Santa Clara
Family Health Plan
The Spirit of Care

www.scfhp.com

CEO UPDATE

November 19, 2015

Board Member Resignation

Ms. Laura Jones, Board member since June 2012, has resigned and will be stepping down after today's meeting. We thank Laura for her service to SCFHP and wish her all the best.

Board Member Request

Dr. Wally Wenner has respectfully requested amendment of the Bylaws to require two physicians on the SCCHA Board. He further recommends that the Board should have official input into the Board of Supervisors' appointment of individuals to our Board. This request will be further considered at a future meeting.

Resignation of Chief Medicare Officer

Tony Solem resigned effective October 23, 2015 to pursue a CEO position in Ohio. Chris Turner has been engaged to serve as our Interim Chief Medicare Officer.

Medical Director Hired

Lily Boris, M.D., will be returning to SCFHP to provide Medical Director services four days per week. Our current part-time Medical Director, Dr. Jimmy Lin, has resigned effective Friday, but will continue to serve SCFHP on our Credentialing and QI Committees.

DHCS Outstanding Performance Award 2015, Medium Scale Plan

In October, SCFHP received the 2015 Outstanding Performance Award for a Medium Scale Plan from DHCS. This award reflects the plan's favorable performance on HEDIS measures.

Consulting Firm Retained

The consulting firm WeiserMazars has been retained to assist SCFHP with four key activities related to critical Plan Objectives. They will be assisting with Medi-Cal and CMS audit readiness, NCQA accreditation readiness, and restructuring our policies and procedures to meet compliance and accreditation needs.

Daughters of Charity

SCFHP reached an agreement with O'Connor Hospital to resume providing full hospital services to our Medi-Cal members effective October 15th, and to include the CMC line of business in the agreement. The contract language is currently under review.

Health Homes

SCFHP responded to the DHCS Health Homes RFI in October. It indicated we would be interested in participating in the Health Homes Program, with an implementation date no sooner than January 2017. The RFI is non-binding.

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Government Affairs

- **MCO Tax**

  The last MCO tax deal on the table would have continued to tax Medi-Cal plans much like what is done today (where plans are mostly held harmless). But it would have hit commercial plans, such as Kaiser Permanente, with a net loss in the tens of millions that would only partially be ameliorated by other tax offsets. There is still some hope for a deal early next year, but painful budget cuts should be anticipated in the budget proposal to be released in January.

- **CCI Sustainability**

  The primary determinant of the future of the CCI program, including the CMC demonstration, is availability of an MCO tax. Without the funds provided by such a tax, the State is not prepared to support continuance of CCI.

Routine Board Updates

- Dashboard – under development
- Orientation – under development
- Annual Compliance Training – to be released soon

From: Jones, Laura [mailto:Laura.Jones@PHD.SCCGOV.ORG]
Sent: Thursday, November 12, 2015 4:51 PM
To: Christine M. Tomcala; Bob Brownstein
Cc: Rita Zambrano
Subject: Resignation from the Health Authority

Hi Christine and Bob,

Please see my letter of resignation from the Health Authority as shared with Supervisor Yeager and the Clerk of the Board today. My last meeting will be 11/19. As I said below, this was a difficult decision but I have so appreciated the opportunity to serve my community in this capacity for the last three years.

Sincerely,

Laura Jones

Dear Supervisor Yeager,

I have enjoyed serving on the Santa Clara County Health Authority as your appointee for the past three years. I am proud to say that, during that time, the Santa Clara Family Health Plan (SCFHP) has achieved several important milestones, including:

- The SCFHP welcomed adults enrolled in Valley Care to Medi-Cal as part of Medi-Cal Expansion; and
- Long-term services and supports were incorporated into its Medi-Cal managed care plan as part of California's Coordinated Care Initiative; and
- Cal MediConnect was launched as a part of California's Coordinated Care Initiative to better serve people in Santa Clara County who are eligible for both Medicare and Medi-Cal; and
- Total membership surpassed over 250,000 members; and
- The SCFHP received the California Department of Health Care Services 2015 Outstanding Performance Award for achievements in the improvement of health care quality and population health.

I have decided to step down from the Health Authority so I can focus on other leadership opportunities. This has been a difficult decision primarily because this continues to be a period of evolution for the SCFHP. With that said, I am confident that the SCFHP team, under the leadership of Christine Tomcala, will successfully continue on its journey to improve the health, well-being, and quality of care that is provided to its members.

It has been a privilege to work alongside and learn from my fellow board members and I wish them all the best in their continued service.

My final meeting with the Health Authority Board will be November 19, 2015.

Thank you again for this opportunity.

Sincerely,

Laura Jones

Compliance Department Activity
September/October/November 2015

Reporting

- Regulatory Filings/Reports/Other:
  - Routine DMHC Plan Filings
    - DMHC 4Q 2015 Upcoming Terminations Request
    - BHT Provider Network
    - Quarterly Network Assessment Q1 2015
  - Routine DHCS Reports – All filed timely
    - Medi-Cal Reports (includes monthly, quarterly, semi-annual and annual filings)
      - DHCS BHT Services Monthly Survey
      - Call Center Report Q3 2015
      - CBAS Report Q3 2015
      - Geo Access
      - Hep C Report
      - SPD Report Q3 2015
      - Subcontractor Report Q3 2015
      - DHCS Mental Health 2Q 2015 Report Resubmission
      - DHCS Medical Exemption Request Denial and COC 2Q 2015 Report Resubmission
      - DHCS 4Q 2015 Upcoming Terminations Request
      - DHCS MLTSS 1Q 2015 HRA and Risk Report Resubmission
    - Cal MediConnect Reports (includes monthly and quarterly filings)
      - DHCS Quarterly CMC Complaint and Resolution Report
      - DHCS Quarterly CMC Risk Assessment and Stratification Report
      - MMP Core 2.1- Members with an assessment completed within 90 days of enrollment
      - MMP Core 2.2- Members with a completed assessment
      - MMP Core 4.2- Grievances and Appeals (Non Part D)
      - MMP Core 5.1- Care Coordinator and member ratio
      - MMP Core 9.1- Emergency room behavioral health services utilization
      - CA 1.1 (Ongoing and backlogged data)- High risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the *timely* Health Risk Assessment (HRA)
      - CA 1.3 (Ongoing and backlogged data)- Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the *timely* Health Risk Assessment (HRA)
      - CA 1.5 (Ongoing and backlogged data)-Members with an ICP completed
      - CA 2.1- The number of critical incident and abuse reports for members receiving LTSS
      - CCIP/QIP reports were submitted

- Ad Hoc Regulatory Requests
  - DHCS Inquiry: BHT Provider Network Submission
  - DHCS Inquiry: MCP Care Coordination Advisory Group Survey
  - DHCS Inquiry: CCI Quarterly Contract Adequacy 2Q 2015 Report
  - DHCS Correction Action Plan for 2014 SPD (Joint) Audit
  - DHCS ACA 1202 Compliance Plan Clarification
  - DHCS APL 15-012 Dental Anesthesia Policy
  - DHCS Resubmission of Q4 2014 Grievance Report
  - DHCS Out Patient Safety Net Auto Assignment Step 3 Submission
  - DHCS Contract Policy and Procedure Request (Federal Disclosure of Ownership, Linguistic Services, MLTSS-PCP Selection, Nondiscrimination in Access to Services, Provider Directory, Suspended Provider)
  - DHCS Power Wheelchair Report
  - DHCS Provider Contract/Claims Inquiry

Regulatory Communications

- General
  - DHCS Contract Extension to December 31, 2016
- Medi-Cal
  - DHCS Approved SCFHP's Formulary
  - DHCS accepted SCFHP's Joint Audit SPD Corrective Action Plan
  - DHCS Approval of BHT Policies (Facility Site Review, Continuity of Care, Out-of-Network and Standards of Care)
  - Member Complaints via Regulator
    - DMHC
      - Two member complaints: Re long wait-time for Valley Physical Therapy. SCFHP contacted VHP who authorized members to go out of network and obtained a timely appointment. Access to be discussed at VHP JOC.
      - Member complaint: Re long wait-time for Valley Neurology Department. SCFHP contacted VHP who authorized members to go out of network and obtained a timely appointment. Access to be discussed at VHP JOC.
      - Member complaint: Audiology Services denial and needs hearing aids. In 2009, Audiology Services were part of benefit cut to members 21 years and older. Audiology Services e.g. hearing tests are not a covered benefit for members 21 years and older. However, hearing aids are a covered Medi-Cal benefit.
      - Member complaint: Kaiser denied medication and wants specialist who can treat her condition. Forwarded case to Kaiser. Kaiser reviewed and had referred member to Cardiologist and had renewed medication.
      - Member complaint: Denial of Erectile Dysfunction medication. As of January 2006, DHCS carved out of the Medi-Cal program, including FFS, all drugs used to treat sexual or erectile dysfunction, unless used to treat a condition other than sexual or erectile dysfunction, as approved by the Food and Drug Administration.
      - Member Requested IMR: SCFHP denial of Novo TTF helmet, a stimulation device for treatment of the member's GBM (Glioblastoma multiforme). SCFHP denied the device as investigational and experimental based on the literature review and consensus opinion of the National Comprehensive Cancer Network. Currently under IMR review.

- Member complaint: Liver cancer patient who said delay in seeing provider and needing treatment for liver cancer. VHP contacted and member was authorized to see new oncologist. Case was referred to Quality for PQI review.
- Member complaint: denial of Brand name drug. Member's provider submitted lab data and denial overturned.
- Provider Complaint: Podiatrist appealing PMG denial of procedure for not having prior authorization. SCFHP Chief Medical Officer overturned denial because services medically necessary at time of new member visit.

▪ DHCS

- Member Assistance Request: Member was an emergency enrollment but could not get services because did not show in SCFHP's eligibility system. Member Services called the member and explained that although the member was not showing in the SCFHP system, she did show as being in SCFHP in the State's system and she could call and make an appointment. Member refused until she showed in SCFHP eligibility. This occurred the next day and member made an appointment.

- Medicare

  - We received a notice of non-compliance (NONC) pertaining to our CMC reporting:
    - The NONC was because SCFHP did not comply with specifications, templates and timeframes for MMP Core 2.1 - Members with an assessment completed within 90 days of enrollment
      - We adjusted our data in accordance with the appropriate HPMS memo and resubmitted the report. This issue has been corrected.

Internal Monitoring/Auditing

- General

  - ICD-10
    - No issues identified since implementation.

  - HIPAA
    - No privacy disclosures were reported to Compliance in September 2015.
    - 171 member appointment of representative requests were processed in September 2015.

- Medi-Cal
  - Monitor DHCS Facility Decertification notices to assure not an SCFHP contracted provider. One provider identified as being included in a blanket LOA. No members in care.

- Medicare
  - We have been monitoring CareCall on a bi-weekly basis and are not routing calls to them during business hours. Their service levels have improved as a result.
  - FWA policy was submitted for review to the P&P committee.

Oversight

- Medi-Cal

  - In 2015, delegation audits have been conducted on all but one group. The remaining audit is due in December 2015. To date, 3 corrective actions plans have been issued.
    - The 2016 delegation audit schedule has been issued to delegates.

- Medicare
    - We had RTI International, a CMS contracted vendor, visit us on 10/29 in an effort to evaluate the Cal MediConnect demonstration. Their main focus was on subgroups such as MLTSS and behavioral health and how implementing the demonstration has affected each subgroup.
    - We are still conducting oversight for CMC vendors. We are evaluating their Policies and Procedures pertaining to Medicare, evaluating their performance, and making sure that their employees who are dealing with SCFHP business are trained in a manner that fulfills CMS requirements.
    - Medicare Compliance is also working closely with Business Owners and IT in order to ensure that pertinent data is being captured in order to effectively monitor each department's performance and to ensure that data elements for CMC annual reports are being captured in a manner that is consistent with the applicable regulations.
    - We have developed an audit checklist and performed a gap analysis for Medicare. Gaps have been identified and business owners are diligently working to correct gaps.
    - We are monitoring Organization Determinations in order to ensure compliance with CMS standards.

Education/Training

- General
    - Annual HIPAA Training for all staff was conducted as part of National Compliance Week November 2-6.
    - Clearwater Compliance HIPAA Boot camp

- Medi-Cal
    - Participation on Conference Calls Re:
        - DHCS Monthly Contract Manager
        - DHCS CCI and Managed Care Calls
        - DMHC Timely Access Webinar

- Medicare
    - Organization Determination Training was provided to Member Service Reps and Nurses and Care Coordinators. This training was in regards to Members requesting an Organization Determination.

Response and Prevention

- General
    - Timely Access to Impacted Services at Valley
      Requesting feedback from VHP regarding referrals being authorized to Valley's impacted services.
    - Fax Intake
      Evaluating process of faxes coming into SCFHP and timeframes in which they are processed if authorizations, appeals, etc.
    - PCP Changes
      Evaluating the reasons for PCP changes and whether or not grievances/quality of care issues are being identified at the time of the change

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SCFHP Quality Improvement Projects 2016

Board of Directors

11/19/2015

Mandated Improvement Projects

- Projects are required by Medi-Cal and Cal-MediConnect
- Medi-Cal
  - Performance Improvement Project (PIP) – Statewide Collaborative
  - Performance Improvement Project (PIP) – Internal
- Cal-MediConnect
  - Chronic Care Improvement Project (CCIP)
  - Quality Improvement Project (QIP)

Medi-Cal PIP

- Statewide Collaborative
  - Must be one of the four selected topics that support Medical Managed Care Program Quality Strategy
    - Diabetes
    - Hypertension
    - Postpartum Visits
    - Immunization of two year olds
- 18 month project
- Multi stage five module process

Medi-Cal PIP

- Topic
  - Diabetes
    - Retinal Eye Exam
    - Low performing HEDIS measure
  - Progress
    - PIP initiation
    - SMART Aim Data Collection
    - Intervention Determination

CMC Improvement Projects

- Chronic Care Improvement Project (CCIP)
  - Topic: Hypertension Management
  - Rationale:
    - Meets CCIP criteria
    - Quality With Hold measure
  - Intervention
    - Provider education
    - Member education
    - Reminder letters from the PBM

CMC Improvement Projects

- Quality Improvement Project
  - Topic: Plan all-Cause Readmission
  - Rationale
    - Mandated by CMS
    - Quality With Hold Measure
  - Interventions
    - Gap reports for Primary Care Providers
    - Hospital Level Readmission Rates to share
    - Post discharge follow up calls

Adherence To Treatment

- Adherence to Hypertension treatment a gateway to treatment of chronic conditions
- Single most important contributor to heart disease and stroke
- Synergistic with Diabetes
- Easy to measure accurately in real time– pharmacy data

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Financial Statements
For Three Months Ended September 2015
(Unaudited)

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Santa Clara Family Health Plan
CFO Finance Report
For the Month and Year to Date Ended September 30, 2015

Summary of Financial Results

For the month of September 2015, SCFHP recorded a net loss of $1.1 million compared to a budgeted net surplus of $1.8 million resulting in an unfavorable variance from budget of $3.0 million. For year to date September 2015, SCFHP recorded a net surplus of $3.3 million compared to a budgeted net surplus of $6.1 million resulting in a unfavorable variance from budget of $2.7 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 – September 2015
Favorable/ (Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$ 88,043,999	$ 77,925,912	$ 10,118,087	13.0%	Revenue	$ 254,270,343	$ 230,455,125	$ 23,815,219	10.3%
86,220,223	72,612,399	(13,607,825)	-18.7%	Medical Expense	242,403,202	214,329,288	(28,073,914)	-13.1%
1,823,776	5,313,514	(3,489,738)	-65.7%	Gross Margin	11,867,141	16,125,837	(4,258,696)	-26.4%
2,911,295	2,947,786	36,491	1.2%	Administrative Expense	8,430,403	8,607,055	176,653	2.1%
(1,087,519)	2,365,728	(3,453,247)	-146.0%	Net Operating Income	3,436,739	7,518,782	(4,082,043)	-54.3%
(24,459)	(478,570)	454,111	94.9%	Non-Operating Income/Exp	(117,218)	(1,435,710)	1,318,493	91.8%
$ (1,111,978)	$ 1,887,158	$ (2,999,136)	-158.9%	Net Surplus/ (Loss)	$ 3,319,521	$ 6,083,071	$ (2,763,550)	-45.4%

Revenue

The Health Plan recorded net revenue of $88.0 million for the month of September 2015, compared to budgeted revenue of $77.9 million, resulting in a favorable variance from budget of $10.1 million, or 13.0%. For year to date September 2015, the Plan recorded net revenue of $254.3 million, compared to budgeted revenue of $230.5 million, resulting in a favorable variance from budget of $23.8 million, or 10.3%, which was primarily driven by the additional In Home Support Services (IHSS) pass-through revenue that also increases the medical expenses commensurately. Higher than budgeted membership also contributed to positive variance in Medi-Cal expansion and Hep C revenues.

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

Member months

For the month of September 2015, overall member months were higher than budget by 7,337 (+2.9%). For year to date September 2015, overall member months were higher than budget by 12,678 (+1.7%).

In the three months since the end of the prior fiscal year, 6/30/2015, membership in Medi-Cal increased by 4.9%, membership in the Healthy Kids program increased by 3.7%, and membership in the Agnews program decreased by 1.8%.

In January 2015, we started enrolling members for the Medicare Line of Business (CMC). For the month of September 2015, membership in the Medicare program was lower than the budget by 652 member months (-7.6%). For year to date September 2015, membership in the Medicare program was lower than the budget by 1,267 member months (-5.%). In the three months since the end of the prior fiscal year, 6/30/2015, membership in Medicare program increased by 10.1%.

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

Medical Expenses

For the month of September 2015, medical expense was $86.2 million compared to budget of $72.6 million, resulting in an unfavorable budget variance of $13.6 million, or -18.7%. For year to date September 2015, medical expense was $242.4 million compared to budget of $214.3 million, resulting in an unfavorable budget variance of $28.1 million, or -13.1%. The increased medical expenses for the month, and year to date, compared to budget is primarily attributable to long-term care institutional expense and IHSS pass-through expense.

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Administrative Expenses

Overall administrative costs were under budget by $36 thousand (+1.2%) for the month of September 2015, and under budget by $177 thousand (+2.1%) for year to date September 2015. Salaries/Benefits are under budget; however, higher than budget Professional Fees/Consulting/Temporary Staffing costs offset some of this favorable variance.

Overall administrative expenses were 3.3% of revenues for year to date September 2015.

Balance Sheet (Page 6)

Current assets at September 30, 2015 totaled $325.5 million compared to current liabilities of $243.8 million, yielding a current ratio (the ratio of current assets to current liabilities) of 1.3 as of September 30, 2015. Working capital increased by $3.3 million for the three months year to date ended September 30, 2015.

Cash as of September 30, 2015, increased by $22.9 million compared to the cash balance as of year-end June 30, 2015. Net receivables increased by $12.3 million during the same three months period ended September 30, 2015. The cash position increased largely due to the continued overpayment of Medi-Cal expansion premium revenues by the DHCS.

Liabilities increased by a net amount of $32.2 million during the three months ended September 2015. This was primarily due to the continued overpayment of Medi-Cal expansion premium revenues by the State and the increase in medical cost reserves as a result of the rapid growth of long term care claims. The plan also recorded a Premium Deficiency Reserve ($18.0 million) for the Cal MediConnect contract period ending December 31, 2017. Additionally, the Health Plan recorded the unfunded Pension Liability of $5.2 million as required by GASB 68, as of June 30, 2015.

Capital Expenses increased by $297 thousand for the three months ended September 30, 2015.

Tangible Net Equity

Tangible Net Equity (TNE) was $75.9 million at September 30, 2015 compared to the minimum TNE required by the Department of Managed Health Care (DMHC) of $23.9 million. A chart showing TNE trends is shown on page 14 of this report.

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

As of September 30, 2015, the Plan's reserves are below this reserves target by about $55.6 million (see calculation below).

Calculation of targeted reserves as of August 31, 2015

Estimate of two months' capitation (based on September 2015) (September-2015 Medi-Cal capitation of $65,770,738 x 2 = $131,541,476)	$131,541,476
Less: Unrestricted Net Equity per balance sheet (rounded)	$ 75,950,475
Approximate reserves below target	$ 55,591,001

Santa Clara County Health Authority
Balance Sheet

	9/30/2015	8/31/2015	7/31/2015	6/30/2015
Assets				
Current Assets				
Cash and Marketable Securities	$ 133,454,211	$ 150,661,832	$ 120,860,288	$ 110,520,927
Premiums Receivable	189,805,625	182,278,826	185,555,010	177,531,031
Due from Santa Clara Family Health Foundation - net	0	0	0	3,612
Prepaid Expenses and Other Current Assets	2,271,185	2,292,669	2,281,825	1,917,101
Total Current Assets	325,531,022	335,233,327	308,697,123	289,972,670
Long Term Assets				
Equipment	12,175,786	12,085,696	11,886,313	11,879,173
Less: Accumulated Depreciation	(7,681,463)	(7,572,258)	(7,465,560)	(7,363,871)
Total Long Term Assets	4,494,323	4,513,438	4,420,753	4,515,302
Total Assets	$ 330,025,345	$ 339,746,764	$ 313,117,877	$ 294,487,972
Deferred Outflow of Resources	$ 1,367,331	$ 1,367,331	1,367,331	1,367,331
Total Deferred Outflows and Assets	331,392,676	341,114,095	314,485,208	295,855,303
Liabilities and Net Position				
Current Liabilities				
Trade Payables	$ 8,553,349	$ 30,532,575	$ 3,555,398	$ 4,924,038
Deferred Rent	160,953	163,013	165,074	167,134
Employee Benefits	868,782	861,161	898,711	973,066
Retirement Obligation per GASB 45	151,777	115,892	57,946	0
Advance Premium - Healthy Kids	61,781	64,208	61,110	64,127
Deferred Revenue - Medicare	0	0	8,224,778	0
Liability for ACA 1202	5,075,257	5,069,591	5,069,271	5,069,225
Payable to Hospitals (SB208)	(35,535)	(35,535)	(35,535)	(35,535)
Payable to Hospitals (AB 85)	1,580,865	1,540,785	2,891,566	4,615,251
Due to Santa Clara County Valley Health Plan	2,824,551	2,389,080	4,600,010	11,230,305
MCO Tax Payable - State Board of Equalization	8,773,976	10,681,043	9,285,348	8,909,559
Due to DHCS	56,389,864	44,318,631	33,491,268	22,173,221
Liability for In Home Support Services (IHSS)	69,537,810	69,537,810	69,537,810	69,537,810
Premium Deficiency Reserve (PDR)	13,088,054	13,088,054	13,088,054	13,088,054
Medical Cost Reserves	76,722,166	74,036,781	76,466,251	70,819,543
Total Current Liabilities	243,753,650	252,363,091	227,357,062	211,535,798
Non-Current Liabilities				
Noncurrent Pension Deficiency Reserve	4,911,946	4,911,946	4,911,946	4,911,946
Net Pension Liability GASB 68	4,883,971	4,883,971	4,883,971	4,883,971
Total Liabilities	253,549,567	262,159,008	237,152,979	221,331,715
Deferred Inflow of Resources	1,892,634	1,892,634	1,892,634	1,892,634
Net Position / Reserves				
Invested in Capital Assets	4,494,323	4,513,438	4,420,753	4,515,302
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	67,831,281	67,812,166	67,904,850	30,416,972
Current YTD Income (Loss)	3,319,521	4,431,499	2,808,641	37,393,330
Net Position / Reserves	75,950,475	77,062,453	75,439,595	72,630,954
Total Liabilities, Deferred Inflows, and Net Assets	$ 331,392,676	$ 341,114,095	$ 314,485,208	$ 295,855,303
Solvency Ratios:				
Working Capital	$ 81,777,372	$ 82,870,236	$ 81,340,062	$ 78,436,872
Working Capital Ratio	1.3	1.3	1.4	1.4
Average Days Cash on Hand	49	58	47	55

Santa Clara County Health Authority
Income Statement for the Three Months Ending Sep 30, 2015

	For the Month of Sep 2015					For Three Months Ending Sep 30, 2015				
	Actual	% of Revenue	Budget	% of Revenue	Variance	Actual	% of Revenue	Budget	% of Revenue	Variance
REVENUES										
MEDI-CAL	$ 79,156,044	89.9%	$ 68,208,400	87.5%	$ 10,947,643	$ 228,278,820	89.8%	$ 202,942,704	88.1%	$ 25,336,116
HEALTHY KIDS	$ 378,512	0.4%	$ 381,261	0.5%	$ (2,749)	$ 1,165,665	0.5%	$ 1,156,444	0.5%	$ 9,221
MEDICARE	$ 8,509,443	9.7%	$ 9,250,571	11.9%	$ (741,128)	$ 24,825,858	9.8%	$ 26,098,936	11.3%	$ (1,273,078)
AGNEWS	$ -	0.0%	$ 85,680	0.1%	$ (85,680)	$ -	0.0%	$ 257,040	0.1%	$ (257,040)
TOTAL REVENUE	$ 88,043,999	100.0%	$ 77,925,912	100.0%	$ 10,118,087	$ 254,270,343	100.0%	$ 230,455,125	100.0%	$ 23,815,219
MEDICAL EXPENSES										
MEDI-CAL	$ 77,206,426	87.7%	$ 62,412,622	80.1%	$ (14,793,803)	$ 214,426,044	84.3%	$ 185,170,906	80.4%	$ (29,255,138)
HEALTHY KIDS	$ 231,207	0.3%	$ 348,241	0.4%	$ 117,034	$ 781,237	0.3%	$ 1,056,288	0.5%	$ 275,051
MEDICARE	$ 8,755,314	9.9%	$ 9,778,821	12.5%	$ 1,023,507	$ 27,056,322	10.6%	$ 27,883,952	12.1%	$ 827,630
AGNEWS	$ 27,277	0.0%	$ 72,714	0.1%	$ 45,437	$ 139,599	0.1%	$ 218,142	0.1%	$ 78,543
TOTAL MEDICAL EXPENSES	$ 86,220,223	97.9%	$ 72,612,399	93.2%	$ (13,607,825)	$ 242,403,202	95.3%	$ 214,329,288	93.0%	$ (28,073,914)
MEDICAL OPERATING MARGIN	$ 1,823,776	2.1%	$ 5,313,514	6.8%	$ (3,489,738)	$ 11,867,141	4.7%	$ 16,125,837	7.0%	$ (4,258,696)
ADMINISTRATIVE EXPENSES										
SALARIES AND BENEFITS	$ 1,478,605	1.7%	$ 1,664,624	2.1%	$ 186,019	$ 4,383,578	1.7%	$ 4,936,081	2.1%	$ 552,503
RENTS AND UTILITIES	$ 123,395	0.1%	$ 139,203	0.2%	$ 15,807	$ 341,921	0.1%	$ 367,608	0.2%	$ 25,687
PRINTING AND ADVERTISING	$ 23,603	0.0%	$ 30,317	0.0%	$ 6,713	$ 110,634	0.0%	$ 141,950	0.1%	$ 31,316
INFORMATION SYSTEMS	$ 119,960	0.1%	$ 124,602	0.2%	$ 4,642	$ 417,740	0.2%	$ 373,805	0.2%	$ (43,935)
PROF FEES / CONSULTING / TEMP STAFFING	$ 878,574	1.0%	$ 695,349	0.9%	$ (183,225)	$ 2,377,374	0.9%	$ 1,911,668	0.8%	$ (465,706)
DEPRECIATION / INSURANCE / EQUIPMENT	$ 129,460	0.1%	$ 173,105	0.2%	$ 43,645	$ 389,748	0.2%	$ 438,384	0.2%	$ 48,636
OFFICE SUPPLIES / POSTAGE / TELEPHONE	$ 94,559	0.1%	$ 55,346	0.1%	$ (39,213)	$ 214,350	0.1%	$ 166,537	0.1%	$ (47,812)
MEETINGS / TRAVEL / DUES	$ 62,360	0.1%	$ 57,599	0.1%	$ (4,761)	$ 188,783	0.1%	$ 248,096	0.1%	$ 59,313
OTHER	$ 778	0.0%	$ 7,642	0.0%	$ 6,864	$ 6,275	0.0%	$ 22,926	0.0%	$ 16,651
TOTAL ADMINISTRATIVE EXPENSES	$ 2,911,295	3.3%	$ 2,947,786	3.8%	$ 36,491	$ 8,430,403	3.3%	$ 8,607,055	3.7%	$ 176,653
OPERATING SURPLUS (LOSS)	$ (1,087,519)	-1.2%	$ 2,365,728	3.0%	$ (3,453,247)	$ 3,436,739	1.4%	$ 7,518,782	3.3%	$ (4,082,043)
GASB 45-POST EMPLOYMENT BENEFITS EXPENSE	$ (35,885)	0.0%	$ (57,946)	-0.1%	$ 22,061	$ (151,777)	-0.1%	$ (173,838)	-0.1%	$ 22,061
GASB 68 - UNFUNDED PENSION LIABILITY	$ -		$ (437,479)		$ 437,479	$ -		$ (1,312,438)		$ 1,312,438
INTEREST & OTHER INCOME	$ 11,425	0.0%	$ 16,855	0.0%	$ (5,430)	$ 34,559	0.0%	$ 50,565	0.0%	$ (16,006)
NET SURPLUS (LOSS) FINAL	$ (1,111,978)	-1%	$ 1,887,158	2.4%	$ (2,999,136)	$ 3,319,521	1.3%	$ 6,083,071	2.6%	$ (2,763,550)

Administrative Expense
Actual vs. Budget
For the Current Month & Fiscal Year to Date - Sep 2015

Favorable/(Unfavorable)

Current Month					Year to Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$ 1,478,605	$ 1,664,624	$ 186,019	11.2%	Personnel	$ 4,383,578	$ 4,936,081	$ 552,503	11.2%
1,432,690	1,283,162	(149,528)	-11.7%	Non-Personnel	4,046,825	3,670,975	$ (375,850)	-10.2%
2,911,295	2,947,786	36,491	1.2%	Total Administrative Expense	8,430,403	8,607,055	176,653	2.1%

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

Three Months Ended Sep 30, 2015

	Medi-Cal (incl. Agnews)	CMC	Healthy Kids	**Grand Total**
P&L (ALLOCATED BASIS)				
REVENUE	222,540,861	30,563,817	$1,165,665	**$254,270,343**
MEDICAL EXPENSES	208,713,493	32,908,472	781,237	**$242,403,202**
(MLR)	93.8%	107.7%	67.0%	**95.3%**
GROSS MARGIN	13,827,368	(2,344,655)	384,429	**11,867,141**
ADMINISTRATIVE EXPENSES	7,282,068	1,013,352	134,983	**8,430,403**
(% MM allocation except CMC)				
OPERATING INCOME/(LOSS)	6,545,299	(3,358,007)	249,446	**3,436,739**
OTHER INCOME/(EXPENSE)	(102,590)	(14,090)	(537)	**(117,218)**
(% of Revenue Allocation)				
NET INCOME/ (LOSS)	$6,442,709	($3,372,097)	$248,909	**$3,319,521**
PMPM (ALLOCATED BASIS)				
REVENUE	$306.27	$1,320.08	$86.54	**$333.14**
MEDICAL EXPENSES	287.24	1,421.35	58.00	**317.59**
GROSS MARGIN	19.03	(101.27)	28.54	**15.55**
ADMINISTRATIVE EXPENSES	10.02	43.77	10.02	**11.05**
OPERATING INCOME/(LOSS)	9.01	(145.04)	18.52	**4.50**
OTHER INCOME / (EXPENSE)	(0.14)	(0.61)	(0.04)	**(0.15)**
NET INCOME / (LOSS)	$8.87	($145.64)	$18.48	**$4.35**
ALLOCATION BASIS:				
MEMBER MONTHS - YTD	*726,628*	*23,153*	*13,469*	***763,250***
Member MONTHS by LOB	*95.2%*	*3.0%*	*1.8%*	***100%***
Revenue by LOB	*87.5%*	*12.0%*	*0.5%*	***100%***

Santa Clara Family Health Plan
Statement of Cash Flows
For Three Months Ended Sep 30, 2015

Cash flows from operating activities		
Premiums received	$	276,080,421
Medical expenses paid	$	(244,906,334)
Administrative expenses paid	$	(7,978,748)
Net cash from operating activities	$	23,195,339
Cash flows from capital and related financing activities		
Purchases of capital assets	$	(296,613)
Cash flows from investing activities		
Interest income and other income, net	$	34,559
Net (Decrease) increase in cash and cash equivalents	$	22,933,285
Cash and cash equivalents, beginning of year	$	110,520,927
Cash and cash equivalents at Sep 30, 2015	$	133,454,211
Reconciliation of operating income to net cash from operating activities		
Operating income (loss)	$	3,284,962
Adjustments to reconcile operating income to net cash from operating activities		
Depreciation	$	317,592
Changes in operating assets and liabilities		
Premiums receivable	$	(12,274,595)
Due from Santa Clara Family Health Foundation	$	3,612
Prepaids and other assets	$	(354,084)
Deferred outflow of resources	$	-
Accounts payable and accrued liabilities	$	639,923
State payable	$	34,081,060
Santa Clara Valley Health Plan payable	$	(8,405,755)
Net Pension Liability	$	-
Medical cost reserves and PDR	$	5,902,623
Deferred inflow of resources	$	-
Total adjustments	$	19,910,377
Net cash from operating activities	$	23,195,339

Santa Clara Family Health Plan Enrollment Summary

	For the Month of Sep 2015			Three Months Ending Sep 2015				
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Prior Year Actual**	**Change FY16 vs. FY15**
Medi-Cal	246,049	238,022	3.4%	726,301	712,439	1.9%	600,389	21.0%
Healthy Kids	4,375	4,408	(0.8%)	13,469	13,371	0.7%	14,974	(10.1%)
Medicare	7,912	8,564	(7.6%)	23,153	24,420	(5.2%)		
Agnews	110	114	0.0%	327	342	0.0%	342	(4.4%)
Total	258,446	251,109	2.9%	763,250	750,572	1.7%	615,705	24.0%

Santa Clara County Health Authority
September 2015

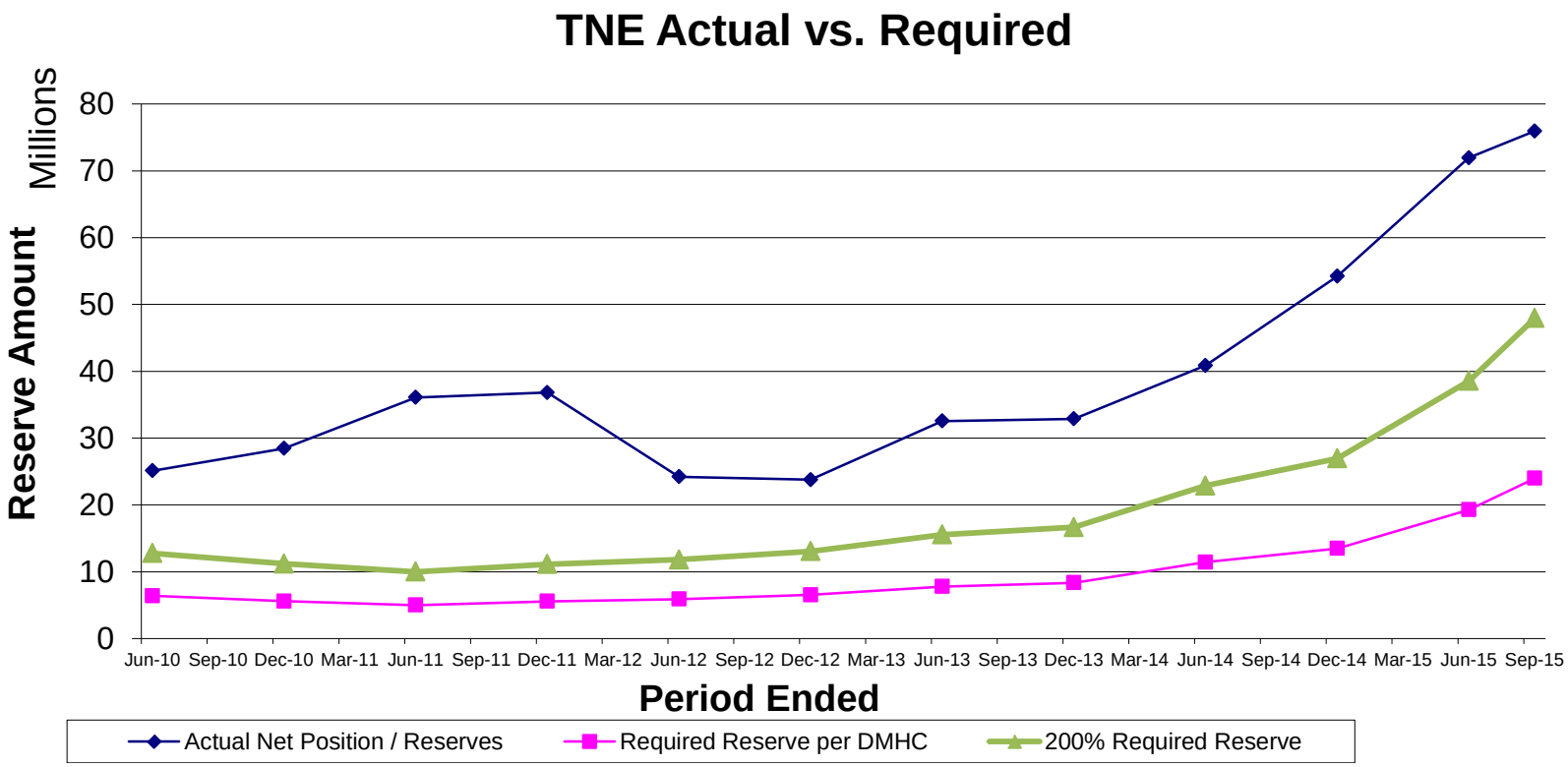
	Medi-Cal		Healthy Kids		CMC		AG		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	19,965	8%	178	4%	7,912	100%	110	100%	28,165	11%
SCVHHS, Safety Net Clinics, FQHC Clinics	134,502	55%	2,959	68%	0	0%	0	0%	137,461	53%
Palo Alto Medical Foundation	6,765	3%	42	1%	0	0%	0	0%	6,807	3%
Physicians Medical Group	44,171	18%	1,057	24%	0	0%	0	0%	45,228	17%
Premier Care	15,143	6%	139	3%	0	0%	0	0%	15,282	6%
Kaiser	25,503	10%	0	0%	0	0%	0	0%	25,503	10%
Total	246,049	100%	4,375	100%	7,912	100%	110	100%	258,446	100%
Enrollment @ 6-30-15	234,497		4,541		7,187		112		246,337	
Net % Change from Beginning of FY	4.9%		-3.7%		10.1%		-1.8%		4.9%	

Santa Clara Family Health Plan
Enrollment by Aid-Category

	2014-10	2014-11	2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09
Family	108,476	110,124	111,221	112,621	112,938	114,279	115,616	117,654	119,402	121,056	123,317	125,357
Aged - Medi-Cal Only	7,836	7,907	7,976	8,206	8,426	8,367	8,507	8,641	8,700	8,601	8,690	8,818
Disabled - Medi-Cal Only	11,825	11,833	11,786	11,651	11,623	11,593	11,505	11,512	11,435	11,404	11,320	11,271
Child (HF conversion)	20,433	20,062	18,951	17,178	16,307	15,346	13,939	12,297	10,683	9,055	7,312	5,592
Adult Expansion	48,161	52,493	55,582	58,724	59,296	61,041	63,346	66,487	68,731	71,192	73,706	75,826
Long Term Care	52	57	60	91	102	104	124	139	157	175	180	187
Total Non-Duals	**196,783**	**202,476**	**205,576**	**208,471**	**208,692**	**210,730**	**213,037**	**216,730**	**219,108**	**221,483**	**224,525**	**227,051**
Aged -Duals	5,327	5,389	5,209	4,288	5,372	6,269	7,342	8,359	9,322	10,022	10,698	11,598
Disabled - Duals	3,513	3,525	3,458	2,465	2,919	3,259	3,668	4,036	4,449	4,732	4,937	5,242
Other Duals	793	837	886	840	884	951	1009	1066	1150	1238	1302	1371
Long Term Care	43	44	43	42	69	102	234	343	468	618	697	787
Total Duals	**9,676**	**9,795**	**9,596**	**7,635**	**9,244**	**10,581**	**12,253**	**13,804**	**15,389**	**16,610**	**17,634**	**18,998**
Total Medi-Cal	**206,459**	**212,271**	**215,172**	**216,106**	**217,936**	**221,311**	**225,290**	**230,534**	**234,497**	**238,093**	**242,159**	**246,049**
Healthy Kids	4,858	4,762	4,820	4,822	4,682	4,648	4,616	4,615	4,559	4,496	4,598	4,375
Agnews	114	113	112	112	112	112	112	112	112	108	109	110
CMC	0	0	0	5415	6001	6,353	7,001	6,590	6,924	7,235	7,381	7,587
CMC - Long Term Care				142	161	195	225	246	263	308	317	325
Total Enrollment	**211,431**	**217,146**	**220,104**	**226,597**	**228,892**	**232,619**	**237,244**	**242,097**	**246,355**	**250,240**	**254,564**	**258,446**

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

	6/30/2010	12/31/2010	6/30/2011	12/31/2011	6/30/2012	12/31/2012	6/30/2013	12/31/2013	6/30/2014	12/31/2014	6/30/2015	9/30/2015
Actual Net Position / Reserves	25,103,011	28,445,504	36,093,769	36,803,460	24,208,576	23,776,902	32,551,161	32,878,950	40,872,580	54,224,335	71,957,916	75,950,475
Required Reserve per DMHC	6,388,000	5,591,000	4,996,000	5,558,000	5,901,000	6,525,000	7,778,000	8,330,000	11,434,000	13,467,000	19,269,000	23,971,000
200% of Required Reserve	12,776,000	11,182,000	9,992,000	11,116,000	11,802,000	13,050,000	15,556,000	16,660,000	22,868,000	26,934,000	38,538,000	47,942,000



Reserve Strategy

Santa Clara Family Health Plan
Board of Governors Meeting

November 19, 2015

Dave Cameron

Chief Financial Officer

Introduction

- **Board of Directors requested analysis of Reserves Policy in June 2015 (Prior review in December 2011)**

- **Today's presentation:**
  - Background Information
    - Discussion on short and long term needs to maintain reserves
    - Education on different measures
  - Current Policy
  - Future Considerations
  - Recommendation

Why Does SCFHP Need Reserves

- Reserves are needed to meet regulatory requirements

- Absorb volatility due to unpredictability of healthcare costs
  - LTSS and Duals Programs paid largely on a FFS basis; more uncertainty
  - Benefit & Program Changes (e.g. Hepatitis C, MH, Autism)
  - Large Inpatient claims

- Stability during periods of insufficient or delayed revenue
  - Pricing on new programs or benefits (SPD, Duals, LTSS, Hepatitis C , MH, Autism)
  - DHCS efficiency factors resulting in rate reductions: MAC, PPA
  - Recent and upcoming ACA Expansion rate reductions
  - Future rate actions that do not cover claim trends

- Provide for potential membership growth and infrastructure investment
- Pilot Programs/Expansion
- Building expansion and or purchase

Reserve Approaches

Regulatory Requirement (TNE)

- Tangible Net Equity (TNE)
  - Must hold 100% of minimum TNE, or DMHC can take control of health plan
  - If 130% or below minimum TNE , health plan must submit monthly financial reports
  - Minimum TNE requirement based upon % of FFS claims
  - Weaknesses in TNE
    - Established in 1979 and not updated since
    - Claims factors appear arbitrary
    - Does not consider non-FFS risks

- Risk Based Capital (RBC)
  - Nationally recognized model maintained by NAIC and reviewed by actuarial taskforce
  - Considers Asset, Underwriting (claims distribution), Credit, and Business risk.
  - If <200% RBC , health plan must file corrective action plan with regulators
  - If <100% RBC , health plan may be taken over by regulator

DMHC has discussed shifting reserve requirement from TNE to RBC

Current Policy

- **Established by Board December 2011:**
  - 2x monthly Medi-Cal Premium revenue
  - Have not met since established
  - Currently at approximately 1.1 months of premium revenue

Reserve Comparison of California Health Plans As of 6/30/2015: SCFHP Below State Averages

TYPE	HEALTH PLAN	MONTHS IN RESERVE	DAYS IN RESERVE	QUARTERLY REVENUE	PROJ ANNUAL REVENUE	RESERVE (TNE LINE)	Reserve as a % of Annual Rev
REG	ON LOK SENIOR HEALTH SERVICES	8.58	257	$ 33,021,216	$ 132,084,864	$ 93,121,601	70.50%
LHP	CENTRAL COAST ALLIANCE FOR HEALTH (Santa Cruz)	5.81	174	$ 241,352,762	$ 965,411,048	$ 461,282,832	47.78%
COMM	KAISER PERMANENTE	4.55	137	$ 15,561,031,000	$ 62,244,124,000	$ 23,300,303,000	37.43%
COMM	BLUE SHIELD (CALIFORNIA PHYSICIANS SERVICE)	3.67	110	$ 3,380,151,000	$ 13,520,604,000	$ 4,079,547,000	30.17%
LHP	PARTNERSHIP HEALTH PLAN OF CALIFORNIA	3.62	108	$ 583,421,854	$ 2,333,687,416	$ 693,515,567	29.72%
LHP	HEALTH PLAN OF SAN MATEO	3.54	106	$ 209,969,286	$ 839,877,144	$ 244,139,900	29.07%
LHP	ALAMEDA ALLIANCE FOR HEALTH	3.32	99	$ 81,495,303	$ 325,981,212	$ 88,827,297	27.25%
LHP	HEALTH PLAN OF SAN JOAQUIN	2.87	86	$ 121,998,757	$ 487,995,028	$ 114,974,026	23.56%
REG	SCAN HEALTH PLAN	2.38	71	$ 554,618,000	$ 2,218,472,000	$ 433,497,000	19.54%
LHP	CALOPTIMA (Orange County)	2.30	69	$ 829,831,280	$ 3,319,325,120	$ 626,149,319	18.86%
LHP	KERN HEALTH SYSTEMS	2.00	60	$ 141,016,000	$ 564,064,000	$ 92,512,000	16.40%
LHP	SAN FRANCISCO HEALTH PLAN	1.71	51	$ 155,583,399	$ 622,333,596	$ 87,222,151	14.02%
LHP	CENCAL HEALTH (Santa Barbara)	1.48	44	$ 187,842,285	$ 751,369,140	$ 91,490,659	12.18%
COMM	ANTHEM BLUE CROSS	1.46	44	$ 4,015,151,000	$ 16,060,604,000	$ 1,925,191,000	11.99%
REG	SHARP HEALTH PLAN	1.35	40	$ 139,206,259	$ 556,825,036	$ 61,614,904	11.07%
COMM	HEALTH NET	1.34	40	$ 1,958,689,890	$ 7,834,759,560	$ 862,106,801	11.00%
LHP	INLAND EMPIRE HEALTH PLAN	1.30	39	$ 1,107,873,418	$ 4,431,493,672	$ 472,003,606	10.65%
LHP	COMMUNITY HEALTH GROUP	1.28	38	$ 240,285,337	$ 961,141,348	$ 100,925,246	10.50%
LHP	SANTA CLARA FAMILY HEALTH PLAN	0.74	22	$ 297,689,000	$ 1,190,756,000	$ 71,958,000	6.04%
REG	CARE FIRST HEALTH PLAN	0.81	24	$ 520,089,042	$ 2,080,356,168	$ 137,821,905	6.62%
COMM	AETNA HEALTH OF CALIFORNIA	0.69	21	$ 481,549,058	$ 1,926,196,232	$ 109,410,032	5.68%
LHP	LA CARE (Local Los Angeles)	0.69	21	$ 1,617,439,835	$ 6,469,759,340	$ 364,861,921	5.64%
REG	MOLINA HEALTHCARE OF CALIFORNIA	0.60	18	$ 532,929,951	$ 2,131,719,804	$ 104,997,960	4.93%
LHP	CONTRA COSTA HEALTH PLAN	0.57	17	$ 214,170,616	$ 856,682,464	$ 40,422,607	4.72%
COMM	PACIFICARE (UHC of Calif)	0.46	14	$ 1,600,760,000	$ 6,403,040,000	$ 243,630,000	3.80%
REG	WESTERN HEALTH ADVANTAGE	0.40	12	$ 156,250,454	$ 625,001,816	$ 20,308,908	3.25%
	Weighted Average	3.04	91	$ 34,963,416,002	$ 139,853,664,008	$ 34,921,835,242	24.97%
	Straight Average	2.21	66.31	$ 1,344,746,769	$ 5,378,987,077	$ 1,343,147,509	18.17%
	Local Health Plans (excluding SCFHP)	1.85	55.37	$ 5,732,280,132	$ 22,929,120,528	$ 3,478,327,131	15.17%

SCFHP Reserve Trend 2012 - 2015

DATYE	DAYS CASH ON HAND	MONTHS IN RESERVE	DAYS IN RESERVE	----------REVENUE---------- QUARTERLY	PROJ ANNUAL	RESERVE (TNE LINE)	RESERVE DIVIDED BY PROJ ANNUAL REVENUE
06/30/12	85	1.19	36	$ 68,046,000	$ 272,184,000	$ 26,590,000	9.77%
06/30/13	84	1.17	35	$ 84,592,000	$ 338,368,000	$ 32,551,000	9.62%
06/30/14	35	0.80	24	$ 156,922,000	$ 627,688,000	$ 41,318,000	6.58%
06/30/15	50	0.74	22	$ 297,689,000	$ 1,190,756,000	$ 71,958,000	6.04%

Discussion: What's the Right Level?

- As of June 30, 2015, 100% RBC was approximately $21.9M and with $71.9M in reserves (328% RBC)

- Milliman Research Paper(1) released June 11, 2015 suggests typical range to be 400-500% for non-profit health plans:
  - 25th / 50th / 75th percentile = 299% / 395% / 512%
  - For-Profit / Non-Profit plans hold a composite RBC of 404% / 457%
    - Non-profits typically hold more capital since for-profits have access to capital markets

- Holding Reserves at industry average levels of around 450% RBC allows SCFHP to withstand a FFS claims spike of 5% and sustain it for up to three years without dropping below 200% RBC

- There is a balance/tension between paying providers as much as possible and meeting reserve goals

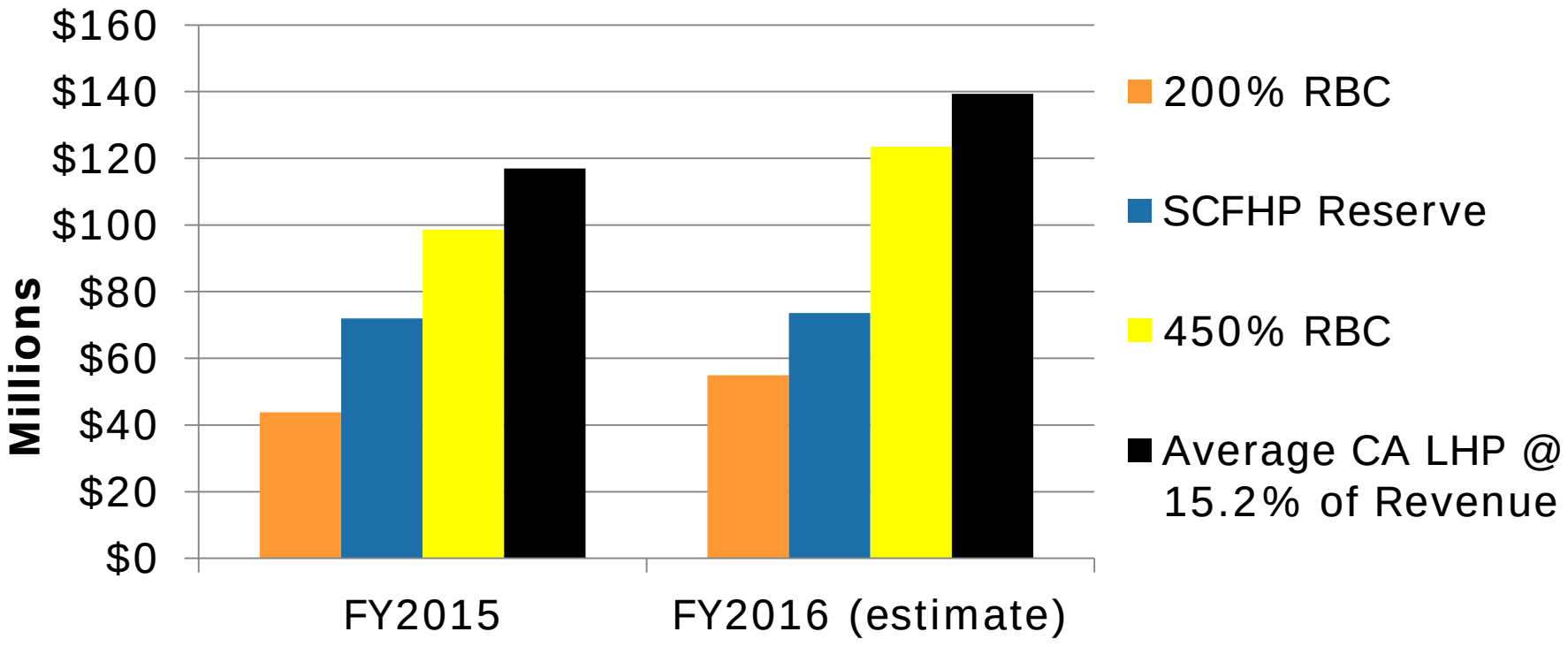
(1): http://us.milliman.com/uploadedFiles/insight/2015/medicaid-risk-based-managed-care.pdf

Discussion: Required RBC Estimate (FY15 & FY16)

	FY2015	FY2016
Annual Premium and Administrative Expense Assumptions		
Medical Premium	$769,418,420	$916,472,493
Administrative Expense	$26,264,826	$31,359,811
Claims Adjustment Expense	$1,782,781	$2,123,513
Assets and Other Balance Sheet Items		
Cash, Cash equivalents, and Short-Term Investments	$112,228,288	$123,835,372
Real Estate, Property, and Equipment Assets	$4,343,344	$4,343,344
Common Stock		
Other Invested Assets		
Receivables	$77,019,816	$91,740,126
Annual Claims Distribution		
Claims paid according to contractual arrangement (i.e. fee schedule, per diem, etc)	$281,589,808	$407,418,789
Capitation Claims paid directly to providers		
Capitation Claims paid to financial intermediaries.	$431,533,111	$428,284,878
Claims paid as a salary to physicians and hospitals		
Claims paid -- Other	$5,737,233	$32,059,089
Implied Annual MLR	93.4%	94.7%
H0 - Asset Risk - Affiliates W/RBC	$0	$0
H1 - Asset Risk	$771,019	$805,841
H2 - U/W Risk	$38,407,483	$50,370,776
H3 - Credit Risk	$21,112,315	$21,718,401
H4 - Business Risk	$1,149,244	$1,366,734
200% of RBC-ACL (need corrective action plan if breached)	$43,849,514	$54,876,419
100% of RBC-ACL (State authorized to take control if breached)	$21,924,757	$27,438,210
Capital	$71,958,000	$73,558,000
Capital as a % of RBC after Covariance	164%	134%
Capital as a % of Authorized Control Level	328%	268%

Discussion: What's the Right Level?

- Assuming a 450% RBC target, FY2016 requirement would be around $123M compared with an estimated reserve level of $74M
- FY2015 and FY2016 TNE requirement is $19M and $26M



Recommendations

- For internal purposes, consider RBC standard in addition to TNE.
- Target reserve levels between 400%-500% of required RBC as this allows SCFHP to absorb extended periods of elevated claims and/or insufficient premium.
- Difficult to increase RBC ratio when business is growing since required capital typically increases at same pace as reserves.
  - Recommend retaining profits which are higher than expected.
  - Recommend retaining profits when growth stabilizes until target RBC % met.
- Provide an annual review of the reserve policy to the governing board concurrent with the approval of the annual operating budget.

Santa Clara Family Health Plan
The Spirit of Care

www.scfhp.com

Santa Clara County Health Authority

Unified Managed Care Strategy
Board Team Meeting

Friday, November 6, 2015
2:00 PM - 3:30 PM
Santa Clara Family Health Plan
Cambrian Room
210 E. Hacienda Avenue
Campbell CA 95008

MINUTES - DRAFT

Members present:
Ms. Michele Lew
Mr. Bob Brownstein
Mr. Paul Murphy

Members not present:
Mr. Christopher Dawes
Ms. Dolores Alvarado

Staff present:
Ms. Christine Tomcala
Mr. Dave Cameron

1. **Call to Order**

Mr. Brownstein called the meeting to order at 2:15 PM.

2. **Public Comment**

There were no public comments.

3. **Minutes Review and Approval**
The Board Team reviewed minutes from the October 14, 2015, meeting.

It was moved, seconded, and approved to approve October 14, 2015 meeting minutes as presented

4. **Unified Managed Care Strategy**

The Board team reviewed the revised Integrated Managed Care Proposal, which reflected feedback from the prior meeting. Mr. Brownstein highlighted changes and provided clarifications. Ms. Lew noted her support for the joint development of a Strategic Plan with identified annual objectives, along with an annual Managed Care Summit.

There was discussion regarding the complexity of the proposed staffing. Ms. Tomcala suggested Santa Clara Family Health Plan could hire a Government Affairs staff member that could be shared equally with Valley Health and Hospital System through an MOU, and who would have a dotted line reporting relationship to the Managed Care Coordinating Council (MCCC) co-chairs. She further suggested that a jointly selected consultant be engaged to lead the proposed strategic planning and summit. The need for administrative support was discussed.

It was acknowledged that although the proposed structure of the MCCC is primarily as a coordinating and advisory body, the group will need to meet the County's expectations with regard to a work plan and outcomes commensurate with the County's investment in this body.

> **It was moved, seconded, and approved** to recommend that the Santa Clara County Health Authority Board approve the Integrated Managed Care Proposal, with the revisions discussed, as a preliminary negotiating position with the County on Unified Managed Care.

5. Adjournment

> **It was moved, seconded and approved** to adjourn the meeting at 3:30 PM.

Integrated Managed Care Proposal

1) The County and SCFHP shall establish a Managed Care Coordinating Council (MCCC).

2) Membership and Rules of Procedure
   a) 8 members – 4 selected by the SCFHP Board and 4 by the County BOS. One member shall be the Chair of the Board of the SCFHP and one member shall be the Chair of the County Health and Hospital Committee; these two individuals will serve as co-chairs of the MCCC.
   b) The CEO of the SCFHP and the Director of VHP shall be Ex Officio members
   c) Decisions require a majority vote
   d) The MCCC shall meet quarterly; special meetings can be called if needed.
   e) The MCCC shall be covered by the Brown Act.

3) Logistics
   a) The MCCC shall be staffed by a Government Affairs Director who will be shared equally by SCFHP and Valley Health and Hospital System (VHHS). This individual shall be hired by SCFHP, with an MOU that provides for equal sharing of staff time and expense with VHHS. This individual will have a dotted line reporting relationship with the MCCC co-chairs.
   b) The MCCC and Government Affairs Director will be supported by an Administrative Assistant who will be hired by SCFHP, with an MOU that splits the expense with VHHS.
   c) The MCCC shall engage a consultant to lead the annual strategic planning and Managed Care Summit described below.
   d) The MCC shall receive annual budgeted funds (50/50) from the two organizations to support the Managed Care Summit, as well as the expense for the consultant noted above.

4) Role and Responsibilities
   a) Through an MOU, the SCFHP and the County of Santa Clara shall authorize the MCCC to take public positions (by a majority vote of members present) on issues relevant to managed care, including but not limited to the following:
      - State Legislation
      - Federal legislation
      - Budgets, and
      - Regulations and responses to changes of ownership and/or control of hospitals or other medical facilities in the region.

   b) As regards all other issues, the MCCC shall be a coordinating and advisory body. Recommendations of the MCCC are subject to approval by the Board of Directors of the SCFHP and the BOS of the County of Santa Clara.

   c) The MCCC shall develop recommendations in the following areas of operations and policy:

      i. On an annual basis, the MCCC shall adopt a Strategic Plan indicating the shared objectives for Managed Care for the coming year. The Plan shall include an analysis of

the external environment in which the member organizations operate and the challenges and opportunities presented by that environment. It shall also include health membership goals, quality of care objectives, and planned program innovations.

ii. The MCCC shall review the structure and functions of the delegation model between SCFHP and VHP and propose modifications as warranted.

iii. The MCCC shall evaluate and make recommendations regarding major operational efficiencies including but not limited to such issues as IT integration, purchasing of pharmaceuticals or medical equipment, the assignment of patients to PCP's and medical management collaboration.

iv. On at least a biannual basis, the MCCC shall receive a report on the capacity of providers to meet specified health care standards including wait times for appointments and access to specialty care. Responses to a lack of capacity may include but are not limited increasing staffing, changing service delivery model, and changing networks on either a temporary or long-term basis. The MCCC shall propose optimal responses to specific capacity issues.

v. The MCCC shall recommend marketing strategies to sustain or improve the market share of the SCFHP and the County in the provision of health care services. The MCCC shall propose priorities for preventive care and recommend the launch of specific preventive care initiatives.

vi. The MCCC shall evaluate and propose priorities for the major investment of resources into the managed care system operated by the two entities, including resources for program innovations.

vii. The MCCC shall invite presentations from consumer advisory groups, evaluate the customer experience and make recommendations regarding patient satisfaction.

viii. The MCCC shall convene an annual Managed Care Summit. The Summit will include a plenary session to brief participants on the status of Managed Care in the public sector in Santa Clara County and to present the Annual Managed Care Strategic Plan. The Summit will include as its audience:

- SCFHP Board Members and Leadership Staff
- Santa Clara County Board Members, their staffs and Management staff of the relevant Santa Clara County Departments (SCVMC, Behavioral Health, Social Services)
- Managed Care Partners of the two respective organizations (Hospitals, Clinics, Physician Groups, Labor Organizations, Elected officials, etc.)

COLLABORATION WORK PLAN
November 16, 2015

	Potential Opportunities	Considerations	Status
1	**Provision of specialty drugs**		**COMPLETE** • Valley joined Diplomat as a specialty drug vendor for FHP (Sept. 1)
2	**Share DME RFP**	o VHP engaging in DME RFP process	**COMPLETE** • FHP provided copy of 2013 RFP upon request (Sept. 2)
3	**Health Plan Alliance membership**	o The trade association for provider-owned health plans does not allow plans in same geographic area to both join without permission	**COMPLETE** • FHP gave HPA permission to enroll VHP (Sept. 28)
4	**Shared PBM RFP**	o FHP engaged SBG to assist with a PBM RFP for a 2017 effective date	**CLOSED** • In researching procurement rules, Bruce identified that staff had already proceeded to Board approval of the RFP

5	**Partial IT integration**	o FHP planning to move Medi-Cal off Monument Express o FHP considering hosting QNXT o FHP and VHP have common TriZetto service staff o FHP supporting VHP QNXT conversion with dedicated consultant rewriting custom data feeds	**IN PROCESS** • FHP asked TriZetto to suggest opportunities for integration with VHP (Sept. 1) • TriZetto's license agreement does not allow for two entities to share one license. Any cost savings for hosting would only be recognized with one instance of QNXT for both Valley and SCFHP
6	**Medical Director collaboration**	o FHP & VHP do not have multiple medical directors to over-read for each other, requiring sending cases out o FHP & VHP are each in need of a part-time medical director, which is difficult to recruit o Sharing a VHP Medical Director will provide Healthlink Access to SCFHP	**IN PROCESS** • Jeff & Dolly now serving as IRO on other lines of business • Bruce received approval to fund a full-time medical director • FHP hired one of its former Medical Directors, who was available to work 4 days/week starting December 7th • Development of an MOU is underway to share the new part-time medical director until VHP is able to recruit someone full-time
7	**Assignment of PCPs for Valley clinic members**	o Develop process to assign PCPs to Valley clinic members to improve timely access to specialists	**IN PROCESS** • Kick-off meeting held (Oct. 6) and subsequent monthly meetings scheduled • Joint work group in process of identifying new procedure and timeline for implementation

8	**Transition Healthy Kids to Valley Kids**	o As Healthy Kids qualify for full Medi-Cal in 2016, consider transitioning residual members (<200) to Valley Kids o Concern that members may lose dental, vision, and physician relationships	**IN PROCESS** • Christine provided the benefit description (Oct. 6) and will share a list of providers utilized • Initial joint meeting with VHHS and Social Services Agency to discuss transition and communication plan (Sept. 26) • Provide SSA Healthy Kids membership file to identify number of children for targeted outreach and enrollment into Medi-Cal (Oct. 2015) • Ongoing, collaborative meetings with VHHS and DHCS regarding transition
9	**Further medical management collaboration**	o Share more pharmacy data to assist with medical management o Share HEDIS scores and develop interventions to improve rates o Access electronic medical records	**IN PROCESS** • Pharmacy data file developed for McKesson Case Management and IMI HEDIS programs, with monthly file updates • Debra Halladay at Valley is facilitating an opportunity for limited time access to HealthLink for HEDIS efforts
10	**Seek to improve member experience related to brand clarity**	o Research call routing and seek process improvements o Review correspondence for branding clarity	**IN PROCESS** • Initiated discussions regarding representation of VHP on communications, with a focus on ID cards
11	**Increase market share**	o Identify enrollment/renewal dates o Identify churn o Get SSA involved—timeliness of app processing	**IN PROCESS** • Discussions took place with SSA regarding the complexities of the redetermination process
12	**Develop joint health education programs**	o Collaborate on health education programs to maximize return on the collective investment in health educator staff and programs	**IN PROCESS** • Kick-off meeting scheduled December 3rd

13	**FHP to consider implementing Cactus for credentialing**	o In researching credentialing systems, FHP will consider implementing the Cactus system, for efficiency in operating on the same system as VHP	**IN PROCESS** • FHP is in the process of drafting an RFP to include all required functionality
14	**Consider hospital & SNF Medi-Cal contracting at FHP level**		**FUTURE INITIATIVE**

Santa Clara County Health Authority
Job Titles Added to Pay Schedule
November 19, 2015

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Application Developer I	Annually	62,706	79,951	97,195
Behavioral Health Case Manager	Annually	72,112	91,943	111,774
Behavioral Health Program Manager	Annually	97,645	126,939	156,233
Director Contact Service Operations and Service Excellence	Annually	112,569	149,153	185,738
Facilities Manager	Annually	72,112	91,943	111,774
Health Educator	Annually	55,618	69,522	83,427
Human Resources Coordinator	Annually	43,867	53,737	63,607
IT Product Manager	Annually	97,645	126,939	156,233
Manager of Provider Database and Reporting	Annually	83,102	108,033	132,964
Pharmacy Support Specialist	Annually	32,166	38,599	45,032
Prior Authorization Supervisor	Annually	43,867	53,737	63,607
Sr. Health Care Financial Analyst	Annually	72,112	91,943	111,774
Utilization Management Operations Supervisor	Annually	55,618	69,522	83,427

Santa Clara County Health Authority
Job Titles Removed from Pay Schedule
November 19, 2015

Job Title	Pay Rate	Minimum	Midpoint	Maximum
Behavioral Health Care Manager	Annually	83,102	108,033	132,964
Human Resources Assistant	Annually	43,867	53,737	63,607
Quality Improvement Specialist	Annually	55,618	69,522	83,427

Santa Clara
Family Health Plan
The Spirit of Care

Regular Meeting of the
Santa Clara County Health Authority
Executive Committee

Thursday, October 22, 2015
8:30 AM - 10:00 AM
210 E. Hacienda Avenue
Campbell CA 95008

VIA TELECONFERENCE AT:
Residence
1985 Cowper Street
Palo Alto, CA 94301

Members present:
Ms. Michele Lew
Ms. Dolores Alvarado
Ms. Linda Williams
Mr. Bob Brownstein

Members present via phone:
Ms. Liz Kniss

Staff present:
Ms. Christine Tomcala, CEO
Mr. Dave Cameron, CFO
Ms. Sharon Valdez, VP Human Resources
Ms. Janet Smith,

Other attendees:
Mr. Dick Noack, Hopkins & Carley LLC

MINUTES - DRAFT

1. **Roll Call**

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

2. **Action item: Review and approve minute's from the July 23, 2015, Executive Committee Regular meeting.**

   It was moved, seconded, and approved to accept July 23, 2015, meeting minutes as presented.

3. Public Comment

Ms. Smith, an employee with SCFHP addressed the Executive Committee with her concerns regarding the acceptance into the Union and the fact that the she was not recognized as an employee, no notification was sent regarding the voting process and that she and other employees did not have the opportunity to voice their reluctance in joining the Union. She stated that she has dealt with Unions in the past and really doesn't want to be a member and was hoping there was a way to opt out. It will also be a financial hardship for me. I work well with my team, my manager, the department director, and the HR director who are always there to listen and help resolve any issues that may occur. I really do not want to be a part of the Union or the bargaining unit and was hoping that there would be a way for those individuals who do not want to be in the Union to opt out.

Ms. Lew responded that this discussion can potentially be agendize for the next Board meeting.

4. Adjourn to Closed Session

a. **Conference with Labor Negotiators** (Government Code Section 54957.6): It is the intention of the Executive Committee to meet in Closed Session to confer with its Designated Representatives:

- Designated Representatives' Names: Dave Cameron, Sharon Valdez, and Richard Noack
- Employee organization: Local 521, SEIU

5. Report from Closed Session

No Action was taken

6. Discussion item: CEO Update

Ms. Tomcala brought to the Boards attention the resignation of Mr. Solem, Chief Medicare Officer and also two of his direct reports have recently departed as well. We will be looking at replacing Mr. Solem on the interim basis until we determine a long-term solution. We are bringing in someone who has Medicare experience that can help the organization with assistance across the Medicare knowledge and also address some concerns that staff may have with this loss of Medicare knowledge.

Also, at the last board meeting the Plan Objectives were discussed and the first being Compliance. We are going to engage consultants to help identify the gaps, so we can address those before audits. The Executive Team has looked at different firms and has selected a firm that we want to engage here imminently. Proceeding of that is a question about how much money we have in the budget.

And lastly O'Conner recently agreed to arrange a proposal for Medi-Cal moving forward, and within the last 24 to 48 hours they came back and were surprised it did not include the Cal Medi-Connect line of business which hadn't been added to the rate posted sheet. We are having a conversation this afternoon to further address that.

It was moved, seconded, and approved to accept CEO update as presented

7. Discussion item: Update on Fiscal 2014-15 Year End Financials

Mr. Cameron stated that at the last Board meeting an update on the year-end financials was presented on the interim financials. The discussion was Premium Deficiency Reserve and the auditors required SCFHP to book and it's still be negotiated, again that was the Cal Medi-Connect/Medicare product. Basically, their interpretation of the accounting requirements is that we have to book Premium Deficiency Reserves through the life of the contract, it's not just through the first six months it's through the whole term. We had booked at that time $14.4M, we are required to be at $18M and that would be in the final numbers. Mr. Cameron commented that this extends through the required contract period, through the end of next calendar year. The auditors. are not allowing us to include any Part D reconciliation, which is pretty-much-guaranteed revenue in terms on the back end. We'll give a more thorough update and projections through September at the November 19th Board meeting and we'll have ten months of run out claims experience in this product.

Dr. Wenner commented that this topic comes up when speaking with other physicians as to why are there such large reserves and why aren't you paying that to the physicians.

Mr. Cameron commented that SCFHP will actually do some comparisons with the other health plans in the state and other health plans in general. Again that's a one-time booking and you would have to adjust it periodically, we will do another review after the December's results

8. Action item: Review and Accept July and August 2015 Financial Statements

Mr. Cameron gave an update on the August year to date highlights through the first two months of the fiscal year. Revenue is right on a budget primarily due to the Medicaid expansion and we did not have to book any additional Pension expenses. Medical expenses were over budget primarily due to our estimates for Cal Medi-Connect/Medicare, we're still estimating and haven't brought in the incurred but not reported claims, but it will be more favorable than our estimate dating through October. Enrollment is up slightly year over year, 1.8% over budget for the first two months, member months went up 21% and again Medi-Cal expansion is the primary growth. Just a note as to why the revenue is so much higher is because it's of IHSS workers, that continues to be a challenging item to budget again its pass through however there's risk to it if they worked over the 196 hours. We haven't received the reconciliation for last year so we don't know if we're positive or negative. It's a unique financing arrangement that the state and the counties did, but they have to run it through Managed Care. So that was $8M over budget but it has no bottom line effect currently, we'll let you know when there is a completed reconciliation.

Mr. Cameron commented that we're at risk because those are the home-based community services members and we have no control if they work over the 196 hours, that's what the revenue is based on, basically working that amount of hours a month on average and if they work fewer hours the health plan keeps the revenue.

Last fiscal year was $60M, and that's another factor of the reserves evolving, a lot of uncontrollable unknowns. Theoretically the county controls those hours and it's by contract. Again the favorable to non-operating can be seen in the final audit statements. By booking the pension requirement called GASB 68, that $6M really was a prior adjustment it looks like we're going to be pretty close going forward. I think we're going to be neutral and again that's a favorable variance from the budget.

It was moved, seconded, and approved to accept the July and August financials as presented.

9. Action Item: Budget Line Item Adjustment

Mr. Cameron commented this is a revenue neutral line and it's basically our PBM, Pharmacy Benefits Manager, who adjudicates all claims, they charge and admin fee and historically we've put it into medical expenses. The department is requiring it to be an administrative expense. We had budgeted it in medical expenses again and it's about $2.4M and we will realign it. It's neutral to the bottom line, but it's out of medical and into the administrative cost.

It was moved, seconded, and approved Approve Budget Line Item Adjustment

10. Discussion Item: Discuss reserve methodology

Mr. Cameron discussed the Reserve Adjustment Strategy, this was requested by the Board in June. We've been working on, how to present it, what the thought process is and how we're going to provide input. Again some background, the last time we updated this was on December 11, 2014, we did the two months capitation. A lot has changed since then, the health plan has more than doubled and the business model has changed slightly. We'll go through the current policy which is two months capitation and then just some considerations for the board and us and a recommendation today.

What are reserves, the private sector calls it equity and we call it safety net because we don't have the ability to generate much equity other than if we did a surplus. There are no other avenues of capitalization, and what's in it is cash investments, accounts receivable and real property can be considered reserves as well. Now we're into new territory, long-term support services, duals which are a fee for service, constant benefit program changes and then

accounting changes and so the GASB 68 used $6M of our required reserves. The ones coming down in 2017 are the retiree health care which is going to require that be booked on the balance sheet also currently we pre-fund that and we are 52% funded, which is great, but we will have to fund the rest or at least book the rest. Again disability all the things that happened when dealing with the state again our rates are not updated 18months out, we try and do trends, but the state doesn't always recognize those trends. So it allows you to deal with long periods of time incurring higher cost. And then efficiency factors that they sometimes do retroactive, which they're doing right now with what's called Pharmacy adjustments, mac adjustments, PPA (Potential Preventable Admissions). It's hard to put any action in place with these, they are really just budget adjustments for the state to, cut rates. Again the current reserves policy is two times monthly premium.

TNE, Tangible Net Equity which is the requirement of the state versus our RBC that's really comparable to risk-based capital. The way we calculate these today, there's not much difference at the base. However, the risk-based capital takes into account under dynamics better than TNE, the fee for service claims, balance sheet risks, it takes those types of factors and what's explained here is a research paper by Milliman that looked at all the Medicaid plans, profit, and non-profit in the other states that do a risk-based capital and what their benchmarks are. DMHC, Department of Managed Health Care has discussed shifting the reserve requirements from TNE to RBC.

We are pretty much the middle of the pack and now everybody's done fairly well with Medi-Cal expansion collectively the reserves have increased tremendously. Looking out 18 months, it looks a little gray however our reserves have never been higher. The qualifier, there is $18M take away in this through the Premium Deficiency Reserve, but there's also an equal amount of that which board has committed to on the ACA 1202 the positions over the next year or two to enhance physician payments that we're continuing. This is a snapshot and it doesn't take into account risk because business models that are all fee for service need a lot more in reserves than someone like us who has a lot in capitation less risk especially when your capitating to the Valley/Kaiser because they have very low credit risk also.

Although our reserves increased significantly we're not over revenue, not when your revenue is billion dollars, five years ago we were at $200M, so we've increased five times.

So what is the right level, at RBC its $21.9M if you're appointed receivership and we are 328% of that. So the reference to Milliman Research paper just released the composite is in an average of 4 to 457. The volatility of spikes in claims and it can happen quick with rate increases or re-negotiations of contracts that aren't embedded in your rates for up to 18 months and as we can share there is that tension balance between paying providers as much as possible and meeting reserve goals. Mr. Brownstein asked if the Milliman paper was national and Mr. Cameron responded its national and he will send it to the Board.

These are the numbers for the fiscal year and where we are currently, and at the end of the fiscal year 2015 and then a projected based on at least our budget, where we'll be at. You can see they are going down because we're anticipating paying out $10M additional to the ACA 1202 physician enhancements. Our revenue is going up so the capital is still increasing, but the RBC is a percentage of that requirement and is going down slightly. This is just a depiction of a comparison of if we were at 450% RBC level which again once you look at the paper you can see that the Medicaid plans throughout the country are at between 400 to 500, it would be $123M.

And last is what we're recommending and again we can absorb this and take it to the full board, is that we consider RBC as our standard and in addition to the TNE present both, but as the target RBC is something the board can adopt and say it's more of the standard in the industry and discuss a reserve target maybe 400 and 500%.

Mr. Brownstein commented that he needs more time to review this and understand it's a national standard; everyplace else doesn't have to deal with the reimbursement rates that California has to deal with. There are other potential uses for revenue's beyond filing into reserves, reserves are an important factor. This looks like a massive shift in terms of making reserves important and making it a top priority which I might be convinced to do, but right now I'm not sure if I'm ready to agree with that. I feel it's going to be an issue for the full board and there is any additional information you can add with other options that would be helpful.

Ms. Williams commented that it might be helpful to have some sort of an incremental plan and asked how long do you foresee it would take to reach that target? She understands the comparative information other California plans interesting and helpful. The California comparison might be more relative and more persuasive to the board.

Mr. Brownstein added that he'smore comfortable trying to balance what is understand to be the real risks versus having reserves to deal with real risks versus other uses of revenue, as what looks to me like an arbitrary standard against what may be what seems to be real needs in terms of providers or other things that this plan could invest its resources into.

Ms. Tomcala commented that this proposal is less than what the Board currently suggested, two months of claims and reserves.

Mr. Brownstein responded that's actually a better way to express it than you're converting it to an estimate of real risk as opposed to some standard from which someone else is doing.

Mr. Cameron commented that we're really never going to make more than 2% surplus because we've dedicated to paying for providers incentives. We would have to be realistic we'd probably have to go with where we are, at 2% that's the only way we grow reserves

Mr. Brownstein responded that his idea would be some kind of methodology so that there is a target and it's expressed in risk opposed to arbitrary target. We have some kind of process that enables us to do some sort of balancing judgment so that we don't feel that we've imprisoned ourselves forever. Saying that adding to the reserves is going to trump everything else no matter how important it is.

Mr. Cameron responded that the board can always make decisions on that excess reserve, what's considered excess reserves or the RBC that does take into account a business model changes. So if it goes up the Valley gets more CAP and your risk goes down and vice versa.

Mr. Cameron responded that we will continue this discussion at the next Board meeting in November. And so to your question Linda making 2% will take 2.5 years so maybe we go 400% or maybe we're comfortable at 350% we can be there in two years if we make 2%

Ms. Williams responded that it's important information and we're not making our current benchmark and in the most volatile health care market we should start with information that captures people's attention and instead of going right into theory is probably helpful.

Mr. Cameron responded that will be the focus going forward.

11. Adjournment

It was moved, seconded, and approved to adjourn the meeting at 3:30 PM.

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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	Lucille Packard Children's Hospital Open House 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. Conference on Adolescent Mental Health Wellness 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.	None		
Review of	Dr. Thad Padua, Chair, noted that a few members arrived late, and a quorum was now present.	None		

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

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Minutes	The minutes from July 9, 2015, were reviewed and approved by Committee as presented.			
CEO Report	<u>OCTOBER 2015 MEMBERSHIP SUMMARY</u> Ms. Christine Tomcala, CEO, presented the October 2015 Membership Summary (copy attached herein). Ms. Tomcala noted total membership exceeded 250,000, with the bulk of our membership in the Medi-Cal program. Ms. Tomcala noted the following for each line of business: • Healthy Kids: 4,362 • Cal MediConnect: 8,354 • Medi-Cal: 249,977 Ms. Tomcala expanded on the Medi-Cal membership by age group noting that it has changed quite a bit from 10 years ago. By comparison from 10 years ago vs today, 77% of health plan's enrollees were children. The breakout is as follows: • Medi-Cal Age 0 – 18: 42% • Medi-Cal Age 19 and over: 58% Ms. Tomcala also discussed the Medi-Cal membership by category: • Adult/Family/Child: 50.90% • Aged: 8.65% • Disabled: 6.72% • Former HF (Healthy Families): 1.83% • LTC (Long Term Care): 0.29% • MCE (Medi-Cal Expansion: 31.59%)	Informational		
	<u>O'Connor Contract</u> Ms. Tomcala noted that she is aware that the community is interested to know the status of the O'Connor contract, and noted that the Health Plan is working very closely with the contracting team for the hospital. There is still intent on both sides to move forward with the agreement, and we continue to work on it. Ms. Tomcala advised the Committee that the Health Plan will extend the current Letter of Agreement for Obstetrics past the term date of October 15th if we need to. Ms. Tomcala offered to answer questions from the Committee. Dr. Ngo inquired as to whether or not the contract will be signed any time soon with O'Connor? Ms. Tomcala indicated that both sides continue to work closely together and there are many moving parts, including the change in leadership at O'Connor. She ensured the Committee that discussions continue to happen and we are hopeful it will happen quickly.			

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Jennifer Clements, Provider Operations, indicated that she has been communicating with the O'Connor contracting team almost daily and we are moving forward quickly. Dr. Padua asked the Committee if anyone had additional questions for Ms. Tomcala. 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. Although some of the rates for the program have been cut by 3% or 6%, 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. 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.			

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Medical Director Update	Dr. Jimmy Lin, Medical Director, provided update, noting that the Health Plan has so many patients coming in and our membership continues to grow, which is very expensive. Pharmacy management alone has a huge impact. Cal MediConnect seniors' medication lists can be greater than 18 drugs. These medications are expensive and Medi-Cal used to cover everything. The Health Plan has been streamlining processes and has improved the turnaround times for prior authorizations. Ms. Tomcala added that with regard to drugs, it appears that we are losing money. Part of this is that CMS has a complex process involving rebates and tiers, and it appears we are losing money. However, the Health Plan should re-gain as we get some of the money back from CMS, hoping to break even. This first year is part of our learning curve as we gain enough experience so that we can actually project how many claims incurred, but not reported. Right now the Health Plan just doesn't have enough experience. Dr. Ngo asked how the Health Plan is encouraging doctors to use more generic medications as many are used to writing non-generic drugs with Medicare. Dr. Lin concurred, indicating that was the case before, but that they all know as they work with SCFHP. Once they come to us, gradually everything will become generic only and they will get the message.			
ACA Payment Update	Ms. Ngoc Bui-Tong, Director of Health Care Economics, updated the Committee on the ACA Payment. She advised that it was actually part of Obamacare or ACA Act. It provided parity for Medi-Cal providers at a Medicare rate for 2013 and 2014. She noted the Health Plan had some reserve from those two years and the Health Plan's Governing Board agreed to continue paying into calendar 2015. Ms. Bui-Tong will review claim data for dates of service for January through June of 2015. Ms. Bui-Tong stated that the Health Plan wanted to wait as long as possible before we started analyzing the data because the process to calculate payment is very labor intensive. The Health Plan will continue to analyze the data and make payments for as long as we have the funds, at this time it looks like it may be approximately one more year.			

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

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
MLTSS	Community Based Adult Services (CBAS) 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. 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). 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. 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. 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. 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	The CBAS flyer will be presented at the next PAC meeting.	L. Anderson	01/07/16

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	SCFHP nurses. The Committee continued to discuss the referral process and the benefits of the program. Ms. Walsh advised the Committee that the CBAS brochure will include all the required information explaining how to refer a patient for CBAS services. The Committee members asked whether there is any oversight by a physician or the member's PCP. Ms. Pouransari said a fax is sent to the referring physician identifying the plan of care and what the facility will do with the patient, and the Health Plan case management department is involved as well. Dr. Padua thanked everyone for their comments and asked that we continue the conversation at the next meeting.			
Children's Complex Care Issues	Ms. Sheri Sager, LPCH representative, reminded the Committee of previous discussions surrounding children's complex care. She indicated that legislation unanimously passed on both the State Senate and the State Assembly to extend the CCS carve-out for another year. It's on the Governor's desk now and he has until Sunday to sign, veto or let it become law without his signature. It would be a one year extension of the carve-out during which time, hopefully, the department would actually work with all of the different stakeholders in a meaningful way to come up with a compromise. Stakeholders meetings have been held throughout this last year with mixed reviews, depending on whom you talk to. There is also discussion to include local initiatives, but again, there is concern about running into a federal problem with approval by CMS. But the beauty of the CCS system is that CCS is the objective neutral party, so by leaving CCS as a carve-out they will actually refer kids to the right place. Ms. Sager stated that getting kids to the right place at the right time actually saves lives and saves costs. Because if we get them later, they are more critical. So, it's still a work in progress. The state has said that even if it gets vetoed, nobody has to worry, it will not happen for at least a year. They are talking about moving the first kids in terms of the County Organized Health system in January 2017 and maybe down in Loma Linda area in inland Empire	An update will be presented at the next meeting.	S. Sager	01/07/16

ITEM	DISCUSSION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	in July of 2017, but, those are "if's". 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.			
Participation Requirements	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.	Draft Committee Charter and suggested edits to the Bylaws for review at the next meeting.	J. Clements	01/07/16
PAC 2016 Calendar	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.	Informational		
Adjournment	Meeting Adjourned at 1:30. Next Meeting is scheduled for January 7th, 2016. A meeting invite will be sent out.	Informational		

Signature:_____ Date:_____

2016

January

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February

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March

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April

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June

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July

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August

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Notes:

SCCHA Governing Board

- January 28th
- April 28th
- June 23rd
- September 22nd
- December 15th

Executive Committee

- February 25th
- March 24th
- May 26th
- July 28th
- August 25th
- October 27th
- November 17th

Provider Advisory Council

- January 7th
- April 7th
- July 7th
- October 6th

Consumer Affairs Committee

- March 8th
- June 14th
- September 13th
- December 13th

Santa Clara
Family Health Plan
The Spirit of Care

Santa Clara Family Health Plan
Operations Report
September and October 2015

Membership
October 2015

Mbr Mths	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	2015-11
Agnews	**112**	**112**	**112**	**112**	**112**	**112**	**108**	**109**	**110**	**110**	**110**
Santa Clara Family Health Plan	112	112	112	112	112	112	108	109	110	110	110
Healthy Kids	**4,795**	**4,665**	**4,623**	**4,584**	**4,595**	**4,541**	**4,496**	**4,598**	**4,375**	**4,362**	**4,325**
Palo Alto Medical Foundation	46	47	44	44	48	47	45	46	42	42	40
Physicians Medical Group	1,134	1,121	1,107	1,106	1,086	1,088	1,076	1,104	1,057	1,064	1,050
Premier Care	167	164	164	150	160	142	145	146	139	138	140
Santa Clara Family Health Plan	161	158	156	163	168	165	172	180	178	192	193
Valley Health Plan	3,287	3,175	3,152	3,121	3,133	3,099	3,058	3,122	2,959	2,926	2,902
Medi_Cal	**216,106**	**217,936**	**221,311**	**225,290**	**230,534**	**234,494**	**238,093**	**242,159**	**246,049**	**249,867**	**254,487**
Kaiser	23,311	23,239	23,799	24,208	24,655	24,903	25,105	25,318	25,503	25,665	25,965
Network 00	3,035	3,943	4,522	5,477	6,307	7,181	7,088	7,389	7,674	8,363	9,090
Palo Alto Medical Foundation	5,196	5,333	5,557	5,787	6,035	6,214	6,386	6,568	6,765	6,883	7,006
Physicians Medical Group	40,584	41,104	41,575	42,022	42,393	43,059	43,400	43,780	44,171	44,617	45,011
Premier Care	14,448	14,612	14,753	14,968	15,126	14,957	15,065	15,180	15,143	15,269	15,460
Santa Clara Family Health Plan	10,205	10,280	10,409	10,566	10,746	10,834	11,562	11,871	12,291	12,345	12,358
Valley Health Plan	119,327	119,425	120,696	122,262	125,272	127,346	129,487	132,053	134,502	136,725	139,597
Cal MediConnect	**5,557**	**6,162**	**6,548**	**7,226**	**6,836**	7,187	**7,543**	**7,698**	**7,912**	**8,354**	**8,906**
Santa Clara Family Health Plan	5,557	6,162	6,548	7,226	6,836	7,187	7,543	7,698	7,912	8,354	8,906
Grand Total	**226,570**	**228,875**	**232,594**	**237,212**	**242,077**	**246,337**	**250,240**	**254,564**	**258,446**	**262,693**	**267,828**

Membership at capitation * Jan 2014 –Start LIHP Transition and MCE

Long Term Services Supports (LTSS) Department
September 2015

Total LTSS Members by Line of Business (LOB)

Long Term Services Support Program (LTSS)	Cal MediConnect	Medi-Cal	Total Members in LTSS Programs
Community-Based Adult Services (CBAS)	95	451	546
In-Home Supportive Services (IHSS)	N/A	N/A	9965
Long Term Care (LTC) – Source: 3387	179	145 Medi-Cal 849 Duals 949 Total	1128
Multipurpose Senior Services Program (MSSP)	48	179	227

In-Home Supportive Services (IHSS) are personal care services for people who are disabled, blind or aged 65+ and unable to live at home safely without help.
Community-Based Adult Services (CBAS) is daytime health care at centers that provide nursing, therapy, activities and meals for people with certain chronic health conditions.
Multipurpose Senior Services Program (MSSP) provides social and health care coordination services for people age 65 and older.
Long-Term Care Facilities provide residential long-term custodial or skilled nursing care.

LTSS ENCOUNTERS	**Total**
CBAS Face-to-Faces (F2F) Completed assessments	21
LTC F2F Completed assessments	15
Provider Site Visits: SNFs 5; CBAS 1	6
LTSS Provider Calls (inbound and outbound calls to LTSS Providers)	269

CCI Stakeholder and LTSS Network Engagement

PROVIDER OR STAKEHOLDER GROUP	PURPOSE/FOCUS OF MEETING
CMC Consumer Advisory Board	Monthly meeting – 3 SCFHP members present; focused on Communications and Outreach for CMC including Ombudsman Report
Valley Medical Center & SNF providers	INTERACT model implementation at designated SNFs to prevent readmissions from SNFs to acute settings.
CCI Stakeholder Advisory Committee Meeting	25 members present; regulatory updates, reports from IHSS, Behavioral Health, Ombudsman, HICAP; discussed deeming and care coordination
MSSP Meeting	Case Managers and LTSS Assessment Review
IHSS CCI Liaison Team Meeting	Cross-training on IHSS provided to case managers and care coordinators

Long Term Services Supports (LTSS) Department
October 2015

Total LTSS Members by Line of Business (LOB)

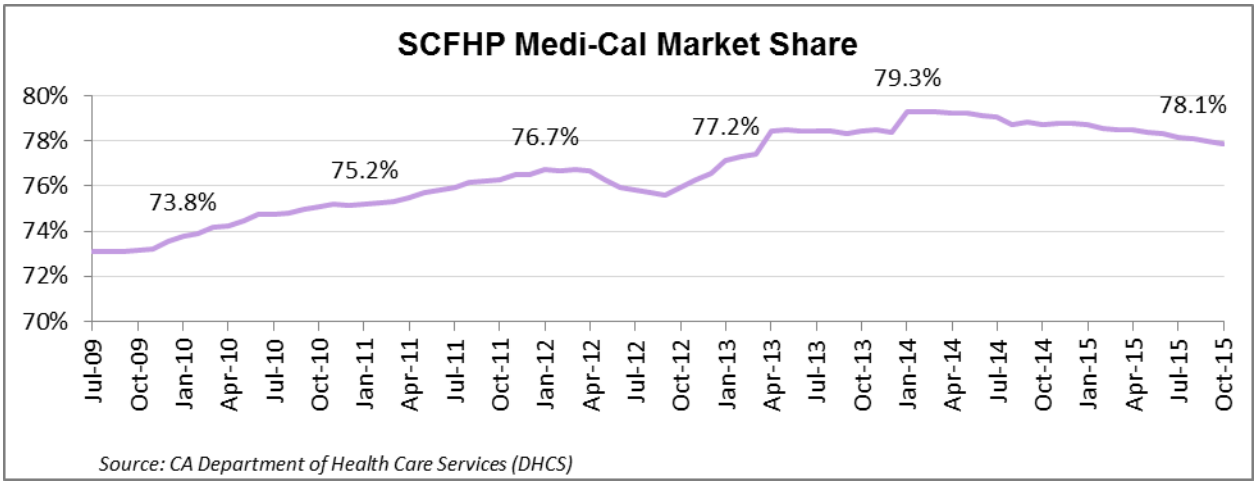
Long Term Services Support Program (LTSS)	Cal MediConnect	Medi-Cal	Total Members in LTSS Programs
Community-Based Adult Services (CBAS)	95	451	546
In-Home Supportive Services (IHSS)	N/A	N/A	9965
Long Term Care (LTC) – Source: 3387	285	158 Medi-Cal 905 Duals 1063 Total	1348
Multipurpose Senior Services Program (MSSP)	39	207	246

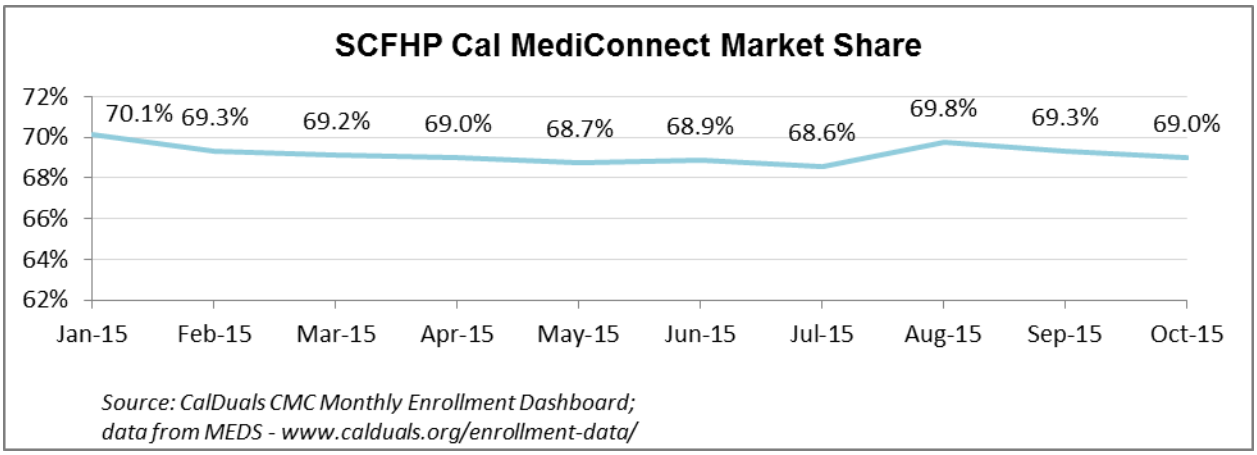
In-Home Supportive Services (IHSS) are personal care services for people who are disabled, blind or aged 65+ and unable to live at home safely without help.
Community-Based Adult Services (CBAS) is daytime health care at centers that provide nursing, therapy, activities and meals for people with certain chronic health conditions.
Multipurpose Senior Services Program (MSSP) provides social and health care coordination services for people age 65 and older.
Long-Term Care Facilities provide residential long-term custodial or skilled nursing care.

LTSS ENCOUNTERS	**Total**
CBAS Face-to-Faces (F2F) Completed assessments	11
LTC F2F Completed assessments	6
Provider Site Visits: SNFs 1; CBAS 8	9
LTSS Provider Calls (inbound and outbound calls to LTSS Providers)	147

Marketing Department
September and October 2015

Market Share





Website Analytics

Self-referral errors continue to inflate traffic numbers. Investigating and addressing issues with the Google Analytics tracking code that may be causing these errors is now on Appnovation's priority list, but is unlikely to be addressed in the near future due to scarce maintenance resources and more critical compliance priorities. We will resume reporting traffic analytics once the self-referral errors have been fixed.

Getting Started Videos

On Friday, October 16, SCFHP launched the first of its "Getting Started" videos.

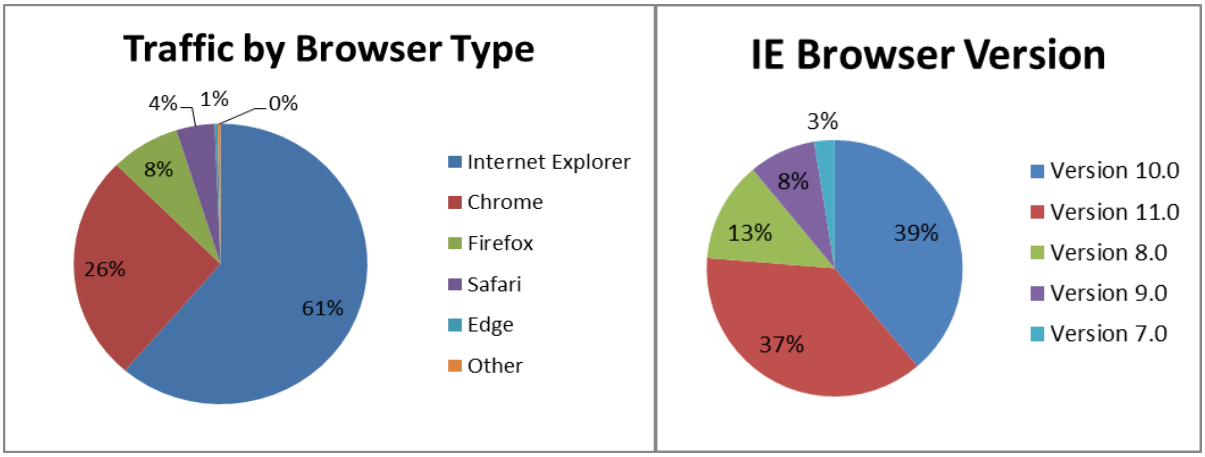
- **Video Views:** 128 in 2 weeks
- **Views with Subtitles:** English – 28, Chinese – 3, Vietnamese – 2
- **Average View Duration:** 1:13. Total length 1:49. YouTube indicates that this is average performance amongst all videos of a similar length.

Carousel Item Performance – October

Item	Pageviews
Welcome new members! Watch videos on getting started.	46
Cal MediConnect – Vietnamese	20
SCFHP Named One of Top 50 Call Centers in North America	15
Has Your Information Changed? Ask us how to update.	11
Get your flu shot now. Find out how!	7
A Pap Test Every 3 Years can help prevent cervical cancer.	1
Medi-Cal Members – You Can Quit Smoking. We can help!	3

Browser Technology

Google Analytics data show that the majority of website users use Internet Explorer (IE) as their web browser. Of those IE users, 24% are using an outdated browser version. Given this information, SCFHP will support IE versions 8 and 9 in the redesigned provider search feature.



Marketing Changes/Trends

Change/Trend	Implications/Actions
New and proposed state and federal regulations for health plan provider directories and provider search functions on websites – SB 137 was signed by Gov Brown.	Develop comprehensive plan to acquire, update, maintain, and publish provider information in compliance with all existing and upcoming regulatory requirements. Marketing has developed master matrix of current and proposed requirements. Affects multiple departments – Provider Ops, IT, QI, Pharmacy, Marketing.
Cal MediConnect: generating new enrollment once passive enrollment ends (12/1/2015 for Santa Clara County).	Plans need active outreach for new enrollment: to Medi-Cal members eligible for CMC but not enrolled, to Medi-Cal members aging into Medicare, to Medicare enrollees newly enrolled in Medi-Cal.
Members and Providers: Increasingly expect communications from health plans to be delivered/available in alternate and multiple electronic formats, e.g., social media, text, video, mobile.	Plans that have not already begun to implement these communication formats or platforms will increasingly move to incorporate the use of video, text messaging, social media (e.g. Facebook, LinkedIn), mobile, etc.
Members and Providers: Increasingly expect self-service options for interaction with a health plan.	Member portal implementation will enable expansion of self-service options.

Marketing Department
Website Analytics

Default Channel Grouping	Sessions	Comments/ Suggestions
Referral	**130.37%** ↑ 26,801 vs 11,634	Likely inflated due to self-referral error mentioned above. ~92% of this traffic is referred from our own website.
Direct	**28.83%** ↑ 35,025 vs 27,186	~75% of this traffic is providers accessing provider login
Organic Search	**-57.48%** ↓ 10,198 vs 23,984	SEO could be improved to increase organic search results by: • Creating a mobile-friendly site • Maintaining an active presence on social media • Adding alt attributes to images
Social	**-99.36%** ↓ 24 vs 3,739	Active presence on social media would increase social traffic
Email	**-99.94%** ↓ 2 vs 3,256	• A member portal could help improve email traffic, because it would allow SCFHP to communicate via email with members. • We could tag the SCFHP URL in email signatures using UTM parameters to ensure Google recognizes this as email traffic. • We could also consider tagging URLs used in provider memo email blasts to make sure Google is accurately capturing the clicks from these emails.
Paid Search	**-100%** ↓ 0 vs 9,764	Benchmark indicates that paid search makes up ~14% of traffic for other health insurance companies. Paid search is an affordable solution SCFHP could consider in the future.
Display	**-100%** ↓ 0 vs 4,976	This refers to banner and display ads. Not likely something that SCFHP will do.
(Other)	**-100%** ↓ 0 vs 4,519	N/A

Outreach and Events

COMPLETED EVENTS – 2015				
Date	**Event**	**Audience**	**Primary Messaging**	**Approximate # of Attendees**
10/10/2015	Open Air Health Fair – Berryessa Flea Market (sponsored by The Health Trust)	Adults, Families	Medi-Cal, Medi-Cal Expansion, Healthy Kids, MLTSS	5,000 total; est 600 booth visits
10/11/2015	Day on the Bay, A Multicultural Festival (sponsored by Supervisor Dave Cortese & Santa Clara County Parks)	Adults, Families	Medi-Cal, Medi-Cal Expansion, Healthy Kids, MLTSS,	8,000; est 700 booth visits
10/24/2015	2015 Senior Health and Wellness Fair (sponsored by County of Santa Clara Social Services Agency Department of Aging and Adult Services)	Seniors	Cal MediConnect, MLTSS	500 total; est 400 booth visits

Pharmacy Department
September and October 2015

Cal MediConnect (CMC) prior authorization (PA) volume and audit pass rates are consistent with year to date performance. There is continued work to improve Comprehensive Medication Review (CMR) for our Medication Therapy Management (MTM) program members.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CalMediConnect												
PA volume	144	266	289	305	214	198	233	210	186	286		
Approved PAs	91	158	181	207	140	148	172	127	122	212		
Denied PAs	30	59	63	50	38	31	35	43	32	42		
PA approval rate	63%	59%	63%	68%	65%	75%	74%	60%	66%	74%		
PA audit sample size	20	20	20	20	20	20	20	20	20	20		
PA audit pass	20	19	19	20	20	20	20	20	20	20		
PA audit fail	0	1	1	0	0	0	0	0	0	0		
PA pass rate	100%	95%	95%	100%	100%	100%	100%	100%	100%	100%		
MTM Eligible Members (YTD)	3,571	4,702	5,573	6,322	6,873	7,538	8,141	8,495	8,945			
MTM Qualified Members (YTD)	61	316	607	947	1,162	1,319	1,476	1,603	1,737			
MTM CMR Completion (YTD)	0	0	11	12	29	32	135	174	199			
MTM CMR Completion Rate (YTD)	0%	0%	2%	1%	2%	2%	9%	11%	11%			
Total claims	34,318	37,361	45,062	47,742	46,822	47,177	49,473	49,177	50,864	54,645		
Approved claims	18,772	19,240	22,951	23,992	23,845	23,818	25,156	25,251	26,471	28,801		
Rejected claims	15,546	18,121	22,111	23,750	22,977	23,359	24,317	23,926	24,393	25,844		
Claim approval rate	55%	51%	51%	50%	51%	50%	51%	51%	52%	53%		
Transition fills	1067	671	736	319	349	322	331	257	273	273		
PDE rejection rate	1.48%	1.24%	1.59%	1.98%	2.45%	2.78%	2.21%	1.99%	1.86%	1.76%		
Denied claims - % reviewed									43%	64%		
Formulary, PA, & ST posting	23-Dec	2-Feb	1-Mar	1-Apr	1-May	1-Jun	1-Jul	31-Jul	31-Aug	30-Sep	30-Oct	
Formulary upload to CMS	None	4-Feb	4-Mar	3-Apr	5-May	3-Jun	1-Jul	4-Aug	2-Sep	5-Oct		
Medi-Cal												
PA volume	1861	1706	1834	1964	1560	1552	1878	1451	1844	1474		
PA audit sample size	20	20	20	20	20	20	20	20	20	20		
PA audit pass	15	20	17	18	In Progress							
PA audit fail	5	0	3	2								
PA pass rate	75%	100%	85%	90%								

Prior Authorization Report:

Medi-Cal:
PA volume is slightly lower but within the variability of the year. Turnaround time compliance rates continue to be high.

	# of PAs	Approved	Closed	Denied	# of PAs not approved in time	% PAs approved w/in 24 hrs
May	1560	757	259	298	28	98.21%
June	1552	808	265	265	9	99.42%
July	1878	1115	292	426	36	98.08%
August	1451	722	246	331	23	98.41%
September	1844	877	293	479	23	98.75%
October	1474	736	284	375	1	99.93%

Cal Medi-Connect:
Prior authorization volume is the lowest of the year. We will continue to monitor this.

Month	# of PAs	Approved	Closed	Denied	# of PAs not approved in time	% PAs approved on time
May	214	140	14	38	0	100%
June	198	148	11	31	0	100%
July	233	172	12	35	0	100%
August	210	127	16	43	0	100%
September	186	122	13	32	0	100%
October	137	67	11	28	0	100%

Target KPI for turnaround time is 95%

Pharmacy Department
September 2015

Pharmacy Costs:

	Month	Jul-15	Aug-15	Sep-15	Running Year Avg
Medi-Cal (includes Agnews; includes HF starting Jan 2013)	Mbr Months	213,096	216,950	220,656	200,288
	Generic ($)	$ 2,548,627	$ 2,564,782	$ 2,599,803	$ 2,589,197
	Generic (vol)	135,166	134,837	138,400	133,771
	Brand ($)	$ 6,031,981	$ 6,047,134	$ 6,478,046	$ 5,288,343
	Brand (vol)	15,411	16,235	17,760	16,674
	Claim admin fee	$ 159,612	$ 160,136	$ 165,530	$ 159,472
	Total	**$ 8,740,219**	**$ 8,772,052**	**$ 9,243,379**	**$ 8,037,013**
	PMPM	**$ 41.02**	**$ 40.43**	**$ 41.89**	**$ 40.04**
	# of Rx PMPM	0.71	0.70	0.71	0.75
	% Generic ($)	31%	31%	30%	34%
	% Generic (vol)	90%	89%	89%	89%
	Avg cost/Rx	$ 58.04	$ 58.07	$ 59.19	$ 53.33
Healthy Kids	**Month**	**Jul-15**	**Aug-15**	**Sep-15**	**Running Year Avg**
	Mbr Months	4,496	4,598	4,375	4,663
	Generic ($)	$ 11,073	$ 11,954	$ 11,891	$ 13,729
	Generic (vol)	374	419	474	516
	Brand ($)	$ 12,347	$ 18,417	$ 24,811	$ 17,008
	Brand (vol)	53	61	74	85
	Claim admin fee	$ 453	$ 509	$ 581	$ 637
	Total	**$ 23,873**	**$ 30,879**	**$ 37,282**	**$ 31,374**
	PMPM	**$ 5.31**	**$ 6.72**	**$ 8.52**	**$ 6.73**
	# of Rx PMPM	0.09	0.10	0.13	0.13
	% Generic ($)	48%	40%	33%	46%
	% Generic (vol)	88%	87%	86%	86%
	Avg cost/Rx	$ 55.91	$ 64.33	$ 68.03	$ 53.12
CMC (January 2015 onwards)	**Month**	**Jul-15**	**Aug-15**	**Sep-15**	**Running Year Avg**
	Mbr Months	7,522	7,479	7,805	6,705
	Generic ($)	$ 652,884	$ 653,774	$ 722,343	$ 575,229
	Generic (vol)	20,926	20,795	21,784	19,070
	Brand ($)	$ 1,822,419	$ 1,972,180	$ 1,992,668	$ 1,786,610
	Brand (vol)	3,887	4,130	4,473	3,791
	Claim admin fee	$ 44,068	$ 44,267	$ 46,632	$ 40,600
	Total	**$ 2,519,371**	**$ 2,670,221**	**$ 2,761,643**	**$ 2,402,439**
	PMPM	**$ 334.93**	**$ 357.03**	**$ 353.83**	**$ 359.42**
	# of Rx PMPM	3.30	3.33	3.36	3.41
	% Generic ($)	27%	26%	28%	25%
	% Generic (vol)	84%	83%	83%	83%
	Avg cost/Rx	$ 101.53	$ 107.13	$ 105.18	$ 105.19

Claims Department
September 2015

COMPLIANCE: % OF CLAIMS PROCESSED WITHIN 64 CALENDAR DAYS (45 WORKING DAYS) (DMHC MINIMUM IS 95%)

2015	2014
September: 81%	September: 83%

*Claims received in July are considered new and are still in progress (claims received in July will be processed in September and October). SCFHP has 64 calendar days from the day of receipt to process these claims.

CLAIMS VOLUME

2015	2014
September: 53,651	September: 40,654

PERCENTAGE OF CLAIMS RECEIVED ELECTRONICALLY (EDI) (GOAL IS 85%)

2015	2014
September: 81%	September: 82%

AUTO ADJUDICATION PERCENTAGE (GOAL IS 85%)

2015	2014
September: 64%	September: 82%

ANALYST PRODUCTIVITY (# OF CLAIMS PROCESSED PER HOUR) (GOAL IS 12 PER HOUR)

2015	2014
September: 16	September: 11

AGE OF PENDED CLAIMS AT MONTH END (CLAIMS MUST BE PROCESSED WITHIN 64 CALENDAR DAYS)

2015		2014	
0-30 DAYS	OVER 30 DAYS	0-30 DAYS	OVER 30 DAYS
September: 10,578	4,237*	September: 8,652	6,533*

*Claims over 30 calendar days old are **not** out of compliance. It is simply a claims aging measure designed to identify which claims need immediate resolution. SCFHP has 64 calendar days from the day of receipt of the claim to either pay or deny the claim.

Claims Department
October 2015

COMPLIANCE: % OF CLAIMS PROCESSED WITHIN 64 CALENDAR DAYS (45 WORKING DAYS) (DMHC MINIMUM IS 95%)

2015	2014
October: 79%	October: 72%

*Claims received in October are considered new and are still in progress (claims received in October will be processed in October and November). SCFHP has 64 calendar days from the day of receipt to process these claims.

Note:
The percent of claims processed within 45 working days in 3rd quarter 2015 is 97%

CLAIMS VOLUME

2015	2014
October: 57,486	October: 43,304

PERCENTAGE OF CLAIMS RECEIVED ELECTRONICALLY (EDI) (GOAL IS 85%)

2015	2014
October: 80%	October: 83%

AUTO ADJUDICATION PERCENTAGE (GOAL IS 85%)

2015	2014
October: 65%	October: 69%

ANALYST PRODUCTIVITY (# OF CLAIMS PROCESSED PER HOUR) (GOAL IS 12 PER HOUR)

2015	2014
October: 14	October: 14

AGE OF PENDED CLAIMS AT MONTH END (CLAIMS MUST BE PROCESSED WITHIN 64 CALENDAR DAYS)

2015		2014	
0-30 DAYS	OVER 30 DAYS	0-30 DAYS	OVER 30 DAYS
October: 12,458	3,991*	October: 7,244	5,575*

*Claims over 30 calendar days old are **not** out of compliance. It is simply a claims aging measure designed to identify which claims need immediate resolution. SCFHP has 64 calendar days from the day of receipt of the claim to either pay or deny the claim.

Medical Management Department
September 2015

Medi-Cal, Healthy Kids and Agnews, Cal MediConnect – Inpatient and Outpatient Prior Authorizations

Inpatient Authorizations by Line of Business													
Month	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**April-15**	**May-15**	**June-15**	**July 15**	**Aug-15**	**Sept-15**
Agnews	3	1	0	2	2	1	1	0	1	0	0	0	1
Healthy Kids	2	4	2	1	3	0	3	4	1	1	1	1	1
Medi-Cal	246	245	186	233	213	249	289	300	313	388	412	377	388
Cal MediConnect											587	254	237
Total	251	250	188	236	218	250	293	304	315	389	1000	632	627

Outpatient Authorizations by Line of Business													
Month	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**April-15**	**May-15**	**June-15**	**July 15**	**Aug-15**	**Sept-15**
Agnews	1	4	0	4	9	11	8	7	4	4	8	6	4
Healthy Kids	1	2	2	1	3	0	1	12	2	1	3	0	3
Medi-Cal	623	682	474	506	518	525	604	594	554	558	596	657	538
Cal MediConnect											258	293	266
Total	625	688	476	511	530	536	613	613	560	563	865	956	811

Outpatient & Inpatient Authorization total by Line of Business													
Month	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**April-15**	**May-15**	**June-15**	**July-15**	**Aug-15**	**Sept-15**
Agnews	4	5	0	6	11	12	9	7	5	4	8	6	5
Healthy Kids	3	6	4	2	6	0	4	16	3	2	4	1	4
Medi-Cal	869	927	660	739	731	774	893	894	867	946	1004	1034	926
Cal MediConnect											845	547	503
Total	**876**	**938**	**664**	**747**	**748**	**786**	**906**	**917**	**875**	**1,797**	**1,861**	**1,588**	**1,438**

Prior Authorization Turnaround Time Medi-Cal and Healthy Kids Target KPI = 95%

Urgency	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015
Routine	95%	97%	95%	94%	97%	97%
Urgent	99%	94%	98%	97%	97%	98%
Retro	100%	98%	96%	100%	98%	100%

Provider Services Department
October 2015

Encounters /Provider Calls by Provider Type

Answer Options	Response Percent	Response Count
Agnews	0.6%	1
Arcwell Administration	0.6%	1
Arcwell / IPC Healthcare PCP	0.6%	1
ASC	0.0%	0
Audiology & Hearing Aids	0.6%	1
Autism	0.0%	0
CBAS	3.1%	5
Chiropractic	0.0%	0
CHME	0.0%	0
Community Clinics	0.0%	0
Dialysis	0.0%	0
DME/MS/Orth/Proth	0.6%	1
Home Health	2.5%	4
Home Infusion	0.6%	1
Hospice	0.6%	1
Hospital	1.2%	2
Laboratory	0.0%	0
LTC PCP	1.2%	2
Mental Health	0.0%	0
Mid-levels	0.0%	0
MSSP	2.5%	4
Non-contracted providers	3.1%	5
NT 10 PCP	1.9%	3
NT 10 Specialists	4.9%	8
PAMF	1.2%	2
PMG - PCP and SPEC	4.3%	7
Premier Care - PCP and SPEC	0.6%	1
PT/OT/ST	0.0%	0
Radiology	0.6%	1
Sleep Disorder	0.0%	0
SNF	61.1%	99
Stanford / LPCH	1.2%	2
Transportation	1.9%	3
Urgent Care	0.0%	0
VMC Clinics	4.3%	7
Wound Care	0.0%	0
	answered question	162

Encounters by Category

Reason		
Answer Options	**Response Percent**	**Response Count**
Claims	30.9%	50
Authorization	9.9%	16
Eligibility User Name/Password	1.2%	2
Connect User Name/Password	7.4%	12
Eligibility or Benefits for a Member	3.7%	6
New Provider Orientation	0.6%	1
Provider Education - Operations	43.2%	70
Provider Request for Member Reassignment	0.6%	1
Billing/Member Refund	0.6%	1
ICD-10	1.9%	3
Comments		26
	answered question	162

Provider Database

Oct-15	
Providers Added	125
Providers Term	28
Other changes*	247
Lic verification	166
W-9	76

*Open, close panels, changed address, add LOB, add network, On Call changes.

Quality Improvement
September and October 2015

Potential Quality Issues

Potential Quality of Care Issue - A Potential Quality of Care Issue (PQI) - is a means a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be confirmed without additional review. Such issues PQIs must be referred to the Quality Improvement Department for review. Not all PQIs are found to be quality of care problems.

Fifty cases reported in September/October
One case at Level IV
One case at Level III
Six cases at Level I
One case Level 0
Forty three cases further investigation is required

PQI Levels

Level 0 – Not a SCFHP member
Level I – No quality of care or quality of service issue identified noted.
Level II – Opportunity for improvement in care, service, or system is present/identified.
Level III – Unacceptable care and/or service identified.
Level IV – Immediate Jeopardy

Facility Site Review

Facility Site Review is a means of assessing a primary care provider's ability to meet state defined standards for the ability to;

- Provide appropriate primary health care services;
- Carry out processes that support continuity and coordination of care;
- Maintain patient safety standards and practices; and
- Operate in compliance with all applicable local, state, and federal laws and regulations.

Five site reviews conducted in September

Five site reviews conducted in October

Member Services Department
September 2015

Member Services Department – All Calls

	September 2015	September 2014	Change	Target KPI *
Total Inbound Calls	19,475	19,084	+2%	----------
Average Talk Time	4:33 minutes	4:36 minutes	-3 seconds	----------
Average Speed of Answer	36 seconds	59 seconds	-23 seconds	<30 seconds
Service Level	70.5%	57%	+13.5%	80% in <30 seconds
Abandonment Rate	4%	6.7%	-2.7%	<5%
Average Hold Time	37 seconds	23 seconds	+14 seconds	≤ 25 seconds

*KPI – Key Performance Indicator

Medi-Cal / Healthy Kids Calls

	September 2015	September 2014	Change	Target KPI *
Total Inbound Calls	16,911	19,084	-11%	----------
Average Talk Time	4:19 minutes	4:36 minutes	-17 seconds	----------
Average Speed of Answer	46 Seconds	59 seconds	-13 seconds	<30 seconds
Service Level	67%	57%	+10%	80% in <30 seconds
Abandonment Rate	4.2%	6.7%	-2.5%	<5%
Average Hold Time	37 seconds	23 seconds	+14 seconds	≤ 25 seconds

Cal-Medi-Connect Calls

	September 2015	September 2014	Change	Target KPI *
Total Inbound Calls	2,564	--------	--------	----------
Average Talk Time	5:35 minutes	--------	--------	----------
Average Speed of Answer	12.3 seconds	--------	--------	<30 seconds
Service Level	80%	--------	--------	80% in <30 seconds
Abandonment Rate	2.5%	--------	--------	<5%
Average Hold Time	40 seconds	-	--------	≤ 120 seconds

Member Services Department
October 2015

Member Services Department – All Call Types

	October 2015	October 2014	Change	Target KPI *
Total Inbound Calls	21,110	20,611	+2.4%	----------
Average Talk Time	4:45 minutes	4:37 minutes	+8 seconds	----------
Average Speed of Answer	45 seconds	57 seconds	-12 seconds	<30 seconds
Service Level	65%	56%	+9%	80% in <30 seconds
Abandonment Rate	4.5%	4.2%	-0.3%	<5%
Average Hold Time	34 seconds	22 seconds	+12 seconds	≤ 25 seconds

*KPI – Key Performance Indicator

Medi-Cal / Healthy Kids Calls

	October 2015	October 2014	Change	Target KPI *
Total Inbound Calls	18,237	201611	+2.4%	----------
Average Talk Time	4:01minutes	4:37 minutes	+8 seconds	----------
Average Speed of Answer	60 Seconds	57 seconds	-12 seconds	<30 seconds
Service Level	57.3%	56%	+8%	80% in <30 seconds
Abandonment Rate	5.2%	4.2%	-0.3%	<5%
Average Hold Time	33 seconds	22 seconds	+12 seconds	≤ 25 seconds

Cal-Medi-Connect Calls

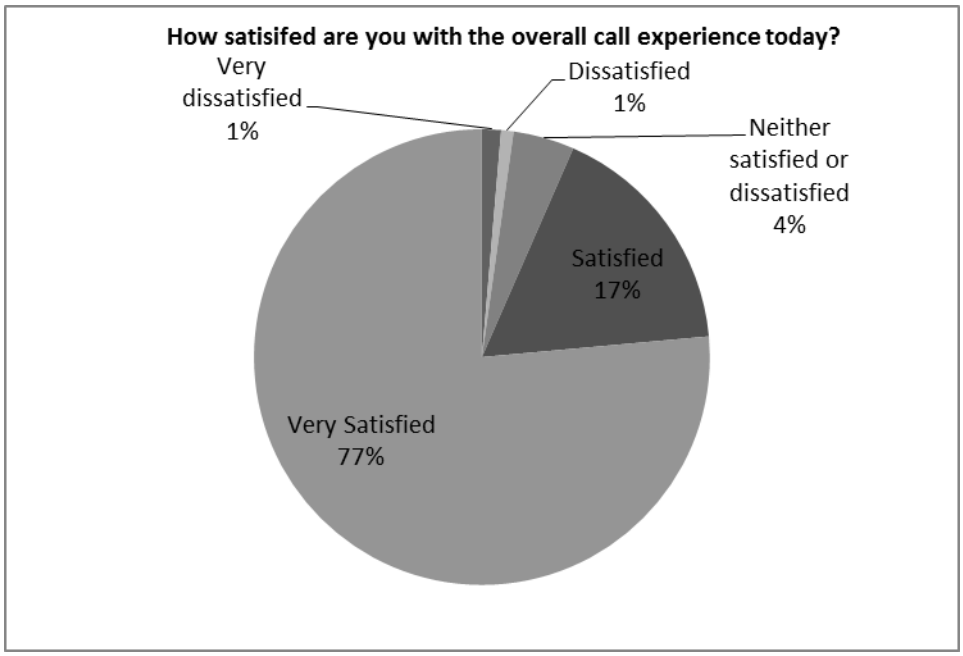
	October 2015	October 2014	Change	Target KPI *
Total Inbound Calls	2,873	--------	--------	----------
Average Talk Time	5:14 minutes	--------	--------	----------
Average Speed of Answer	14 seconds	--------	--------	<30 seconds
Service Level	80.3%	--------	--------	80% in <30 seconds
Abandonment Rate	2.7%	--------	--------	<5%
Average Hold Time	40 seconds	-	--------	≤ 120 seconds

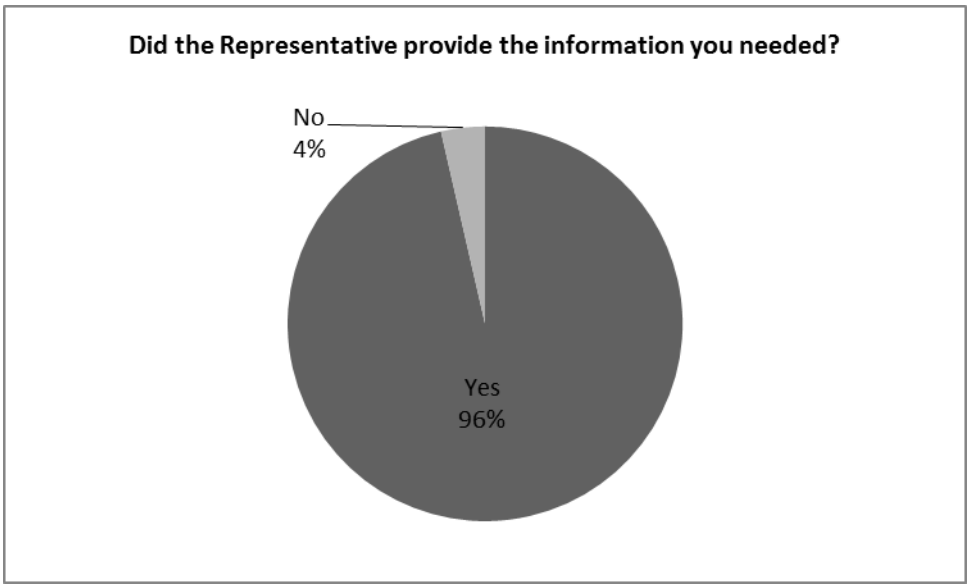
Member Services Department
September and October 2015

After Call Satisfaction Survey Analysis

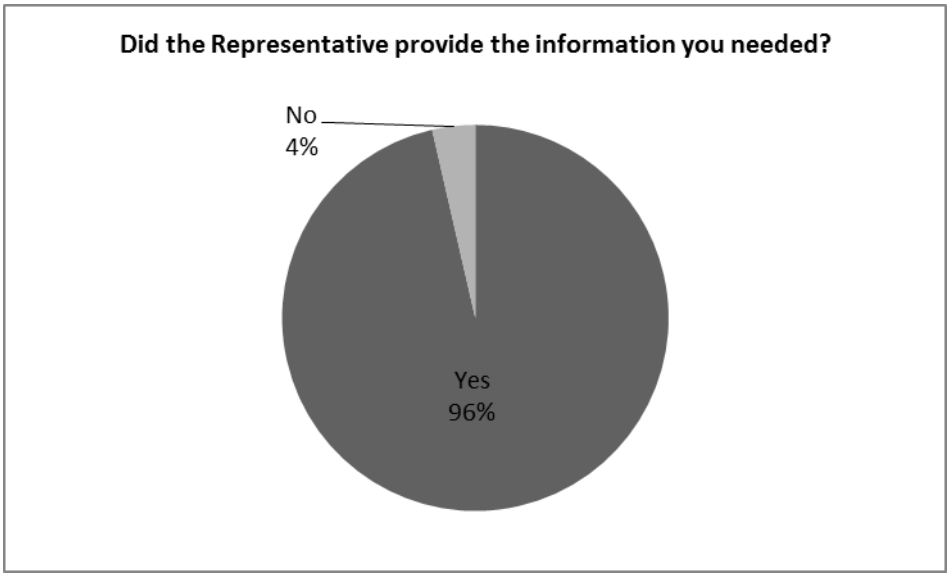
Satisfied or Very Satisfied = 94%
Response rate for the month 9.7%

MEMBER SATISFACTION RATING

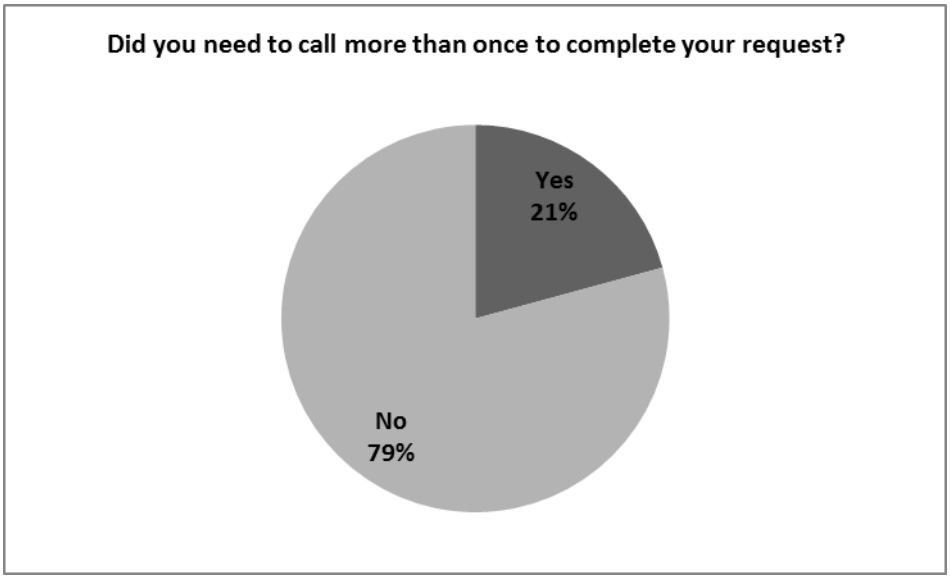




TRAINING & DEVELOPMENT RATING



ONE CALL RESOLUTION RATING



Healthy Kids Program
September 2015

- Healthy Kids Application Activity: 114 applications processed
- Healthy Kids Renewal Applications Activity: 196 renewal applications processed
- Healthy Kids Renewal Applications Families Transitioned to Medi-Cal for Families: 19 Families and 27 Children

Healthy Kids Program
October 2015

- Healthy Kids Application Activity: 123 applications processed
- Healthy Kids Renewal Applications Activity: 208 renewal applications processed
- Healthy Kids Renewal Applications Families Transitioned to Medi-Cal for Families: 36 Families and 36 Children