment		250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384	280,380

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

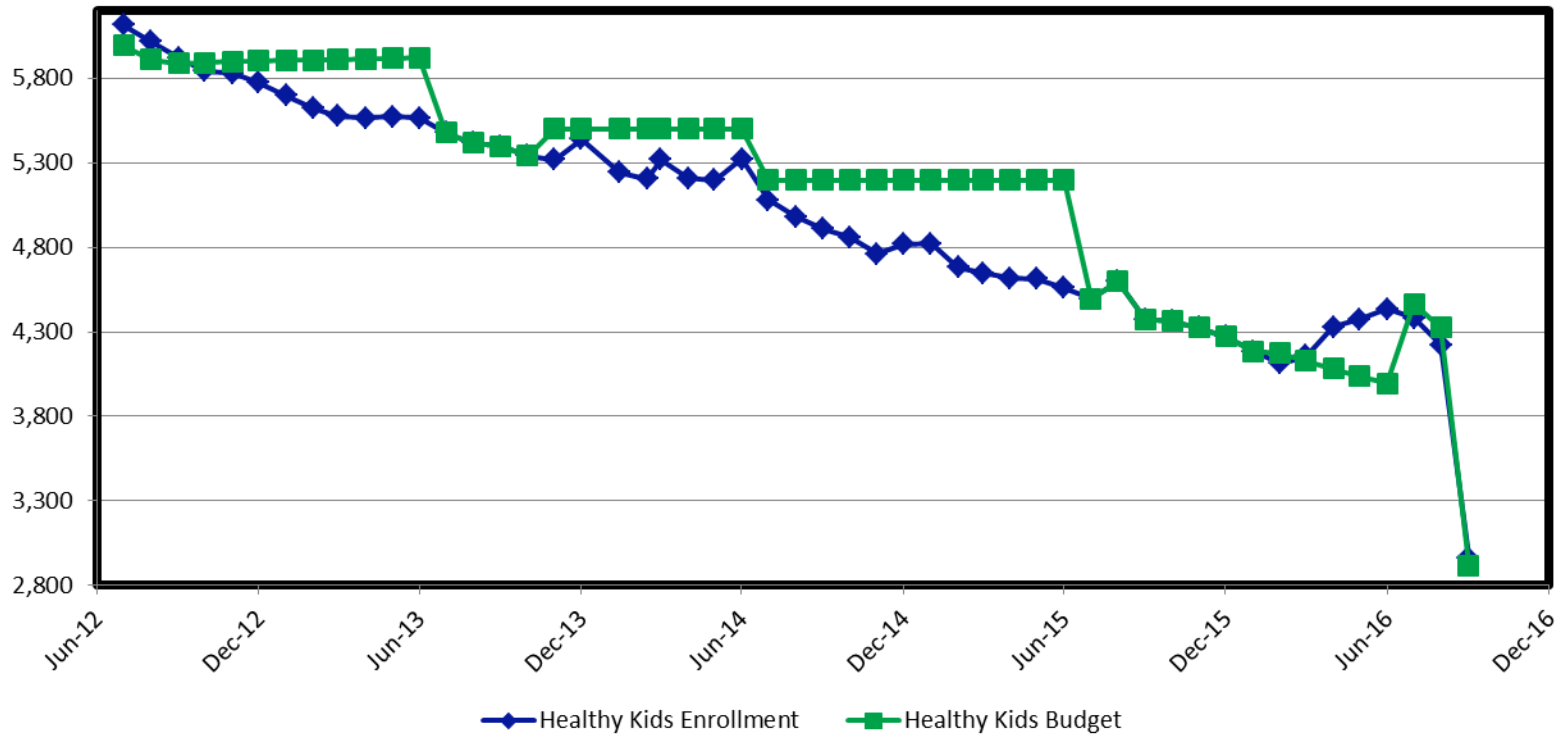
	<u>6/30/2010</u>	<u>6/30/2011</u>	<u>6/30/2012</u>	<u>6/30/2013</u>	<u>6/30/2014</u>	<u>6/30/2015</u>	<u>6/30/2016</u>	<u>9/30/2016</u>
Actual Net Position / Reserves	25,103,011	36,093,769	24,208,576	32,551,161	40,872,580	72,630,954	100,293,456	103,948,231
Required Reserve per DMHC	6,388,000	4,996,000	5,901,000	7,778,000	11,434,000	19,269,000	32,375,000	32,375,000
200% of Required Reserve	12,776,000	9,992,000	11,802,000	15,556,000	22,868,000	38,538,000	64,750,000	64,750,000
	3.930	7.225	4.102	4.185	3.575	3.769	3.098	3.211



SCFHP Medi-Cal Enrollment as of Sep 2016



SCFHP Healthy Kids Enrollment as of Sep 2016





September 2016 Financial Summary

SCCHA Executive Committee Meeting
October 27, 2016



Fiscal Year 2016-17 Highlights

- **Net Surplus** — Sep \$2.2m surplus and YTD \$3.7m surplus (\$0.3m favorable to budget)
- **Enrollment** — Sep 2016 membership: 280,380 (2.1% favorable to budget) and Sep YTD: 837,075 member months (1.8% favorable to budget and 9.7% higher than Sep YTD last year)
 - Continued growth in Adult and Aged Medi-Cal membership. CMC membership has been trending downward. HK membership is transitioning to Medi-Cal.
- **Revenue** — over budget by \$11.3 m (+4.0%)
 - Increase is due to higher than budgeted members year to date, which was partially offset by unfavorable variance in Hep C revenue and Medi-Cal CMC revenue. Medicare revenue was higher due to higher risk scores of the plan members. However, Part D Medicare revenue was lower than the budget.
- **Medical Expenses** — over budget by \$10.4m (-3.8%)
 - Increase is due to higher than budgeted member months resulting in higher capitation costs and higher hospital, LTC, and risk sharing expenses, which are partially offset by lower Professional FFS, Outpatient, and Pharmacy expenses.
- **Administrative Expenses** — over budget by \$0.6 million (-5.4%)
 - Increase is due to open positions being filled by consulting/temporary resources and the overall vacancy rate being lower than budget. Some of this increase was offset by lower information service expenses and legal expenses.
- **Other Expenses** — over budget by \$31k due to lower interest income than budget
- **Balance Sheet**
 - Cash position increased due to the receipt of Medicare RAF receivable and an overall increase in the payables.
 - Receivables for CCI rate recast continued to increase (partially offset by Medi-Cal Expansion rate overpayments).
 - TNE of \$103.9M or 321% of Required TNE of \$32.4m per DMHC (\$9.3 million below the SCFHP low-end Equity Target and \$55.7 million above the low-end Liquidity Target).
 - Capital Expenses increased by \$1.1 million due to capitalization of work-in-progress expenses of the Trizetto project.



Consolidated Performance

September 2016 and Year to Date

	Month of September	FYTD through September
Revenue	\$99.7 million	\$296.2 million
Medical Costs	\$93.7 million	\$281.4 million
Medical Loss Ratio	94.0%	95.0%
Administrative Costs	\$3.7 million (3.7%)	\$10.8 million (3.6%)
Other Income/ Expense	(\$98,666)	(\$288,426)
Net Surplus (Loss)	\$2,242,483	\$3,654,775
Cash on Hand		\$183.1 million
Receivables		\$505.6 million
Current Liabilities		\$583 million
Tangible Net Equity		\$103.9 million
Pct. Of Min. Requirement		321%



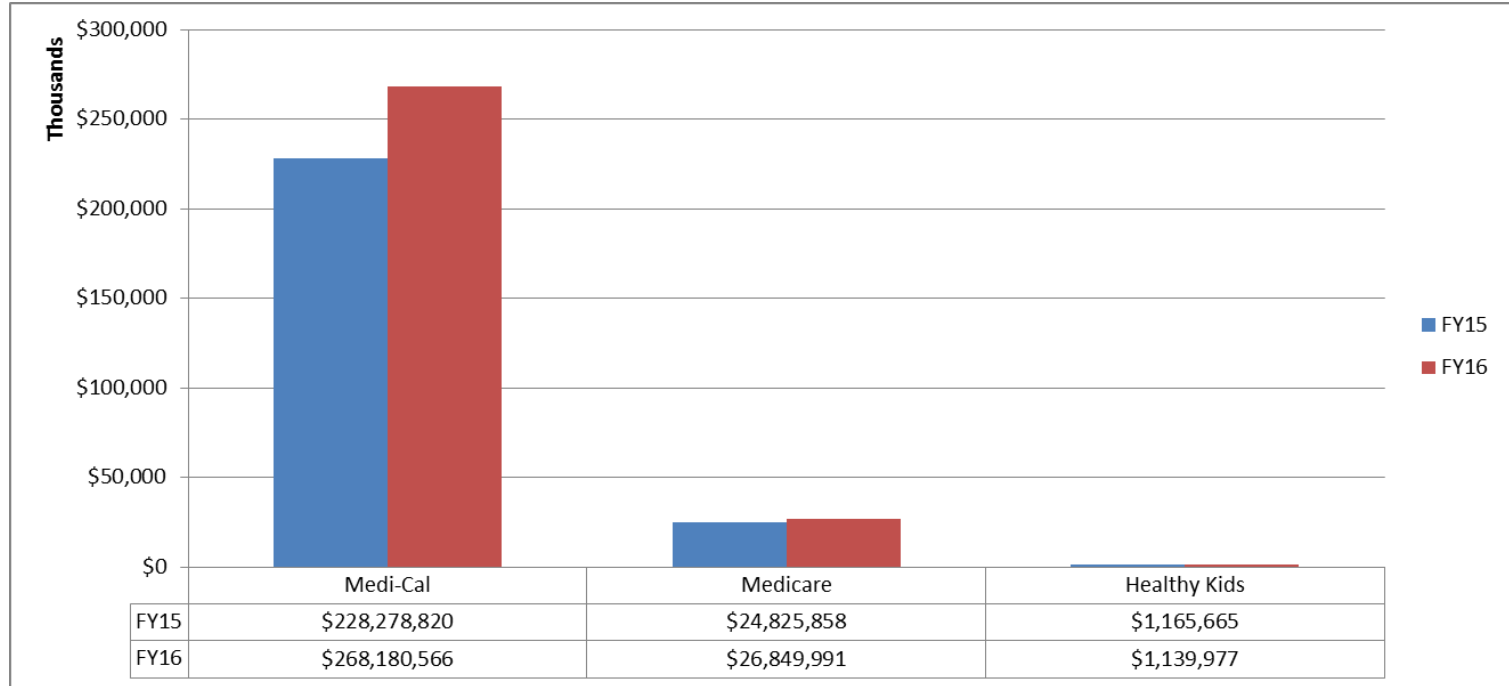
Consolidated Performance

Summary Operating Results - Actual vs. Budget
For the Current Month & Fiscal Year to Date - Sep 2016
 Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %
\$ 99,699,958	\$ 94,932,637	\$ 4,767,321	5.0%	Revenue	\$ 296,170,535	\$ 284,867,212	\$ 11,303,322	4.0%
93,691,322	90,335,894	(3,355,428)	-3.7%	Medical Expense	281,426,116	271,045,396	(10,380,720)	-3.8%
6,008,637	4,596,743	1,411,893	30.7%	Gross Margin	14,744,419	13,821,816	922,603	6.7%
3,667,488	3,167,079	(500,409)	-15.8%	Administrative Expense	10,801,218	10,250,422	(550,796)	-5.4%
2,341,149	1,429,665	911,484	63.8%	Net Operating Income	3,943,201	3,571,394	371,807	10.4%
(98,666)	(85,842)	(12,823)	-14.9%	Non-Operating Income/Exp	(288,426)	(257,527)	(30,899)	-12.0%
\$ 2,242,483	\$ 1,343,822	\$ 898,661	66.9%	Net Surplus/ (Loss)	\$ 3,654,775	\$ 3,313,867	\$ 340,908	10.3%



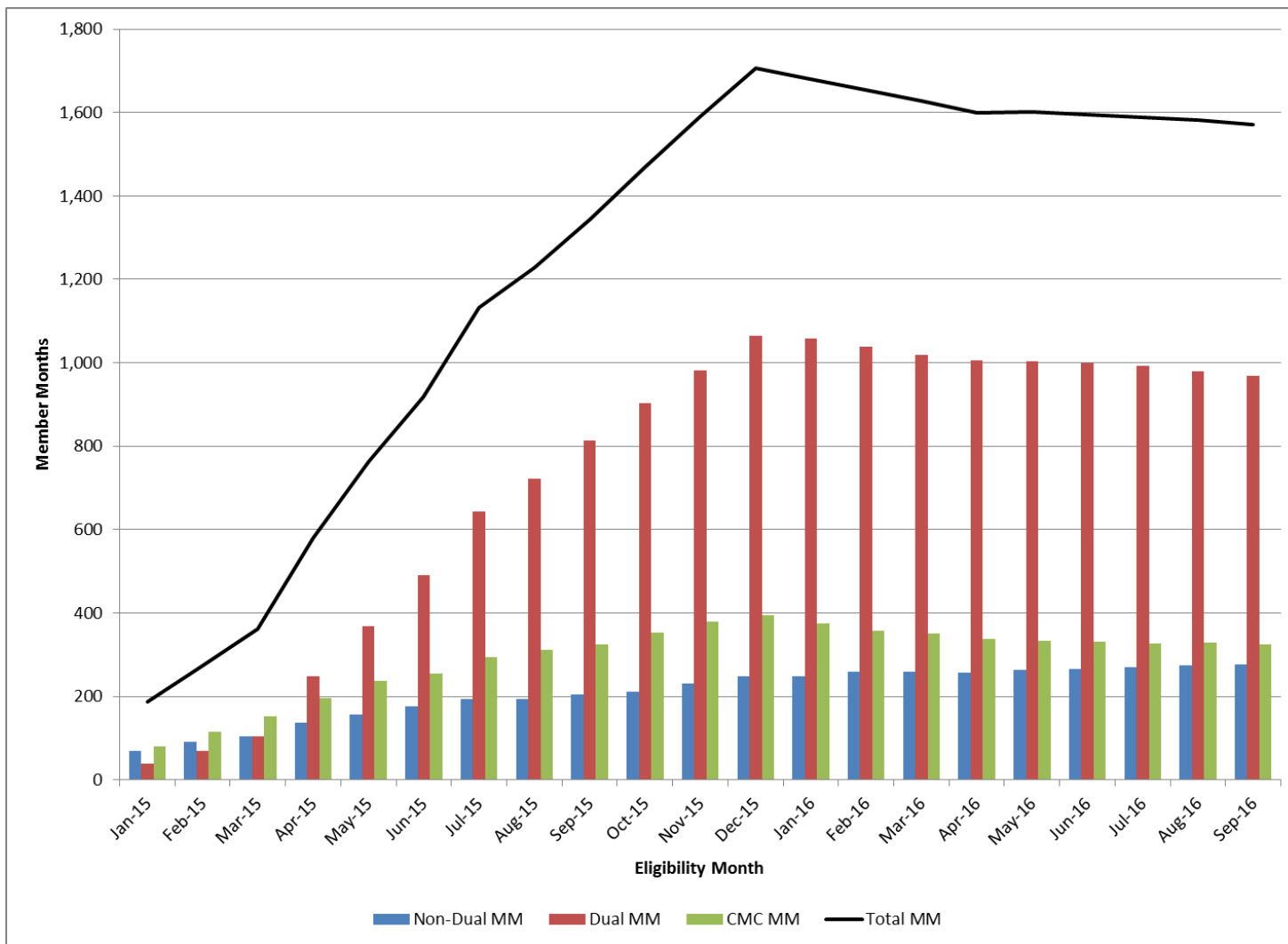
Year Over Year Revenue Trend



Medi-Cal revenue increased by 17% and Medicare revenue increased by 8%.



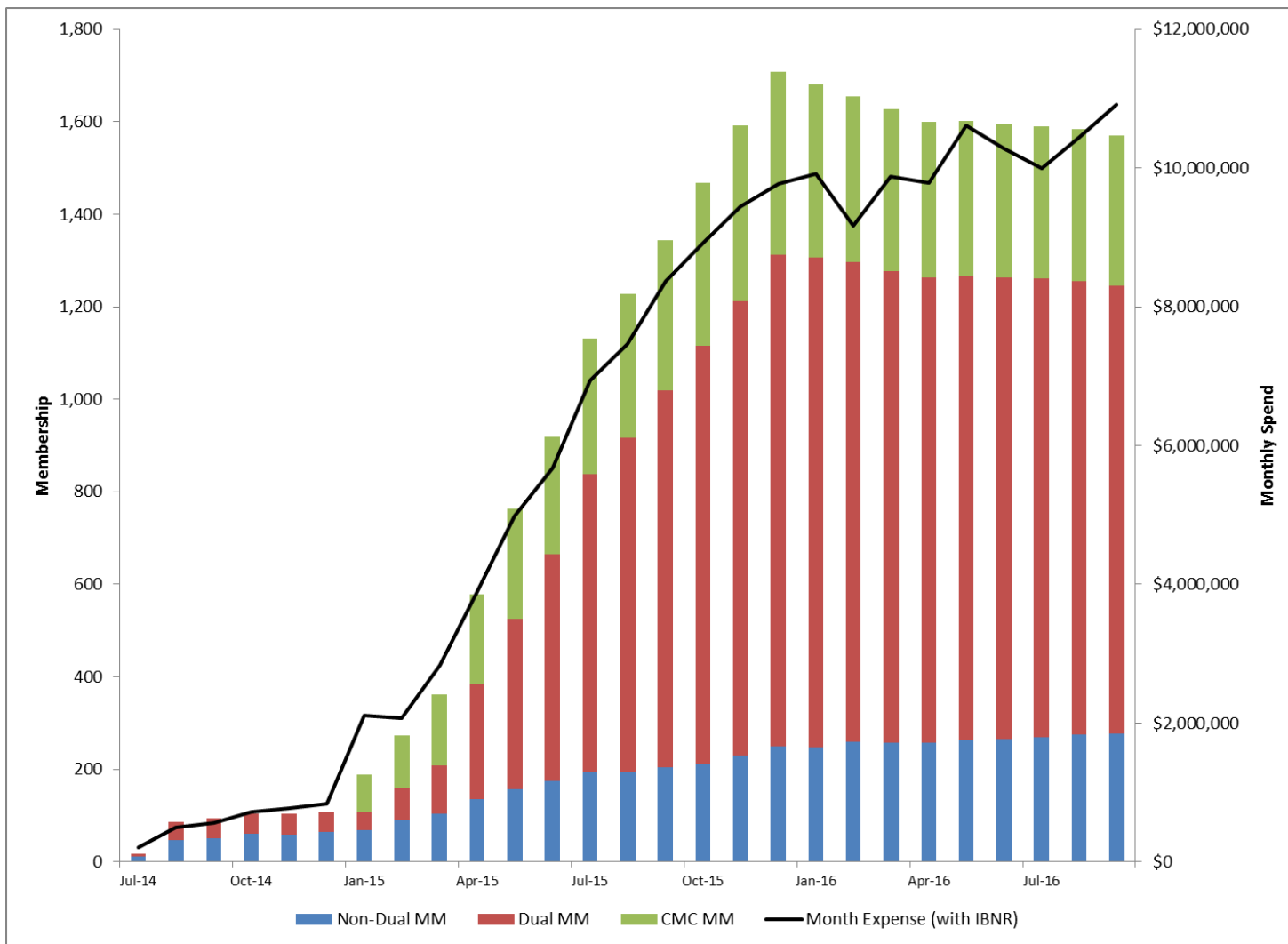
Long Term Care Membership Medi-Cal and CMC





Medi-Cal Long Term Care Experience

Jul 2014 – Sep 2016





Enrollment Summary September and YTD

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Sep 2016			Three Months Ending Sep 2016				
	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>Prior Year Actual</u>	<u>FY17 vs. FY16</u>
Medi-Cal	269,509	263,950	2.1%	801,467	787,084	1.8%	726,628	10.3%
Healthy Kids	2,962	2,916	1.6%	11,566	11,707	(1.2%)	13,469	(14.1%)
Medicare	7,909	7,753	2.0%	24,042	23,659	1.6%	23,153	3.8%
Total	280,380	274,619	2.1%	837,075	822,450	1.8%	763,250	9.7%



Enrollment by Network - YTD

Santa Clara Health Authority
Sep 2016

Network	Medi-Cal		Healthy Kids		CMC		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contact Physicians	25,518	9%	217	7%	7,909	100%	33,644	12%
SCVVHS, Safety Net Clinics, FQHC Clinics	143,711	53%	1,726	58%	-	0%	145,437	52%
Palo Alto Medical Foundation	7,585	3%	38	1%	-	0%	7,623	3%
Physicians Medical Group	48,706	18%	818	28%	-	0%	49,524	18%
Premier Care	16,641	6%	163	6%	-	0%	16,804	6%
Kaiser	27,348	10%	-	0%	-	0%	27,348	10%
Total	269,509	100%	2,962	100%	7,909	100%	280,380	100%
Enrollment at June 30, 2016	260,031		4,435		8,203		272,669	
Net Change from Beginning of FY17	3.6%		-33.2%		-3.6%		2.8%	

Membership has increased 2.8% since the beginning of the Fiscal Year, primarily due to growth in Adult and Aged Medi-Cal membership.



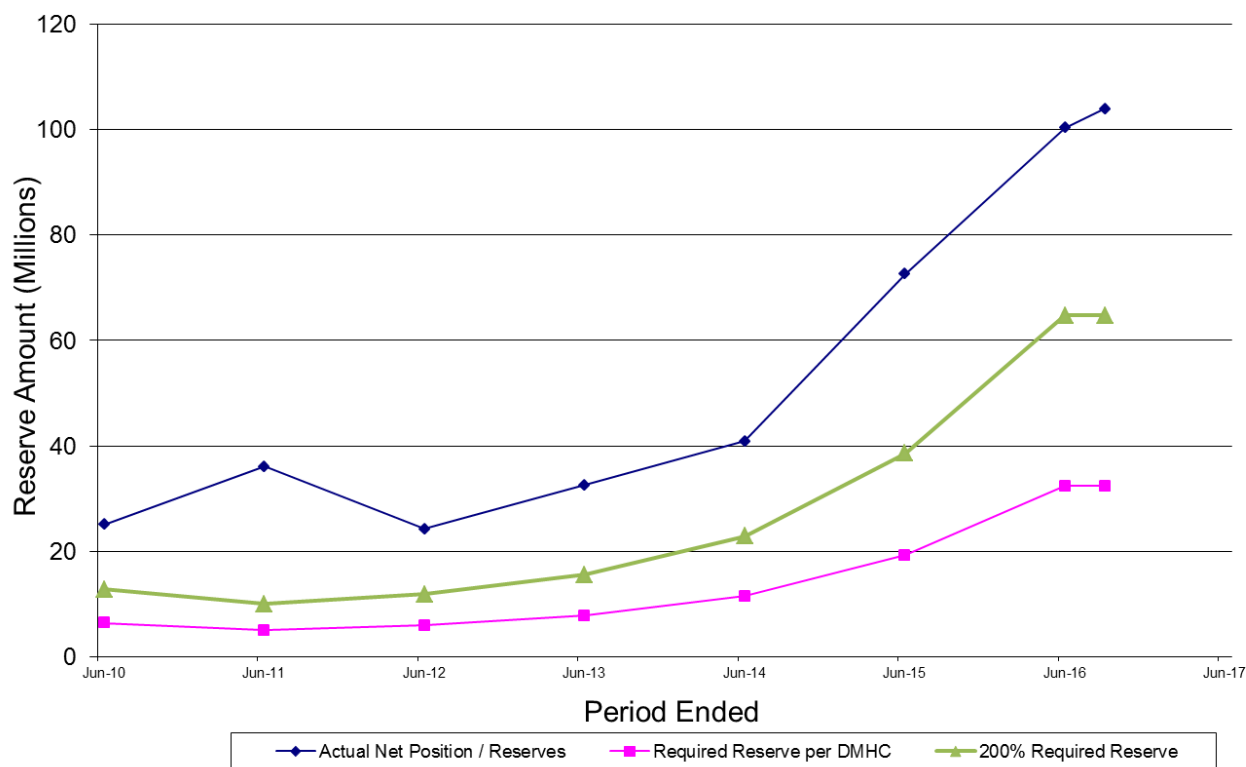
Enrollment by Aid Category

		2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	2016-07	2016-08	2016-09
NON DUAL	Adult (over 19)	27,844	27,331	27,080	27,148	27,229	27,493	27,509	27,485	27,857	27,436	27,431	27,482	29,530	31,200	31,372
	Adult (under 19)	92,783	95,565	97,889	99,823	101,802	103,083	102,501	103,018	104,740	104,443	105,205	105,342	105,841	107,019	108,006
	Aged - Medi-Cal Only	8,642	8,730	8,858	8,909	9,103	9,235	9,241	9,158	9,150	9,145	9,144	9,101	9,256	10,150	10,138
	Disabled - Medi-Cal Only	11,421	11,345	11,294	11,249	11,261	11,123	11,106	11,066	10,998	10,954	10,895	10,843	10,812	10,912	11,026
	Child (HF conversion)	9,541	7,791	6,032	4,575	3,837	3,461	3,211	2,863	2,556	2,301	2,045	1,828	1,725	1,542	1,350
	Adult Expansion	71,183	73,695	75,814	77,756	79,406	81,235	79,284	79,393	81,325	79,934	80,941	81,786	82,983	83,572	83,721
	Other	48	47	55	47	45	45	40	40	42	42	40	38	40	38	38
	Long Term Care	194	194	205	212	230	249	248	259	258	257	264	266	270	275	277
Total Non-Duals		221,656	224,698	227,227	229,719	232,913	235,924	233,140	233,282	236,926	234,512	235,965	236,686	240,457	244,708	245,928
DUAL	Aged	10,003	10,678	11,583	12,426	13,381	14,035	14,074	14,246	14,328	14,301	14,415	14,496	14,524	14,521	14,729
	Disabled	4,727	4,932	5,235	5,544	5,852	6,042	6,049	6,070	6,058	6,050	6,018	6,037	6,033	6,083	6,027
	Other	1,238	1,303	1,370	1,458	1,483	1,638	1,638	1,654	1,701	1,711	1,787	1,814	1,817	1,843	1,856
	Long Term Care	644	722	814	904	982	1,064	1,058	1,038	1,019	1,006	1,003	998	992	980	969
Total Duals		16,612	17,635	19,002	20,332	21,698	22,779	22,819	23,008	23,106	23,068	23,223	23,345	23,366	23,427	23,581
Total Medi-Cal		238,268	242,333	246,229	250,051	254,611	258,703	255,959	256,290	260,032	257,580	259,188	260,031	263,823	268,135	269,509
Healthy Kids		4,496	4,598	4,375	4,362	4,325	4,273	4,186	4,114	4,158	4,328	4,375	4,435	4,380	4,224	2,962
CMC	CMC Non-Long Term Care	7,249	7,386	7,587	8,002	8,527	9,305	8,784	8,528	8,377	8,151	8,033	7,871	7,781	7,697	7,585
	CMC - Long Term Care	294	312	325	352	379	394	375	358	351	337	334	332	327	328	324
	Total CMC	7,543	7,698	7,912	8,354	8,906	9,699	9,159	8,886	8,728	8,488	8,367	8,203	8,108	8,025	7,909
Total Enrollment		250,307	254,629	258,516	262,767	267,842	272,675	269,304	269,290	272,918	270,396	271,930	272,669	276,311	280,384	280,380



Tangible Net Equity at September 30, 2016

TNE is \$103.9 million or 321% of the Required TNE of \$32.4m per the Department of Managed Health Care (DMHC). The Plans reserves are roughly \$9.3 million below the SCFHP low end TNE target and \$55.7 million above the SCFHP low end liquidity target.



Meeting Minutes
SCCHA Quality Improvement Committee
 Wednesday, November 09, 2016

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

Non-Voting Staff Members	Title	Present Y or N
Andres Aguirre	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	Y
Jennifer Clements	Director of Provider Operations	Y
Caroline Alexander	Administrative Assistant	Y
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Angela Sheu-Ma	Health Educator	N
Divya Shah	Quality Improvement Coordinator	N

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Chairman Ria Paul, MD called the meeting to order at 6:05 p.m. Quorum was established.			
Review and Approval of August 10, 2016 minutes	The minutes of the August 10, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the August 10, 2016 meeting were approved as presented.		
Public Comment	No attendees from public.			
CEO Update	Christine Tomcala reported Medi-Cal membership is currently at 271, 186. Healthy Kids membership is currently at 2,458. Cal MediConnect membership is at 7,583. Total membership is 281,334. There is new leadership at O'Connor Hospital and at Verity Health Systems. Will reach out to the new leadership and			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	<p>CPG analysis. Measures looked at were as follows:</p> <ul style="list-style-type: none"> • Comprehensive Diabetes Care HbA1c Test/Poor/Control • Comprehensive Diabetes Care Eye Exam/Med Attn Neph/BP <140/90 • Controlling High Blood Pressure • ADD Initiation Phase • ADD C&M Phase • Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Childhood Immunization Status • Immunizations for Adolescents • Prenatal Postpartum Care-Timeliness of Prenatal Care • Prenatal Postpartum Care-Post Partum Care 			
<p>Committee Reports A. Credentialing Committee</p>	<p>Dr. Lin presented the October 5, 2016 Credentialing Committee Report. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.</p>	<p>Credentialing Committee report was approved as presented.</p>		
<p>B. Pharmaceutical and Therapeutics Committee</p>	<p>Dr. Lin presented the 2nd Quarter 2016 Pharmacy and Therapeutics Committee minutes. Pharmacy Dashboard was presented. As of May 2016, percentage of expedited authorizations completed within one business day is 100% for Medi-Cal. For Cal MediConnect, percentage of standard prior authorizations completed within 72 hours is 100%. Committee Charter was presented with a recommendation to add information on how members are appointed to the Pharmacy and Therapeutics Committee. During Class Reviews, approved the following recommendations:</p> <ul style="list-style-type: none"> • Remove ST on Focalin IR • Add all strengths to formulary and remove ST on Metadate CD • Remove ST on Ritalin • Change prior authorization to ST on Focalin XR • Remove Dexedrine from formulary, input prior authorization for existing users • Add ST for new starts on Concerta 	<p>2nd Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.</p>		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	<ul style="list-style-type: none"> • Add Invokana and Invokamet to formulary with ST to match that of Januvia (trial of metformin and another oral DM agent) • Add bromocriptine capsules to formulary 			
C. Utilization Management Committee	Dr. Lin presented the 3rd Quarter 2016 Utilization Management Committee minutes. CEO presented an update on DMHC/DHCS audit results. Dr. Boris presented report for Inpatient Utilization, Inpatient Readmissions, as well as Frequency of Selected Procedures. 2016 Inter Rater Reliability Report was also presented by Dr. Boris.	3rd Quarter 2016 Utilization Management Committee minutes were approved as presented.		
D. Dashboard	Dr. Liu presented the 3 rd Quarter Dashboard report, including data through October 2016. Quality Improvement department will develop a more in depth dashboard for presentation to the Quality Improvement Committee. Dashboard reports on Facility Site Reviews (FSR's), Membership, timeliness of Potential Quality Issues (PQI's) and Grievance timeliness.	Present Quarterly dashboard at Quality Improvement Committee	Johanna Liu/Andres Aguirre	Ongoing; Quarterly
Adjournment	Meeting adjourned by Dr. Ria Paul at 7:23 p.m.			
Next Meeting	Wednesday, February 08, 2017- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD
Quality Improvement Committee Chairperson

POLICY



Santa Clara
Family Health Plan

Policy Title:	Screening, Brief Intervention, and Referral to Treatment for Misuse of Alcohol	Policy No.:	QI.12
Replaces Policy Title (if applicable):		Replaces Policy No. (if applicable):	
Issuing Department:	Quality Improvement	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Healthy Kids	<input type="checkbox"/> CMC

I. Purpose

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

II. Policy

- A. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of SBIRT when indicated during administration of the Staying Healthy Assessment or at any time the PCP identifies a potential alcohol misuse problem.
- B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for identification, referral, and coordination of care for members requiring alcohol abuse treatment services.

III. Responsibilities

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

IV. References

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

POLICY

V. Approval/Revision History

First Level Approval		Second Level Approval		
				
Signature Johanna Liu, PharmD		Signature Jeff Robertson, MD		
Name Director of Quality and Pharmacy		Name Chief Medical Officer		
Title November 9, 2016		Title November 9, 2016		
Date		Date		
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement	Approve: 11/9/2016	

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

**Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
June 16, 2016 CONFIDENTIAL**

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

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	Y
Christine Tomcala	Chief Executive Officer	N
Tami Ogino, PharmD	Clinical Pharmacist	Y
Joseph Cherian, PharmD	MedImpact Clinical Program Manager	Y
Angelique Tran	Prior Authorization Supervisor	Y
Dan Johns	Appeals and Grievance Manager	N

Item	Discussion	Follow-Up Action
I.	<p>The meeting convened at 6:15 PM.</p> <p>REVIEW, REVISE, AND APPROVE MEETING MINUTES of March 24, 2016. The minutes were reviewed by Committee as submitted.</p>	<p>Upon motion duly made and seconded, the P&T Committee minutes of March 24, 2016 were approved as submitted and will be forwarded to the QI Committee and Board of Directors.</p>

**Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
June 16, 2016 CONFIDENTIAL**

Item	Discussion	Follow-Up Action
II.	REPORTS	
	a. Appeals and Grievances	
	Ms. Ogino presented the 1 st Quarter 2016 Pharmacy Appeals. 65 MediCal appeals were received during the 1 st Quarter of 2016. 13 State Fair Hearings were requested. No trends or changes were identified for MediCal appeals during the 1 st Quarter of 2016. 34 Cal MediConnect appeals were received during the 1 st Quarter of 2016. Trend of high overturn rate for Cal MediConnect appeals continued through 1 st Quarter of 2016.	No action required.
	b. Membership	
	Dr. Robertson presented the Membership Report to date as of June 2016. Membership is at 272, 667 overall including both lines of business. 8,203 are Cal MediConnect members. MediCal line of business shows slow and steady growth.	No action required.
	c. Pharmacy Dashboard	
	Dr. Robertson presented the Pharmacy Dashboard for MediCal and Cal MediConnect. For MediCal, the goal for percentage of standard prior authorizations completed within 1 business day is 95%. As of May 2016, percentage completed within 1 business day is 99.3%. Goal for percentage of expedited prior authorizations completed within 24 hours is 95%. As of May 2016, percentage completed within 24 hours is 100%. For Cal MediConnect, percentage of standard prior authorizations completed within 72 hours is 100% as of May 2016. Percentage of expedited prior authorizations completed within 24 hours is 100% as of May 2016. Goal for Medication Therapy Management (MTM) completion rate is 22% at year end. Currently at 9% completion rate as of May 2016. On target to meet year end goal of 22%.	No action required.
III.	OLD BUSINESS/DISCUSSION ITEMS	
	No old business to discuss since interim from last meeting.	

**Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
June 16, 2016 CONFIDENTIAL**

Item	Discussion	Follow-Up Action
IV.	<p>NEW BUSINESS/ACTION ITEMS</p> <p>a. P & T Committee Charter Ms. Liu presented an overview of the Pharmacy and Therapeutics Committee Charter. Charter recently approved by the Board. Committee recommended adding information on how members are appointed to the Pharmacy and Therapeutics Committee.</p> <p>b. Formulary Modifications/ Prior Authorization Guideline Review Project</p> <p style="padding-left: 20px;">i. Presented proposed changes to existing guidelines.</p> <p>c. MedImpact P & T Minutes Ms. Ogino and Ms. Liu reviewed the MedImpact P&T Minutes and approved as written.</p> <p>d. New Drugs</p> <p style="padding-left: 20px;">i. Inflectra-Presented as informational only</p> <p style="padding-left: 20px;">ii. Taltz-Presented as informational only</p> <p style="padding-left: 20px;">iii. Allzital-Presented as informational only</p> <p style="padding-left: 20px;">iv. Adzenys XR ODT-Presented as informational only</p>	<p>Amend Charter to state "Chief Executive Officer appoints committee members by recommendation of the Chief Medical Officer."</p> <p>Upon motion duly made and seconded, Formulary Modifications and proposed changes to Prior Authorization Guidelines were approved as submitted</p> <p>Review utilization data and revisit proposed guideline on Ambien at next Pharmacy and Therapeutics Committee meeting</p> <p>Upon motion duly made and seconded, MedImpact 1Q16 P&T Minutes as well as ad hoc minutes were approved as submitted.</p> <p>Informational only. No action required</p>

**Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
June 16, 2016 CONFIDENTIAL**

Item	Discussion	Follow-Up Action
	<p>e. Class Reviews</p> <p>i. ADHD Stimulants Proposed items for discussion: Focalin IR-remove ST Metadate CD-add all strengths to formulary and remove ST Ritalin LA-remove ST Focalin XR-generic strengths are formulary, change PA to ST (to look for lower cost XR products) Dexedrine-Remove from formulary, input PAs for existing users Concerta-Add ST (to look for lower cost XR products) for new starts</p> <p>ii. Oral Diabetics Proposed item for discussion: Should SCFHP have a SGLT2 inhibitor available on the formulary? Propose add Ivokana and Invokamet to formulary with ST to match that of Januvia (trial of metformin and another oral DM agent)</p> <p>iii. Parkinson's Disease Proposed items for discussion: Leave Xadago as non-formulary Leave Nuplazid as non-formulary Add bromocriptine capsules to formulary</p> <p>f. 2Q2016 Drug Trend and Utilization Review</p> <p>g. Medi-Cal Formulary Drug Updates No proposed actions.</p> <p>h. Generic Pipeline-Presented as informational only</p>	<p>Upon motion duly made and seconded, recommendations were approved as presented</p> <p>Upon motion duly made and seconded, recommendations were approved as presented</p> <p>Upon motion duly made and seconded, recommendations were approved as presented</p> <p>Informational only. No action required.</p>
V.	<p>ADJOURNMENT The meeting was adjourned at 7:25 PM.</p>	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
June 16, 2016 CONFIDENTIAL


Submitted by:

Internal Approved By:

External Approved by:


Date: 9/15/16
Caroline Alexander
Administrative Assistant


Date: 9/15/16
Johanna Liu, PharmD
Pharmacy Director, SCFHP


Date: 9/15/16
Jimmy Lin, MD
Pharmacy & Therapeutics Chair



MINUTES
UTILIZATION MANAGEMENT COMMITTEE
July 20, 2016

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

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Alegre	Utilization Management Manager	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:10 p.m. Introduced Jana Alegre, Utilization Management Manager to the group. The minutes of the April 20, 2016 and June 02, 2016 meetings were approved as presented.	
II. CEO Update	Ms. Tomcala presented the update for Santa Clara Family Health Plan. DMHC/DHCS audit took place April 18 th through 29 th . Preliminary results from DHCS were shared with the leadership team. 36 findings were identified. Santa Clara Family Health Plan was given an opportunity to respond and is in the process of submitting additional documents to DHCS. Results from DMHC are not yet available. Findings were based on past performance, from March 2015 through March 2016.	
III. Old Business	Dr. Boris gave an update on the combination of authorization grids for Medi-Cal, Healthy Kids, and CalMediConnect. Utilization Management Manager and Utilization Management Supervisor worked to combine the two grids but could not combine them as it was less easy to read in that format. It was decided to keep the Healthy Kids and Cal MediConnect grids separate. The latest version of both authorization grids are posted on the Santa Clara Family Health Plan provider portal.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. Action Items	<p>a. UM Program Description 2016 Dr. Robertson presented the updates to the UM Program Description for review by the committee. After discussion, it was moved, seconded to approve updates as presented.</p>	<p>All updates approved by committee as presented.</p>
V. Standing Reports	<p>a. Membership Dr. Robertson reported membership is at 276, 309 in July. Cal MediConnect membership is at 8,108 and MediCal is at 268, 201. Of note is the increase of 4, 000 members in MediCal from June to July. Estimate a ceiling of 300,000 for membership.</p> <p>b. UM Reports 2016</p> <p>i. Quarterly: CMC and Medi-Cal Dr. Boris presented the report on Inpatient Utilization for Medi-Cal Non-Seniors and Persons with Disabilities (SPD), Medi-Cal SPD, Cal MediConnect, as well as Inpatient Readmissions for the above mentioned populations, respectively. Also presented Frequency of Selected Procedures for Medi-Cal population, as well as Medi-Cal Behavioral Health Metrics. Request from committee to obtain information on readmission rates from other Cal MediConnect plans, as well as readmits by hospital for Non SPD and SPD cases in CY 2015 and first Quarter of 2016.</p> <p>ii. 2016 IRR Report Dr. Boris presented the Inter Rater Reliability Report. It is the policy of Santa Clara Family Health Plan to monitor the consistency and accuracy of review criteria applied by all reviewers (physicians and non-physicians) who are responsible for conducting Utilization Management reviews and to act on improvement opportunities identified through this monitoring. The Plan classifies reviews into one of two performance categories: Proficient (85-100% of the records are in compliance with the review criteria); Not proficient (below 85% in compliance). 12 staff were reviewed and findings indicate that all but 2 staff performed as Proficient.</p>	<p>Dr. Boris to follow up with Molly Regan to provide requested data at next Utilization Management Committee meeting</p>

ITEM	DISCUSSION	ACTION REQUIRED
	<p>iii. Turn Around Time Dr. Boris presented the Prior Authorization Turn Around Time Report for fourth Quarter 2015 through second Quarter 2016. Goal is 95% compliance rate. Working on revising Cal MediConnect Turn Around Time Report. (NCQA Requires plan to report by type of status: Routing, Urgent, Retroactive).</p>	
VI. Adjournment	Meeting adjourned at 7:05 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, October 19, 2016, 6:00 PM	All: Calendar this event and plan to attend.

Prepared by:

Caroline Alexander
 Caroline Alexander
 Administrative Assistant

Date 10/19/16

Reviewed and approved by:

Jimmy Lin, M.D.
 Jimmy Lin, M.D. for
 Committee Chairperson

Date 10-19-16



Regular Meeting of the Santa Clara Community Health Authority Governing Board

**Thursday, December 15, 2016
2:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008**

Agenda

- | | | | |
|--|----------------|------|--------|
| <p>1. Roll Call</p> | Mr. Brownstein | 2:30 | 5 min. |
| <p>2. Public Comment
Members of the public may speak to any item not on the agenda; two minutes per speaker. The Board reserves the right to limit the duration of public comment period to 30 minutes.</p> | Mr. Brownstein | 2:35 | 3 min. |
| <p>3. Meeting Minutes
Review meeting minutes of the January 28, 2016 Regular Board Meeting.
Possible Action: Approve January 28, 2016 Regular Board Meeting minutes</p> | Mr. Brownstein | 2:38 | 3 min |
| <p>4. Bylaws Committee Report
Review minutes of the June 16, November 2 and 29, 2016 Committee meetings.
Possible Action: Accept the June 16, November 2 and 29, 2016 Bylaws Committee report as presented</p> | Mr. Darrow | 2:41 | 4 min. |
| <p>5. Amendments to the Bylaws
Review draft amendments to the Santa Clara Community Health Authority Bylaws.
Possible Action: Approve proposed amendments to the Santa Clara Community Health Authority Bylaws</p> | Mr. Darrow | 2:45 | 5 min. |

- | | | | |
|--|--------------------|-------------|---------------|
| <p>6. Conflict of Interest Code
 Consider adoption of the Conflict of Interest Code.
 Possible Action: Adopt Resolution approving the Conflict of Interest Code</p> | <p>Ms. Pianca</p> | <p>2:50</p> | <p>5 min.</p> |
| <p>7. Annual Report to the County Board of Supervisors
 Review draft report regarding the activities of the Joint Powers Authority as incorporated in the Annual Report of the Santa Clara County Health Authority.
 Possible Action: Approve the Annual Report to be submitted to the County Board of Supervisors</p> | <p>Ms. Tomcala</p> | <p>2:55</p> | <p>5 min.</p> |
| <p>8. Adjournment</p> | | <p>3:00</p> | |

Notice to the Public—Meeting Procedures

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

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

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

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

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



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

Thursday, January 28, 2016

4:45 PM - 5:00 PM

210 E. Hacienda Avenue

Campbell, CA 95008

Minutes - DRAFT

Board Members Present

Bob Brownstein, Chair
Dolores Alvarado
Brian Darrow
Christopher Dawes
Kathleen King
Liz Kniss
Paul Murphy
Brenda Taussig
Wally Wenner, M.D.

Staff Present

Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Jeff Robertson, Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Pat McClelland, VP Member Services & Medical
Operations
Gary Kaplan, VP Vendor Relations & Delegation
Oversight
Sharon Valdez, VP Human Resources
Beth Paige, Compliance Officer
Rita Zambrano, Executive Assistant

1. Roll Call

Chairman Brownstein called the meeting to order at 5:02 pm. Roll call was taken, and a quorum was established.

2. Public Comment

There were no public comments.

3. Overview of Community Health Authority

Dave Cameron provided an overview of the Santa Clara Community Health Authority, which was established in 2005 through a Joint Powers Agreement (JPA) of Santa Clara County and Santa Clara County Health Authority. The Community Health Authority is a Knox-Keene plan that manages the non-Medi-Cal lines of business, with Santa Clara County Health Authority providing the necessary administrative services. Mr. Cameron indicated that through this structure, the Quality Improvement Fee (QIF) was not assessed on the non-Medi-Cal lines of business.

4. Bylaws Committee

The Community Health Authority Board has not routinely met and there is a need to revise the Bylaws. Christine Tomcala requested that the Bylaws Committee convene and work with Elizabeth Pianca, County Counsel, to draft amendments addressing aspects of the Bylaws that are no longer applicable.

It was moved, seconded, and unanimously **approved** to direct the Bylaws Committee to convene to draft suggested amendments to the Santa Clara Community Health Authority Bylaws.

5. Adjournment

The meeting was adjourned at 5:15 pm.

Elizabeth Pianca, Secretary to the Board



Santa Clara
Family Health Plan
The Spirit of Care



Santa Clara County Health Authority Bylaws Committee Special Meeting

Thursday, June 16, 2016
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

Minutes - **DRAFT**

Members Present

Brian Darrow
Paul Murphy

Staff Present

Christine Tomcala, Chief Executive Officer
Rita Zambrano, Executive Assistant

Members Absent

Liz Kniss

Others Present

Elizabeth Pianca, Secretary

1. Roll Call

The meeting was called to order at 10:45 am. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Amendments to the Bylaws

The Committee met, discussed, and considered amendments to the Santa Clara County Health Authority Bylaws. The Committee members agreed to reconvene to continue the process of reviewing and recommending revisions of the Bylaws to the Board.

4. Adjournment

The meeting was adjourned at 11:00 am.

Elizabeth Pianca, Secretary to the Board



Santa Clara Community Health Authority Bylaws Committee Special Meeting

Wednesday, November 2, 2016
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

MINUTES – DRAFT

Members Present

Brian Darrow
Liz Kniss
Paul Murphy

Staff Present

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

Others Present

Elizabeth Pianca, Secretary

1. Roll Call

Brian Darrow called the meeting to order at 12:10 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the June 16, 2016 Bylaws Committee Meeting were reviewed.

It was moved, seconded and the June 16, 2016 Bylaws Committee minutes were **approved**, with a correction to the spelling of Liz Kniss' name.

Liz Kniss arrived.

4. Revisions to the Bylaws

Proposed revisions to the Santa Clara Community Health Authority Bylaws were reviewed and discussed. The Committee agreed to reconvene for a final review of the draft Bylaws on November 29, 2016 from 3:00-4:30 pm.

It was moved, seconded, and approved to recommend Governing Board approval of the draft Bylaws with the revisions discussed, subject to final review on November 29, 2016.

5. Adjournment

The meeting was adjourned at 1:35 pm.

Elizabeth Pianca, Secretary to the Board



Santa Clara
Family Health Plan
The Spirit of Care

Santa Clara County Health Authority Bylaws Committee Special Meeting

Tuesday, November 29, 2016
210 E. Hacienda Avenue (Cambrian)
Campbell, CA 95008

Minutes – DRAFT

Members Present

Brian Darrow
Liz Kniss
Paul Murphy

Staff Present

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

Others Present

Elizabeth Pianca, Secretary

1. Roll Call

Brian Darrow called the meeting to order at 3:50 pm. Roll Call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the June 16, 2016 Bylaws Committee were reviewed.

It was moved, seconded, and the June 16, 2016 Bylaws Committee minutes were **approved** as presented. Liz Kniss abstained.

4. Amendments to the Bylaws

Proposed amendments to the Santa Clara County Health Authority Bylaws were discussed, including revisions consistent with the proposed amendments to the Community Health Authority Bylaws.

The Committee members agreed to reconvene in January to continue review and revision of the Bylaws.

5. Adjournment

The meeting was adjourned at 4:40 pm.

Elizabeth Pianca, Secretary to the Board



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

Tuesday, December 13, 2016

6:00 – 7:00 pm

210 E. Hacienda Avenue

Campbell, CA 95008

Minutes - DRAFT

Committee Members present:

Waldemar Wenner, M.D.
Danette Zuniga
Hung Vinh
Myrna Vega
Rachel Hart
Tran Vu
Margaret Kinoshita
Rebecca Everett (Guest)
Angeli Gonzaga (Guest)
Danielle Moua (Guest)
Brittney Perez (Guest)

Staff Present:

Laura Watkins, Director, Marketing and
Communications
Chelsea Byom, Marketing and Communications
Manager
Sherita Gibson, Marketing Coordinator
Andres Aguirre, Quality Improvement Manager
Sherry Holm, Behavioral Health Program Manager

1. Roll Call

Dr. Waldemar Wenner, Chairperson, called the meeting to order at 6:06 pm. Introductions were completed and a quorum was established.

2. Public Comments

There were no public comments.

3. Meeting Minutes

Minutes of the September 13, 2016 meeting were reviewed. **It was moved and seconded** to approve the September 13, 2016 meeting minutes. The minutes were **approved** as presented.

4. Health Plan Updates – Laura Watkins

Ms. Watkins presented enrollment updates as follows: Medi-Cal enrollment is about same as last month at 269,893 members. Cal MediConnect enrollment went down slightly due to no longer having passive enrollment. The decrease of only 50+ members means we are seeing stabilization of enrollment due to various outreach efforts and internal process improvements. Healthy Kids

enrollment is continuing to decrease. As of December 1, we have just under 2,600 members enrolled in Healthy Kids, with fewer than 1,000 members enrolled through the traditional Healthy Kids application process. We estimate about 500 of these kids enrolled through the traditional Healthy Kids application process are eligible for either Healthy Kids through C-CHIP or eligible for Medi-Cal, and should be enrolled in one of those programs instead of the traditional Healthy Kids program. We continue to conduct outreach to help these families apply.

We have implemented streamlined enrollment for Cal MediConnect. This means that Medi-Cal members who are eligible can now call SCFHP for assistance in enrolling in Cal MediConnect. This process has been in place for about 3 weeks.

Consumer Advisory Committee Charter was approved by the SCFHP Governing Board at the 9/22/2016 meeting.

5. Group Needs Assessment Results – Andres Aguirre

Mr. Aguirre discussed the goals of the Group Needs Assessment (GNA) and how data is gathered. He shared three major findings:

1. In the Medi-Cal population of seniors and persons with disabilities, Asian members were diagnosed more frequently with Type II diabetes, Hypertension, and Hyperlipidemia when compared to other ethnicities.
2. In the Medi-Cal adult population, Asian members were diagnosed more frequently with Type II diabetes, Hypertension, and Hyperlipidemia in the sub population when compared to other ethnicities.
3. In the Medi-Cal child population, Hispanic children were most frequently diagnosed with Acute Upper Respiratory Infections, Cough, and Unspecified Fever when compared to other ethnicities.

Mr. Aguirre explained these findings are based on what the member defined as their ethnicity at time of enrollment. Ms. Kinoshita asked if the data was for the whole state or just Santa Clara County. Mr. Aguirre stated it was for SCFHP members only.

Next steps are to meet with health education team members that are within QI to look at developing interventions that will address chronic disease health education in a culturally appropriate manner. Additionally, we will work to improve utilization of the 24-hour Nurse Advice line in Spanish for our child members through our website and in certain geographic areas.

The CAC members and guests asked questions about the results of the GNA and engaged in discussion with Mr. Aguirre.

Mr. Aguirre explained that HEDIS is a tool that measures three different areas: 1) Preventive care for children; 2) Counter-disease measures; and 3) Women's Health measures. He agreed to come back and explain HEDIS in more detail at a future meeting.

Mr. Aguirre said the QI department is targeting completion of GNA next steps in the first six months of 2017, but there are no regulatory requirements on the timeframe for next steps.

4. Mental and Behavioral Health Benefits – Sherry Holm

Ms. Holm reported that SCFHP has a dedicated Behavioral Health Department, set up about a year ago. The department includes BHT services for Autism, behavioral health services for substance use disorders, and mental health. She noted that behavioral health services involve an intricate relationship with county and primary care clinics.

Ms. Holm explained that basic health care around depression, anxiety, or situational reactions are handled in primary care clinics. In primary care clinic offices, doctors can do a brief assessment of substance use issues. Some clinics have psychology, psychiatry, and case workers on staff, while some do not.

The county behavioral health department is in the process of merging mental health services and drug and alcohol treatment. Currently, detox and residential treatment are provided through the Gateway Program. The county does triage for people who are coming in and having difficulties with a major diagnosis, homeless, or unemployed. These beneficiaries are referred to the county behavioral health clinics or the community based organizations. Momentum for Mental Health is the largest and provides full service care.

SCFHP is responsible for the payment of a number of services for mild to moderate diagnoses. This may also include the care for members who have a severe diagnosis but are currently stable. These members receive services through their PCP.

Ms. Holm provided key phone numbers and information about how to get help.

- County Call Center: Triage calls to connect callers to the appropriate level of help. May take a while and require the caller to call back. According to County policies, they must triage severe cases within 5 days. Triage will take 10-15 days for less severe cases.
- Mental Health Urgent Care: Provides services from 8am – 10pm, including offering services for children. Anyone can walk in and be seen by a clinician right away. If needed, patient can see a psychiatrist within a couple of hours.
- Gateway Services: Does assessment for substance use disorder and may ask the person to call back to determine if inpatient or outpatient care is needed. The substance abuse treatment is 100% county funded and is limited right now. Hoping for expansion soon.
- SCFHP Customer Service: Can help members get to county call center or to the SCFHP Behavioral Health department. If members have problems getting services, Customer Service can help troubleshoot issues and help file an appeal, if needed.
- Suicide Prevention Hotline: 24/7 support with well-trained people.

There is no limit to Medi-Cal benefits for behavioral health, and if the provider is contracted with the health plan, an authorization is not required to see an in-network provider. SCFHP is working to increase the number of agencies and individual providers contracted to provide these services.

Ms. Zuniga asked if there is a new list of providers for autism. Ms. Holm said they have some new contracted providers, but they can also do a letter of agreement with any provider who is willing to

work with SCFHP. Ms. Everett asked about a situation regarding her son. Ms. Holm offered some advice on how to move forward.

Dr. Wenner asked the CAC members for ideas on how the health plan can make the mental health phone numbers more available to others. Ms. Zuniga suggested that the number be added to the ID card. Ms. Watkins let the group know that the plan recently added this number to ID cards, showing an image of the redesigned ID card. Additional conversation was held about the ID cards for Healthy Kids C-CHIP members. Ms. Zuniga asked how Healthy Kids members enrolled through C-CHIP should renew their coverage. Ms. Watkins took this as an action item to follow up on, as this is a process managed by the state through Covered California, not a process managed by SCFHP.

Ms. Gonzaga asked about the plan's outreach for substance use disorder programs. Ms. Holm responded that there is no active outreach at this time and acknowledged that it takes a lot of support to get through the system. It helps to have a support person that can help the person get through the process.

5. CAC New Member Appointment Process

Ms. Watkins reviewed the process for accepting new members to the CAC.

6. Recent SCFHP Member Communications

Ms. Watkins reviewed recent communications from the health plan to members, including website postings, direct mail, and telephone calls. This will be a standing item on the CAC agenda.

Ms. Watkins also reviewed the new Medi-Cal and Healthy Kids ID Cards that now show the provider's name, phone number, clinic name and network name. The Santa Clara County Mental Health Services phone number has also been added to the cards.

7. Future Meetings and Agenda Items

2017 meeting dates were reviewed. Topic suggestions for the next meeting include HEDIS, differences between Healthy Kids C-CHIP and traditional Healthy Kids, mental health benefits/care for seniors and for children.

Dr. Wenner encouraged CAC members to reach out to Ms. Gibson if they have topic ideas so those can be put on the agenda for upcoming meetings.

Ms. Holm agreed to bring a list of mental health providers to the next meeting. Ms. Watkins offered to invite Laura Luna from County Mental Health Department to the next meeting. Discussion continued about the importance of accessing mental health services. Ms. Zuniga commented that providers are not always able to help parents connect with mental health resources, because the options vary based on insurance. Ms. Watkins said based on tonight's discussion, we will look at how SCFHP Marketing and Behavioral Health departments can work together to better communicate with members and providers about behavioral health services.

Ms. Kinoshita commented that the SCFHP website has been really helpful and very informational. Ms. Watkins thanked her for her feedback and invited all CAC members to offer suggestions for website content.

8. Adjournment

The meeting was adjourned at 7:15 pm.

Waldemar Wenner, MD
Consumer Affairs Committee Chairperson

DRAFT

**BYLAWS OF
THE SANTA CLARA COMMUNITY HEALTH AUTHORITY**

**ARTICLE I
AUTHORITY, PURPOSES, STATUS AND POWERS**

Section 1.1 Authority. These Bylaws are adopted by the Santa Clara Community Health Authority ("Joint Powers Authority") to establish rules for its proceedings. The Joint Powers Authority is a local public agency created by a Joint Powers Agreement entered into by and between Santa Clara County ("County") and Santa Clara County Health Authority, pursuant to Chapter 5, Division 7, Title 1 of the Government Code of the State of California (commencing with Section 6500), as from time to time amended.

Section 1.2 Purposes. The purposes of the Joint Powers Authority are to [manage and operate non-Medi-Cal health programs](#) to demonstrate ways of promoting quality care and cost efficiency, and to further such other purposes as are contemplated by the Joint Powers Agreement.

Section 1.3 Status. The Joint Powers Authority is an entity separate from the County and separate from Santa Clara County Health Authority. Obligations, acts, omissions or liabilities of the Joint Powers Authority shall be obligations, acts omissions or liabilities solely of the Joint Powers Authority, and shall not, directly or indirectly, be obligations, acts, omissions or liabilities of the County or any officials, employees or agents of the County. Either party to the Joint Powers Agreement may separately contract for or assume responsibility for specific debts, liabilities, or obligations of the Joint Powers Authority.

Section 1.4 Powers. The Joint Powers Authority shall have the power to negotiate and enter into contracts with the [Department of Health Care Services, Centers for Medicare and Medicaid Services](#) and other commercial businesses, and to accept assignment of contracts from the Santa Clara County Health Authority for the [qualifying programs](#). To the extent authorized by the Joint Powers Agreement, the Joint Powers Authority may also enter into contracts to arrange for the provision of health care services to individuals under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals. The Joint Powers Authority shall have all rights, powers, duties, privileges and immunities expressed, either directly or implicitly, set forth in the Joint Powers Agreement. The Joint Powers Authority may adopt any fictitious names, trade names and trademarks it deems appropriate for the conduct of its business and the identification and marketing of its health care programs.

Chapter 1 of Division A6 of the Ordinance Code of the County, containing general rules and procedural requirements applicable to boards and commissions of the county, shall not apply to the Joint Powers Authority.

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ARTICLE II
GOVERNING
BOARD

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Section 2.1 Governance. Subject to the provisions of the Joint Powers Agreement and Government Code Section 6508, responsibility for governing and managing the affairs of the Joint Powers Authority shall be vested in a Governing Board.

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Section 2.2 Members. The Governing Board of Santa Clara County Health Authority shall serve, *ex officio*, as the Governing Board of the Joint Powers Authority (the "Governing Board").

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Section 2.3 Term. The term of office for a member of the Governing Board of the Joint Powers Authority ("Governing Board Member") shall run simultaneously with the term that that member serves on the Santa Clara County Health Authority governing board.

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Section 2.4 End of Term. A Member of the Governing Board shall cease to be a Member upon the expiration of his/her term as a member of the Santa Clara County Health Authority governing board.

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ARTICLE III
OFFICERS AND ADMINISTRATIVE BODY

Deleted: Section 2.5 Reimbursement Of Expenses. Governing Body Members, other than County employees, may be reimbursed for services and out-of-pocket expenses at a rate to be determined by the Governing Body for each Governing Body meeting attended.¶

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Section 3.1 Designation. The officers of the Santa Clara County Health Authority, and its Chief Executive Officer, shall serve, *ex officio*, as the Officers of the Joint Powers Authority. All officers and the Chief Executive Officer shall have the same respective duties and responsibilities in carrying out the business of the Joint Powers Authority as they have for Santa Clara County Health Authority.

Section 3.2 Administrative Body. Santa Clara County Health Authority shall serve as the administrative body, appointed by the Joint Powers Authority, and will provide all administrative services necessary for the conduct of the business of the Joint Powers Authority.

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ARTICLE
IV MEETINGS

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Section 4.1 Regular And Special Meetings. Regular meetings of the Governing Board shall be held at the same time and place as the meetings for the governing board of the Santa Clara County Health Authority. Special meetings of the Governing Board shall be held at the request of the Chairperson or a majority of the Members at any place within the County at a time that has been designated in the notice of meeting. Emergency meetings of the Governing Board may be held as permitted by the Ralph M. Brown Act. The Governing Board shall meet no less than one time per year.

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Section 4.2 Open And Public. Meeting shall be open and public and all persons shall be permitted to attend, except for closed sessions, all as required and permitted by applicable law, including the Ralph M. Brown Act (Gov. Code 54950 *et. seq.*)

Section 4.3 Notice. Meeting notices, agendas and procedures of the Governing Board shall be governed by applicable provisions of the Ralph M. Brown Act.

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Section 4.4 Attendance And Participation. Governing Board Members must attend the regular meetings of the Governing Board and of committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of the Joint Powers Authority.

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Section 4.5 Quorum. A quorum is a majority of the Governing Board Members. A quorum must be present to initiate the transaction of business at any regular or special meeting of the Governing Board.

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Section 4.6 Meeting Agendas. For all meetings that are open and public pursuant to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), the provisions of Sections 4.6.1 through 4.6.3 shall apply.

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4.6.1 The Chief Executive Officer of the Joint Powers Authority shall prepare an agenda for every meeting of the Governing Board setting forth a brief general description of each item of business to be transacted or discussed at the meeting and the time and location of the meeting. Each agenda for a regular meeting shall provide an opportunity for members of the public to address the Governing Board directly on items of interest to the public that are within the subject matter jurisdiction of the Joint Powers Authority. At least seventy-two (72) hours before a regular meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted online and at the main entrance of the Joint Powers Authority's executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public.

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4.6.2 No action shall be taken at a regular meeting on any item not appearing on the posted agenda; provided, however, that the Governing Board Members may take action on items of business not appearing on the posted agenda under the following conditions:

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4.6.2.1 The Governing Board determines by a majority vote of the Governing Board Members present that an emergency situation exists under Government Code 54956.5; or

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4.6.2.2 The Governing Board determines by a two-thirds vote of the Governing Board, or, if less than two-thirds of the Governing Board Members are present, by a unanimous vote of those Members present, that the need to take the action arose subsequent to the posting of the agenda; or

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The item was included in the posted agenda for a meeting of the Governing Board occurring not more than five (5) calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

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4.6.2.3

4.6.3 At least twenty-four (24) hours before a special meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted with the call and notice of the meeting at the main entrance of the Joint Powers Authority executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public. No business not set forth in the posted agenda shall be considered by the Governing Board at such special meeting.

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Section 4.7 Conduct Of Business. The items on the agenda shall be considered in order unless the Chairperson shall announce a change in the order of consideration. Unless an agenda item identifies a particular source for a report, the Chief Executive Officer, the Governing Board Members, the Joint Powers Authority staff and consultants shall report first on the item, after which the item shall then be open to public comment upon recognition of the speaker by the Chairperson. The proceedings of the Governing Board shall be guided by the provisions of law applicable thereto and, except as herein otherwise provided, by Robert's Rules of Order, newly revised. Provided, further, that the failure to follow the Robert's Rules of Order shall not invalidate any action taken.

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Section 4.8 Official Acts. All official acts of the Joint Powers Authority shall be taken and adopted on motion, duly made, seconded and adopted by vote of the Governing Board Members.

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Section 4.9 Voting. Except as otherwise provided by these Bylaws, when a quorum is present all official acts of the Governing Board shall require the affirmative vote of a majority of the Governing Board Members present and eligible to vote.

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Section 4.10 Disqualification From Voting. A Governing Board Member shall be disqualified from voting on any resolution relating to a transaction in which he or she has a financial interest, as required by law or by the Conflicts of Interest Policy of the Joint Powers Authority, as described in Article IX. Except as required by law or by the Conflict of Interest Policy of the Joint Powers Authority, no Governing Board Member shall be disqualified from serving as a Governing Board Member or taking part in any proceedings of the Governing Board because of any financial interest of the Member.

Deleted: ing, so long as all applicable quorum requirements have been met. No official act shall be approved with less than the affirmative vote of four (4) Members, unless the number of Governing Body Members prohibited from voting because of conflicts of interest precludes adequate participation in the vote

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Section 4.11 Minutes. The Secretary shall cause to have prepared the minutes of each meeting of the Governing Board. The minutes shall be an accurate summary of the Governing Board's consideration of each item on the agenda and an accurate record of each action of the Governing Board. At a subsequent meeting, the Secretary shall submit the minutes to the Governing Board for approval by a majority vote of Governing Board Members in attendance at the meeting covered by the minutes. When approved, the minutes shall be signed by the Secretary and kept with the proceedings of the Governing Board.

Section 4.12 Closed Sessions. The Governing Board shall meet in closed session only as permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*). The Governing Board shall post an agenda and report the actions taken at a closed session to the public to the extent required by applicable law. A closed session minute book may be established and maintained for minutes of closed sessions, which shall reflect only the topics of discussion and decisions made at the session. The closed session minute book shall be kept confidential, shall not be a public record, and shall be available to the Governing Board Members, except as otherwise required by applicable law.

Section 4.13 Public Records. All documents and records of the Joint Powers Authority, not exempt from disclosure under applicable law, shall be public records under the California Public Records Act (Government Code 6250 *et seq.*). The Governing Board and the Chief Executive Officer shall take appropriate steps to maintain the confidentiality of all documents and records of the Governing Board for which exemptions from disclosure are available under applicable statutes.

Section 4.14 Adjournment. The Governing Board may adjourn any meeting to a time and place specified in the resolution of adjournment, notwithstanding less than a quorum may be

present and voting. If no member of the Governing Board is present at a regular or adjourned meeting, the Chief Executive Officer or his or her designee may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in Section 4.3 of the Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

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ARTICLE V
COMMITTEES OF THE GOVERNING BOARD

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Section 5.1 Committees. The Committees of the Santa Clara County Health Authority shall serve, *ex officio*, as the committees of the Joint Powers Authority, unless otherwise determined by the Governing Board by resolution. Notices, agendas and minutes shall be prepared in accordance with the Santa Clara County Health Authority Bylaws governing committee meetings.

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The Governing Board may by resolution, from time to time, create and appoint the members of such additional committees and subcommittees of the Governing Board as it deems necessary to carry out its purposes. No committee or subcommittee may be composed of a number of Governing Board Members constituting a quorum of voting Members.

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Section 5.2 Joint Powers Authority. All such other committees and subcommittees shall be advisory only, unless otherwise specified by the Governing Board.

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ARTICLE VI
EXECUTION OF DOCUMENTS

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Section 6.1 Contracts and Instruments.

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6.1.1 The Governing Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Joint Powers Authority, and this Joint Powers Authority may be general or confined to specific instances; and, unless so authorized or ratified by the Governing Board, no officer, agent or employee shall have any power or Joint Powers Authority to bind the Joint Powers Authority by any contract or engagement or to render it liable for any purpose or for any amount.

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6.1.2 The Secretary shall have the Joint Powers Authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of the Joint Powers Authority and to certify the incumbency of those signatories.

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6.1.3 Each and every contract, indenture, mortgage, loan or credit document, lease, or other instrument or obligation of the Joint Powers Authority shall contain a statement to the effect that the Joint Powers Authority is a separate legal entity from the County, that the County, and its officials, employees and agents, are not responsible for the obligations of the Joint Powers Authority, and that (except if the county is a direct party to the particular document or instrument) the parties to the particular document or instrument do not intend to, or have the power to, confer on any person or entity any rights or remedies against the County or any officials, employees or agents of the County.

Section 6.2 Checks, Drafts, Evidences of Indebtedness. All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of the Joint Powers Authority or payable to the order of the Joint Powers Authority, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined for the County Health Authority.

**ARTICLE VII
CONFLICT OF INTEREST POLICY**

Section 7.1 Adoption. The Governing Board shall by resolution adopt and from time to time may amend a Conflict of Interest Policy for the Joint Powers Authority as required by applicable law.

Section 7.2 Governing Board Member Statements. Each Governing Board Member shall file statements disclosing reportable investments, business positions, interests in real property and income in accordance with the Political Reform Act of 1974 (Government Code 81000 *et seq.*) and the regulations of the Fair Political Practices Joint Powers Authority.

Section 7.3 Prohibition on Governing Board Members With Financial Interest. A Governing Board Member shall not make, participate in making, or in any way attempt to influence a Governing Board decision in which the Governing Board Member knows, or has reason to know, that he or she has a financial interest as defined by California law or as set forth in the Joint Powers Authority's Conflict of Interest Policy.

**ARTICLE VIII
PROCEDURES, PRACTICES AND POLICIES
RELATING TO IMPLEMENTATION OF THE TWO-PLAN MODEL**

Section 8.1 Contract Negotiation and Renegotiation. The Joint Powers Authority shall, in negotiating and renegotiating contracts, give preference to providers (sometimes referred to herein as "preferred providers"): (1) based on (a) the number of Section 8.1.1 categories a provider is within, and (b) the number of and extent to which the factors set forth in each Section 8.1.1 category apply to the provider; (2) in the manner prescribed in Section 8.1.2; and (3) in accordance with the standards set forth in Section 8.2.

8.1.1 The following are the preference categories that shall be applicable for the Joint Powers Authority in negotiating and renegotiating contracts:

(a) Disproportionate Share Hospitals. The Joint Powers Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program. For purposes of the Section 8.1.1(a), "regularly and repeatedly" means that, at any particular time, the hospital has been recognized as a disproportionate share hospital under the Medi-Cal program for no less than three (3) of the most recent four (4) years. Among hospitals that have regular and repeatedly qualified for disproportionate share status, the Joint Powers Authority shall give greater preference to those hospitals that historically have had the highest levels of disproportionality, as measured on both a relative and absolute basis, over the most recent four (4) years.

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¶
The Board of Supervisors appointed the Governing Body Member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.¶

¶
The contract authorizes the Governing Body Member or the organization the Governing Body Member represents to provide services to beneficiaries under the Joint Powers Authority's programs.¶

¶
The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Governing Body Member was appointed to represent.¶

¶
The Governing Body Member does not influence or attempt to influence the Governing Body or another Governing Body Member to enter into the contract in which the Governing Body Member is interested.¶

¶
The Governing Body Member discloses the interest to the Governing Body and abstains from voting on the contract.¶

¶
The Governing Body notes the Governing Body Member's disclosures and abstention in its official records and authorizes the contract in good faith by a vote of the Governing Body sufficient for the purpose without counting the vote of the interested Governing Body Member.¶

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(b) Safety Net Providers. The Joint Powers Authority shall give preference to FQHCs and any other providers that SDHS has defined as safety net providers in the general policies relating to the Two-Plan Model.

(c) Traditional Medi-Cal Providers. The Joint Powers Authority may give preference to community-based clinics and private providers with a history of serving a substantial proportion of Medi-Cal patients. For purposes of this Section 8.1.1(c), "substantial proportion" means that in each of two (2) of the most recent four (4) years, a community-based clinic or private provider has received at least \$25,000 in payments per year from serving Medi-Cal patients.

(d) Medically Indigent and Uninsured Care Providers. The Joint Powers Authority shall give substantial preference to providers that have regularly and repeatedly provided the highest levels of ratios of care to the medically indigent and uninsured.

8.1.2 The following prescribes the manner in which the Joint Powers Authority shall give preference to providers in negotiating and renegotiating contracts:

(a) Generally. Preference shall be given in a fashion to preserve the health care safety net in the County, including public health services and in accordance with the standards set forth in Section 8.2.

(b) Disproportionate Share Hospitals. The Joint Powers Authority shall give substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program.

(c) All Preferred Providers. Subject to provider capacity and patients' medical interests, the Joint Powers Authority may take one or more of the following measures, as necessary or appropriate to meet the requirements of the Section 8.1.2: (1) assign patients to preferred providers, especially to those providers entitled to substantial preference under Section 8.1.1(a) and 8.1.1(d); (2) give preferential pricing terms to preferred providers; (3) give rights of first refusal on negotiating and renegotiating contracts to preferred providers; and (4) furnish preferred providers with such special or additional administrative or clinical support services as may be necessary or appropriate to assist such providers in transitioning to a managed care environment.

(d) Impact of Preferences. As among preferred providers, it is expected that higher levels of funding may be given by the Joint Powers Authority to those entitled to substantial preference, as compared to other preferred providers. The Joint Powers Authority shall fulfill its obligations under this Section 8.2 notwithstanding any detriment or adverse impact to non-preferred providers that may be caused by the fulfillment of such obligations, and notwithstanding that certain special or additional administrative clinical support services may be unavailable to non-preferred providers.

Section 8.3 Establishment and Maintenance of Provider Network. The Joint Powers Authority shall meet the standards set forth in this Section 8.3 in establishing and maintaining the provider network and in implementing the preferences described in Section 8.2.

8.3.1 The Joint Powers Authority shall foster and maintain the clinical relationships between medically indigent and uninsured patients and their health care providers.

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8.3.2 The Joint Powers Authority shall, in establishing and maintaining the provider network, recognize and accommodate the cultural and linguistic diversity of medically indigent and uninsured patients.

8.3.3 The Joint Powers Authority shall, in establishing and maintaining the provider network, recognize, accommodate and support those special programs and activities of providers that have been regularly and repeatedly successful in addressing the medical and social needs of medically indigent and uninsured patients.

ARTICLE X
MISCELLANEOUS, PROCEDURES, PRACTICES AND
POLICIES, INSURANCE, BONDS

Section 9.1 Purchasing, Hiring, Personnel, Etc. The Community Health Authority shall follow the same policies and procedures for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property and improvements, hiring employees, managing its personnel and for all other matters, as followed by the County Health Authority.

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Section 9.2 Enforcement. Subject to the ultimate Joint Powers Authority of the Governing Board, the Chief Executive Officer shall be responsible to implement all policies adopted by the Governing Board.

Section 9.3 Insurance. The Chief Executive Officer shall procure, at the Governing Board's direction, such liability, property, casualty, workers' compensation, and such other insurance (including, without limitation, directors' and officers' liability, professional liability, and health plan re-insurance) in such amounts and with such carriers as the Governing Board shall from time to time determine is prudent in the conduct of its activities; provided, the Governing Board may in its discretion provide self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

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Section 9.4 Bonds. The Joint Powers Authority shall require all of the Governing Board Members, as well as the Joint Powers Authority's officers, employees and agents, to be covered by fidelity bonds to the extent required by law, and otherwise to the extent the Governing Board determines prudent in the conduct of its activities. The cost of such bonds shall be paid for by the Joint Powers Authority.

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Section 9.5 Defense and Indemnification. So long as such individual was acting within the scope of his or her employment or official capacity, the Joint Powers Authority shall defend and hold harmless its current and former members, officers, employees, and other agents to the full extent set forth by the California Tort Claims Act (Gov. Code 810 *et seq.*).

Section 9.6 Immunities. The Joint Powers Authority, all Governing Board Members, and all officers, employees, and agents of the Joint Powers Authority shall, to the full extent set forth by law, be protected by the Immunities applicable to public entities and individuals as provided by the California Tort Claims Act (Gov. Code 810 *et seq.*)

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Section 9.7 Reports to County Board of Supervisors. The Governing Board shall prepare and deliver to the County Board of Supervisors an annual written report describing the activities of the Joint Powers Authority during the preceding year, and outlining, in general terms, the

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anticipated nature of the Joint Powers Authority's activities for the forthcoming year. [The report may be included as part of the annual report submitted by the Santa Clara County Health Authority to the Board of Supervisors.](#)

ARTICLE X
AMENDMENT OF BYLAWS

The Bylaws may be amended or repealed. Proposed changes to amend or repeal the Bylaws may be forwarded in writing by any Governing [Board](#) member to the Chairperson of the Bylaws Committee. The Bylaws Committee by a majority vote must approve proposed changes in advance of submitting proposed Bylaws changes to the Governing [Board](#). If approved by the Bylaws committees, the proposed Bylaws changes shall be placed on the agenda and provided to the Governing [Board](#) members at least [3 \(three\)](#) days prior to the Governing [Board](#) meeting at which the proposed Bylaw changes shall be considered. The Governing [Board](#) shall adopt the proposed changes by the voting approval of at least a majority of members of the Governing [Board](#).

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CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

That I am the duly elected and acting Secretary of the Governing Board of the Santa Clara Community Health Authority, an independent local public agency; and

That the foregoing Bylaws, comprising _ pages, including this page, constitute the Bylaws of the Santa Clara Community Health Authority, as duly adopted by the Governing Board of that Authority at a regular meeting, duly called on the __ day of __, 200_ at Campbell, California.

Secretary/Treasurer

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¶
Delegating Authority to its Chief Executive Officer and Chief Financial Officer to Enter into Management Services Agreements and Other Agreements Necessary to the Operations of the Joint Powers Authority¶

¶
¶

WHEREAS, the Santa Clara County Board of Supervisors approved creation of a Joint Powers Authority by Santa Clara County and Santa Clara County Health Authority; and,¶

¶

WHEREAS, the purposes of the Joint Powers Authority are to meet the problems of delivery of publicly assisted medical care in the County, to demonstrate ways of promoting quality care and cost efficiency and for further such purposes as are contemplated by the Joint Powers Agreement; and,¶

¶

WHEREAS, under the Joint Powers Agreement the Governing Body and officers of the Santa Clara County Health Authority shall serve, ex officio, as the Governing Body of the Joint Powers Authority; and,¶

¶

WHEREAS, the Joint Powers Authority needs to have the power to negotiate and enter into contracts with the Managed Risk Medical Insurance Board and other commercial businesses to accept assignment of contracts from the Santa Clara County Health Authority for the Healthy Families and/or Healthy Kids programs;¶

¶

NOW, THEREFORE, BE IT RESOLVED by the Santa Clara Community Health Authority that the Chief Executive Officer and Chief Financial Officer are hereby authorized through the Joint Powers Agreement to enter into management services agreements and other agreements as necessary to the operations of the Joint Powers Authority¶

¶

Passed and Adopted by(s)for, (s) against, (s) abstained, on November 17, 2005.¶

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BYLAWS OF THE SANTA CLARA COMMUNITY HEALTH AUTHORITY

ARTICLE I AUTHORITY, PURPOSES, STATUS AND POWERS

Section 1.1 Authority. These Bylaws are adopted by the Santa Clara Community Health Authority ("Joint Powers Authority") to establish rules for its proceedings. The Joint Powers Authority is a local public agency created by a Joint Powers Agreement entered into by and between Santa Clara County ("County") and Santa Clara County Health Authority, pursuant to Chapter 5, Division 7, Title 1 of the Government Code of the State of California (commencing with Section 6500), as from time to time amended.

Section 1.2 Purposes. The purposes of the Joint Powers Authority are to manage and operate non-Medi-Cal health programs to demonstrate ways of promoting quality care and cost efficiency, and to further such other purposes as are contemplated by the Joint Powers Agreement.

Section 1.3 Status. The Joint Powers Authority is an entity separate from the County and separate from Santa Clara County Health Authority. Obligations, acts, omissions or liabilities of the Joint Powers Authority shall be obligations, acts omissions or liabilities solely of the Joint Powers Authority, and shall not, directly or indirectly, be obligations, acts, omissions or liabilities of the County or any officials, employees or agents of the County. Either party to the Joint Powers Agreement may separately contract for or assume responsibility for specific debts, liabilities, or obligations of the Joint Powers Authority.

Section 1.4 Powers. The Joint Powers Authority shall have the power to negotiate and enter into contracts with the Department of Health Care Services, Centers for Medicare and Medicaid Services and other commercial businesses, and to accept assignment of contracts from the Santa Clara County Health Authority for the qualifying programs. To the extent authorized by the Joint Powers Agreement, the Joint Powers Authority may also enter into contracts to arrange for the provision of health care services to individuals under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals. The Joint Powers Authority shall have all rights, powers, duties, privileges and immunities expressed, either directly or implicitly, set forth in the Joint Powers Agreement. The Joint Powers Authority may adopt any fictitious names, trade names and trademarks it deems appropriate for the conduct of its business and the identification and marketing of its health care programs.

Chapter 1 of Division A6 of the Ordinance Code of the County, containing general rules and procedural requirements applicable to boards and commissions of the county, shall not apply to the Joint Powers Authority.

ARTICLE II
GOVERNING
BOARD

Section 2.1 Governance. Subject to the provisions of the Joint Powers Agreement and Government Code Section 6508, responsibility for governing and managing the affairs of the Joint Powers Authority shall be vested in a Governing Board.

Section 2.2 Members. The Governing Board of Santa Clara County Health Authority shall serve, *ex officio*, as the Governing Board of the Joint Powers Authority (the "Governing Board").

Section 2.3 Term. The term of office for a member of the Governing Board of the Joint Powers Authority ("Governing Board Member") shall run simultaneously with the term that that member serves on the Santa Clara County Health Authority governing board.

Section 2.4 End of Term. A Member of the Governing Board shall cease to be a Member upon the expiration of his/her term as a member of the Santa Clara County Health Authority governing board.

ARTICLE III
OFFICERS AND ADMINISTRATIVE BODY

Section 3.1 Designation. The officers of the Santa Clara County Health Authority, and its Chief Executive Officer, shall serve, *ex officio*, as the Officers of the Joint Powers Authority. All officers and the Chief Executive Officer shall have the same respective duties and responsibilities in carrying out the business of the Joint Powers Authority as they have for Santa Clara County Health Authority.

Section 3.2 Administrative Body. Santa Clara County Health Authority shall serve as the administrative body, appointed by the Joint Powers Authority and will provide all administrative services necessary for the conduct of the business of the Joint Powers Authority.

ARTICLE
IV MEETINGS

Section 4.1 Regular And Special Meetings. Regular meetings of the Governing Board shall be held at the same time and place as the meetings for the governing board of the Santa Clara County Health Authority. Special meetings of the Governing Board shall be held at the request of the Chairperson or a majority of the Members at any place within the County at a time that has been designated in the notice of meeting. Emergency meetings of the Governing Board may be held as permitted by the Ralph M. Brown Act. The Governing Board shall meet no less than one time per year.

Section 4.2 Open And Public. Meeting shall be open and public and all persons shall be permitted to attend, except for closed sessions, all as required and permitted by applicable law,

including the Ralph M. Brown Act (Gov. Code 54950 *et. seq.*)

Section 4.3 Notice. Meeting notices, agendas and procedures of the Governing Board shall be governed by applicable provisions of the Ralph M. Brown Act.

Section 4.4 Attendance And Participation. Governing Board Members must attend the regular meetings of the Governing Board and of committees to which they are appointed and shall contribute their time and special abilities as may be required for the benefit of the Joint Powers Authority.

Section 4.5 Quorum. A quorum is a majority of the Governing Board Members. A quorum must be present to initiate the transaction of business at any regular or special meeting of the Governing Board.

Section 4.6 Meeting Agendas. For all meetings that are open and public pursuant to the Ralph M. Brown Act (Gov. Code 54950 *et seq.*), the provisions of Sections 4.6.1 through 4.6.3 shall apply.

4.6.1 The Chief Executive Officer of the Joint Powers Authority shall prepare an agenda for every meeting of the Governing Board setting forth a brief general description of each item of business to be transacted or discussed at the meeting and the time and location of the meeting. Each agenda for a regular meeting shall provide an opportunity for members of the public to address the Governing Board directly on items of interest to the public that are within the subject matter jurisdiction of the Joint Powers Authority. At least seventy-two (72) hours before a regular meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted online and at the main entrance of the Joint Powers Authority's executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely accessible to members of the public.

4.6.2 No action shall be taken at a regular meeting on any item not appearing on the posted agenda; provided, however, that the Governing Board Members may take action on items of business not appearing on the posted agenda under the following conditions:

4.6.2.1 The Governing Board determines by a majority vote of the Governing Board Members present that an emergency situation exists under Government Code 54956.5; or

4.6.2.2 The Governing Board determines by a two-thirds vote of the Governing Board, or, if less than two-thirds of the Governing Board Members are present, by a unanimous vote of those Members present, that the need to take the action arose subsequent to the posting of the agenda; or

4.6.2.3 The item was included in the posted agenda for a meeting of the Governing Board occurring not more than five (5) calendar days prior to the date action is taken on the item, and at the prior meeting the item was continued to the meeting at which action is being taken.

4.6.3 At least twenty-four (24) hours before a special meeting, the Chief Executive Officer shall cause the agenda for the meeting to be posted with the call and notice of the meeting at the main entrance of the Joint Powers Authority executive offices, or, as determined by duly adopted resolution of the Governing Board, any other location that is freely

accessible to members of the public. No business not set forth in the posted agenda shall be considered by the Governing Board at such special meeting.

Section 4.7 Conduct Of Business. The items on the agenda shall be considered in order unless the Chairperson shall announce a change in the order of consideration. Unless an agenda item identifies a particular source for a report, the Chief Executive Officer, the Governing Board Members, the Joint Powers Authority staff and consultants shall report first on the item, after which the item shall then be open to public comment upon recognition of the speaker by the Chairperson. The proceedings of the Governing Board shall be guided by the provisions of law applicable thereto and, except as herein otherwise provided, by Robert's Rules of Order, newly revised. Provided, further, that the failure to follow the Robert's Rules of Order shall not invalidate any action taken.

Section 4.8 Official Acts. All official acts of the Joint Powers Authority shall be taken and adopted on motion, duly made, seconded and adopted by vote of the Governing Board Members.

Section 4.9 Voting. Except as otherwise provided by these Bylaws, when a quorum is present all official acts of the Governing Board shall require the affirmative vote of a majority of the Governing Board Members present and eligible to vote.

Section 4.10 Disqualification From Voting. A Governing Board Member shall be disqualified from voting on any resolution relating to a transaction in which he or she has a financial interest, as required by law or by the Conflicts of Interest Policy of the Joint Powers Authority, as described in Article IX. Except as required by law or by the Conflict of Interest Policy of the Joint Powers Authority, no Governing Board Member shall be disqualified from serving as a Governing Board Member or taking part in any proceedings of the Governing Board because of any financial interest of the Member.

Section 4.11 Minutes. The Secretary shall cause to have prepared the minutes of each meeting of the Governing Board. The minutes shall be an accurate summary of the Governing Board's consideration of each item on the agenda and an accurate record of each action of the Governing Board. At a subsequent meeting, the Secretary shall submit the minutes to the Governing Board for approval by a majority vote of Governing Board Members in attendance at the meeting covered by the minutes. When approved, the minutes shall be signed by the Secretary and kept with the proceedings of the Governing Board.

Section 4.12 Closed Sessions. The Governing Board shall meet in closed session only as permitted by applicable law, including, but not limited to, the Ralph M. Brown Act (Gov. Code 54950 *et seq.*). The Governing Board shall post an agenda and report the actions taken at a closed session to the public to the extent required by applicable law. A closed session minute book may be established and maintained for minutes of closed sessions, which shall reflect only the topics of discussion and decisions made at the session. The closed session minute book shall be kept confidential, shall not be a public record, and shall be available to the Governing Board Members, except as otherwise required by applicable law.

Section 4.13 Public Records. All documents and records of the Joint Powers Authority, not exempt from disclosure under applicable law, shall be public records under the California Public Records Act (Government Code 6250 *et seq.*). The Governing Board and the Chief Executive Officer shall take appropriate steps to maintain the confidentiality of all documents and records

of the Governing Board for which exemptions from disclosure are available under applicable statutes.

Section 4.14 Adjournment. The Governing Board may adjourn any meeting to a time and place specified in the resolution of adjournment, notwithstanding less than a quorum may be present and voting. If no member of the Governing Board is present at a regular or adjourned meeting, the Chief Executive Officer or his or her designee may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided in Section 4.3 of the Bylaws for special meetings, unless such notice is waived as provided for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

ARTICLE V COMMITTEES OF THE GOVERNING BOARD

Section 5.1 Committees. The Committees of the Santa Clara County Health Authority shall serve, *ex officio*, as the committees of the Joint Powers Authority, unless otherwise determined by the Governing Board by resolution. Notices, agendas and minutes shall be prepared in accordance with the Santa Clara County Health Authority Bylaws governing committee meetings.

The Governing Board may by resolution, from time to time, create and appoint the members of such additional committees and subcommittees of the Governing Board as it deems necessary to carry out its purposes. No committee or subcommittee may be composed of a number of Governing Board Members constituting a quorum of voting Members.

Section 5.2 Joint Powers Authority. All such other committees and subcommittees shall be advisory only, unless otherwise specified by the Governing Board.

ARTICLE VI EXECUTION OF DOCUMENTS

Section 6.1 Contracts and Instruments.

6.1.1 The Governing Board may authorize any officer or officers, agent or agents, employee or employees to enter into any contract or execute any instrument in the name of and on behalf of the Joint Powers Authority, and this Joint Powers Authority may be general or confined to specific instances; and, unless so authorized or ratified by the Governing Board, no officer, agent or employee shall have any power or Joint Powers Authority to bind the Joint Powers Authority by any contract or engagement or to render it liable for any purpose or for any amount.

6.1.2 The Secretary shall have the Joint Powers Authority to attest to the signatures of those individuals authorized to enter into contracts or execute instruments in the name of and on behalf of the Joint Powers Authority and to certify the incumbency of those signatories.

6.1.3 Each and every contract, indenture, mortgage, loan or credit document, lease, or other

instrument or obligation of the Joint Powers Authority shall contain a statement to the effect that the Joint Powers Authority is a separate legal entity from the County, that the County, and its officials, employees and agents, are not responsible for the obligations of the Joint Powers Authority, and that (except if the county is a direct party to the particular document or instrument) the parties to the particular document or instrument do not intend to, or have the power to, confer on any person or entity any rights or remedies against the County or any officials, employees or agents of the County.

Section 6.2 Checks, Drafts, Evidences of Indebtedness. All checks, drafts or other orders for payment of money, notes or other evidences issued in the name of or on behalf of the Joint Powers Authority or payable to the order of the Joint Powers Authority, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined for the County Health Authority.

ARTICLE VII CONFLICT OF INTEREST POLICY

Section 7.1 Adoption. The Governing Board shall by resolution adopt and from time to time may amend a Conflict of Interest Policy for the Joint Powers Authority as required by applicable law.

Section 7.2 Governing Board Member Statements. Each Governing Board Member shall file statements disclosing reportable investments, business positions, interests in real property and income in accordance with the Political Reform Act of 1974 (Government Code 81000 *et seq.*) and the regulations of the Fair Political Practices Joint Powers Authority.

Section 7.3 Prohibition on Governing Board Members With Financial Interest. A Governing Board Member shall not make, participate in making, or in any way attempt to influence a Governing Board decision in which the Governing Board Member knows, or has reason to know, that he or she has a financial interest as defined by California law or as set forth in the Joint Powers Authority's Conflict of Interest Policy.

ARTICLE VIII PROCEDURES, PRACTICES AND POLICIES RELATING TO IMPLEMENTATION OF THE TWO-PLAN MODEL

Section 8.1 Contract Negotiation and Renegotiation. The Joint Powers Authority shall, in negotiating and renegotiating contracts, give preference to providers (sometimes referred to herein as "preferred providers"): (1) based on (a) the number of Section 8.1.1 categories a provider is within, and (b) the number of and extent to which the factors set forth in each Section 8.1.1 category apply to the provider; (2) in the manner prescribed in Section 8.1.2; and (3) in accordance with the standards set forth in Section 8.2.

8.1.1 The following are the preference categories that shall be applicable for the Joint Powers Authority in negotiating and renegotiating contracts:

- (a) Disproportionate Share Hospitals. The Joint Powers Authority shall give

substantial preference to those hospitals that have regularly and repeatedly qualified for disproportionate share status under the Medi-Cal program. For purposes of the Section 8.1.1(a), "regularly and repeatedly" means that, at any particular time, the hospital has been recognized as a disproportionate share hospital under the Medi-Cal program for no less than three (3) of the most recent four (4) years. Among hospitals that have regular and repeatedly qualified for disproportionate share status, the Joint Powers Authority shall give greater preference to those hospitals that historically have had the highest levels of disproportionality, as measured on both a relative and absolute basis, over the most recent four (4) years.

(b) Safety Net Providers. The Joint Powers Authority shall give preference to FQHCs and any other providers that SDHS has defined as safety net providers in the general policies relating to the Two-Plan Model.

(c) Traditional Medi-Cal Providers. The Joint Powers Authority may give preference to community-based clinics and private providers with a history of serving a substantial proportion of Medi-Cal patients. For purposes of this Section 8.1.1(c), "substantial proportion" means that in each of two (2) of the most recent four (4) years, a community-based clinic or private provider has received at least \$25,000 in payments per year from serving Medi-Cal patients.

(d) Medically Indigent and Uninsured Care Providers. The Joint Powers Authority shall give substantial preference to providers that have regularly and repeatedly provided the highest levels of ratios of care to the medically indigent and uninsured.

8.1.2 The following prescribes the manner in which the Joint Powers Authority shall give preference to providers in negotiating and renegotiating contracts:

(a) Generally. Preference shall be given in a fashion to preserve the health care safety net in the County, including public health services and in accordance with the standards set forth in Section 8.2.

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(c) All Preferred Providers. Subject to provider capacity and patients' medical interests, the Joint Powers Authority may take one or more of the following measures, as necessary or appropriate to meet the requirements of the Section 8.1.2: (1) assign patients to preferred providers, especially to those providers entitled to substantial preference under Section 8.1.1(a) and 8.1.1(d); (2) give preferential pricing terms to preferred providers; (3) give rights of first refusal on negotiating and renegotiating contracts to preferred providers; and (4) furnish preferred providers with such special or additional administrative or clinical support services as may be necessary or appropriate to assist such providers in transitioning to a managed care environment.

(d) Impact of Preferences. As among preferred providers, it is expected that higher levels of funding may be given by the Joint Powers Authority to those entitled to substantial preference, as compared to other preferred providers. The Joint Powers Authority shall fulfill its obligations under this Section 8.2 notwithstanding any detriment or adverse impact to non-preferred providers that may be caused by the fulfillment of such obligations, and

notwithstanding that certain special or additional administrative clinical support services may be unavailable to non-preferred providers.

Section 8.3 Establishment and Maintenance of Provider Network. The Joint Powers Authority shall meet the standards set forth in this Section 8.3 in establishing and maintaining the provider network and in implementing the preferences described in Section 8.2.

8.3.1 The Joint Powers Authority shall foster and maintain the clinical relationships between medically indigent and uninsured patients and their health care providers.

8.3.2 The Joint Powers Authority shall, in establishing and maintaining the provider network, recognize and accommodate the cultural and linguistic diversity of medically indigent and uninsured patients.

8.3.3 The Joint Powers Authority shall, in establishing and maintaining the provider network, recognize, accommodate and support those special programs and activities of providers that have been regularly and repeatedly successful in addressing the medical and social needs of medically indigent and uninsured patients.

ARTICLE IX **MISCELLANEOUS, PROCEDURES, PRACTICES AND** **POLICIES, INSURANCE, BONDS**

Section 9.1 Purchasing, Hiring, Personnel, Etc. The Community Health Authority shall follow the same policies and procedures for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property and improvements, hiring employees, managing its personnel and for all other matters, as followed by the County Health Authority.

Section 9.2 Enforcement. Subject to the ultimate Joint Powers Authority of the Governing Board, the Chief Executive Officer shall be responsible to implement all policies adopted by the Governing Board.

Section 9.3 Insurance. The Chief Executive Officer shall procure, at the Governing Board's direction, such liability, property, casualty, workers' compensation, and such other insurance (including, without limitation, directors' and officers' liability, professional liability, and health plan re-insurance) in such amounts and with such carriers as the Governing Board shall from time to time determine is prudent in the conduct of its activities; provided, the Governing Board may in its discretion provide self-insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

Section 9.4 Bonds. The Joint Powers Authority shall require all of the Governing Board Members, as well as the Joint Powers Authority's officers, employees and agents, to be covered by fidelity bonds to the extent required by law, and otherwise to the extent the Governing Board determines prudent in the conduct of its activities. The cost of such bonds shall be paid for by the Joint Powers Authority.

Section 9.5 Defense and Indemnification. So long as such individual was acting within the

scope of his or her employment or official capacity, the Joint Powers Authority shall defend and hold harmless its current and former members, officers, employees, and other agents to the full extent set forth by the California Tort Claims Act (Gov. Code 810 *et seq.*).

Section 9.6 Immunities. The Joint Powers Authority, all Governing Board Members, and all officers, employees, and agents of the Joint Powers Authority shall, to the full extent set forth by law, be protected by the Immunities applicable to public entities and individuals as provided by the California Tort Claims Act (Gov. Code 810 *et seq.*)

Section 9.7 Reports to County Board of Supervisors. The Governing Board shall prepare and deliver to the County Board of Supervisors an annual written report describing the activities of the Joint Powers Authority during the preceding year, and outlining, in general terms, the anticipated nature of the Joint Powers Authority's activities for the forthcoming year. The report may be included as part of the annual report submitted by the Santa Clara County Health Authority to the Board of Supervisors.

ARTICLE X AMENDMENT OF BYLAWS

The Bylaws may be amended or repealed. Proposed changes to amend or repeal the Bylaws may be forwarded in writing by any Governing Board member to the Chairperson of the Bylaws Committee. The Bylaws Committee by a majority vote must approve proposed changes in advance of submitting proposed Bylaws changes to the Governing Board. If approved by the Bylaws committees, the proposed Bylaws changes shall be placed on the agenda and provided to the Governing Board members at least 3 (three) days prior to the Governing Board meeting at which the proposed Bylaw changes shall be considered. The Governing Board shall adopt the proposed changes by the voting approval of at least a majority of members of the Governing Board.

CERTIFICATE OF SECRETARY

I, the undersigned, do hereby certify:

That I am the duly elected and acting Secretary of the Governing Board of the Santa Clara Community Health Authority, an independent local public agency; and

That the foregoing Bylaws, comprising _ pages, including this page, constitute the Bylaws of the Santa Clara Community Health Authority, as duly adopted by the Governing Board of that Authority at a regular meeting, duly called on the __ day of __, 200_ at Campbell, California.

Secretary/Treasurer

**RESOLUTION OF THE SANTA CLARA COMMUNITY
HEALTH AUTHORITY**

**Delegating Authority to its Chief Executive Officer and Chief Financial Officer
to Enter into Management Services Agreements and Other Agreements
Necessary to the Operations of the Joint Powers Authority**

WHEREAS, the Santa Clara County Board of Supervisors approved creation of a Joint Powers Authority by Santa Clara County and Santa Clara County Health Authority; and,

WHEREAS, the purposes of the Joint Powers Authority are to meet the problems of delivery of publicly assisted medical care in the County, to demonstrate ways of promoting quality care and cost efficiency and for further such purposes as are contemplated by the Joint Powers Agreement; and,

WHEREAS, under the Joint Powers Agreement the Governing Body and officers of the Santa Clara County Health Authority shall serve, ex officio, as the Governing Body of the Joint Powers Authority; and,

WHEREAS, the Joint Powers Authority needs to have the power to negotiate and enter into contracts with the Managed Risk Medical Insurance Board and other commercial businesses to accept assignment of contracts from the Santa Clara County Health Authority for the Healthy Families and/or Healthy Kids programs;

NOW, THEREFORE, BE IT RESOLVED by the Santa Clara Community Health Authority that the Chief Executive Officer and Chief Financial Officer are hereby authorized through the Joint Powers Agreement to enter into management services agreements and other agreements as necessary to the operations of the Joint Powers Authority

Passed and Adopted by ____ vote(s) for, ____ vote(s) against, ____ vote(s) abstained, on November 17, 2005.

Supervisor James T. Beall, Chairman

RESOLUTION OF
THE SANTA CLARA COMMUNITY HEALTH AUTHORITY
ADOPTION OF A
CONFLICT OF INTEREST CODE

WHEREAS, the Political Reform Act, Government Code 87300-87313, requires each public agency in California to adopt a conflict of interest code; and

WHEREAS, past and future amendments to the Political Reform Act and implementing regulations may require conforming amendments to be made to the agency's conflict of interest code; and

WHEREAS, a regulation adopted by the Fair Political Practices Commission, 2 CCR 18730, provides that incorporation by reference of the terms of that regulation, along with an agency-specific appendix designating positions and disclosure categories shall constitute the adoption and amendment of a conflict of interest code in conformance with Government Code 87300 and 87306;

NOW, THEREFORE BE IT RESOLVED that the Santa Clara County Community Health Authority adopts the following Conflict of Interest Code including its list Designated Employees and Disclosure Categories, attached hereto and incorporated herein as Exhibit 1.

PASSED AND ADOPTED by the Santa Clara County Community Health Authority of the County of Santa Clara, State of California on _____, 2016 by the following vote:

AYES:

NOES:

ABSENT:

Signed:

Chair

Attest:

Secretary

Attachment to this Resolution:

Exhibit 1—Positions Required to File and
Disclosure Categories

SANTA CLARA COUNTY COMMUNITY HEALTH AUTHORITY CONFLICT OF INTEREST CODE

The Political Reform Act (Government Code §§ 81000, *et seq.*, hereinafter referred to as the Act) requires state and local government agencies to adopt and promulgate conflict of interest codes. The Fair Political Practices Commission (“FPPC”) has adopted a regulation (2 California Code of Regulations § 18730) which contains the terms of a standard conflict of interest code, which can be incorporated by reference in an agency’s code. After public notice and hearings it may be amended by the FPPC to conform to amendments in the Act. Therefore, the terms of § 18730 and any amendments to it adopted by the FPPC are hereby incorporated by reference. This regulation and the text here designating officials and employees and establishing disclosure categories shall constitute the conflict of interest code of the Santa Clara County Community Health Authority.

The full text of Section 18730, together with any amendments thereto, may be found at

<http://www.fppc.ca.gov/content/dam/fppc/NS>

Documents/LegalDiv/Regulations/Index/Chapter7/Article2/18730.pdf.

Individuals holding a designated position shall file Statements of Economic Interests with the agency’s filing official. If Statements are received in signed paper format, the agency’s filing official shall make and retain a copy and forward the original Statements to the filing officer, the County of Santa Clara Clerk of the Board of Supervisors. If Statements are electronically filed using the County of Santa Clara’s Form 700 e-filing system, both the agency’s filing official and the County of Santa Clara Clerk of the Board of Supervisors will receive notice and access to the e-filed Statements simultaneously. Statements of Economic Interests are public records available for public inspection and reproduction pursuant to Government Code section 81008.

DESIGNATED POSITIONS: The designated positions listed below are required to file Form 700 Statements of Economic Interests disclosing certain personal financial interests. These positions are required to file the applicable individual schedules to report investments, business positions, sources of income and interests in real property located in the agency’s jurisdiction. The applicable schedules to be filed for each position are based on the disclosure category assigned to the designated position.

Position	Disclosure Category Number
Health Authority Board Member	1
Chief Executive Officer	1
Chief Financial Officer	2
Chief Operating Officer	2
Chief Medical Officer	2
Chief Information Officer	2
Director of Provider Network Management	6
Director of Infrastructure and System Support	4
Director of Quality and Pharmacy	6
Medical Director	6
Consultant	7
Newly Created Position	*

*** Newly Created Positions**

A newly created position that makes or participates in the making of governmental decisions that may foreseeably have a material effect on any financial interest of the position-holder, and which specific position title is not yet listed in the agency’s conflict of interest code is included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code, subject to the following limitation: the Santa Clara County Community Health Authority may determine in writing that a particular newly created position, although a “designated position,” is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the broadest disclosure requirements, but instead must comply with more tailored disclosure requirements specific to that newly created position. Such written determination shall include a description of the newly created position's duties and, based upon that description, a statement of the extent of disclosure requirements. The Santa Clara County Community Health Authority’s determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code. (Gov. Code Section 81008.)

As soon as the agency has a newly created position that must file statements of economic interests, the agency’s filing official shall contact the County of Santa Clara Clerk of the Board of Supervisors Form 700 division to notify it of the new position title to be added in the County’s electronic Form 700 record management system, known as eDisclosure. Upon this notification, the Clerk’s office shall enter the actual position title of the newly created position into eDisclosure and the agency’s filing official shall ensure that the name of any individual(s) holding the newly created position is entered under that position title in eDisclosure.

Additionally, within 90 days of the creation of a newly created position that must file statements of economic interests, the agency shall update this conflict-of-interest code to add the actual position title in its list of designated positions, and submit the amended conflict of interest code to the County of Santa Clara Office of the County Counsel for code-reviewing body approval by the County Board of Supervisors. (Gov. Code Sec. 87306.)

DISCLOSURE CATEGORIES:

Category 1. Persons in this category shall disclose (1) all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority; and (2) all investments, business positions and income, including gifts, loans and travel payments, from all sources.

Category 2. Persons in this category shall disclose all investments, business positions and income, including gifts, loans and travel payments, from all sources.

Category 3. Persons in this category shall disclose all interests in real property in Santa Clara County located entirely or partly within the boundaries of the County, or within two miles of the County's boundaries, or of any land owned or used by the Authority.

Category 4. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority.

Category 5. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from all sources that either contract to provide education or training required by the Authority to qualify for or maintain a license, or that provide education or training services which courses or curricula are approved by the Authority.

Category 6. Persons in this category shall disclose all investments, business positions, and income (including gifts, loans, and travel payments) from (1) all sources that provide leased facilities, goods, equipment, vehicles, machinery or services, including training or consulting services, of the type utilized by the Authority, and (2) all sources that are of the type to receive grants or other monies from or through the Authority, including, but not limited to, nonprofit organizations.

Category 7. Each Consultant, as defined for purposes of the Political Reform Act, shall disclose pursuant to the broadest disclosure category in the conflict of interest code subject to the following limitation: The Chief Executive Officer may determine in writing that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements of the broadest disclosure category, but instead must comply with more tailored disclosure requirements specific to that consultant. Such a determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. All such determinations are public records and shall be retained for public inspection along with this conflict of interest code.