Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, February 28, 2019, 11:30 AM - 1:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Approved

Members Present
Brian Darrow, Chair
Dolores Alvarado
Liz Kniss
Linda Williams

Members Absent
Bob Brownstein

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer *(via telephone)*
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Neal Jarecki, Controller
Sharon Valdez, VP, Human Resources
Benjamin McLarin, Director, Infrastructure & Support
Rita Zambrano, Executive Assistant

Other Present
Daphne Annett, Burke, Williams & Sorenson, LLP *(via telephone)*

1. **Roll Call**

   Brian Darrow, Chair, called the meeting to order at 11:30 am. Roll call was taken and a quorum was not established.

2. **Public Comment**

   There were no public comments.

3. **Adjourn to Closed Session**

   a. **Existing Litigation**
   The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding CalPERS Case No. 2017-1114; OAH Case No. 2018051223.

Liz Kniss and Dolores Alvarado joined the meeting at 11:43 am.

b. Existing Litigation
The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding CalPERS Case No. 2017-1115; OAH Case No. 2018051029.

Mr. Darrow recused himself.

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

Mr. Darrow rejoined the meeting.

4. Report from Closed Session

Mr. Darrow reported the Executive/Finance Committee met in Closed Session to discuss Items 4(a) & (b). The Committee authorized counsel to explore options for a potential settlement of the Walsh/Gellman claims in a manner consistent with previous direction of the Board.

Ms. Tomcala noted that the Committee discussed Item 4 (c).

5. Meeting Minutes

The minutes of the November 15, 2018 Executive/Finance Committee were reviewed.

It was moved, seconded, and the November 15, 2018 Executive/Finance Committee Minutes were **unanimously approved.**

6. November and December 2018 Financial Statements

Neal Jarecki, Controller, presented the November and December 2018 financial statements. The November statements reflected a current month net loss of $100 thousand ($705 thousand unfavorable to budget) and a year-to-date net surplus of $148 thousand ($1.1 million unfavorable to budget). The December statements reflected a current month net surplus of $7.9 million ($7.1 million favorable to budget) and year-to-date net surplus of $8.1 million ($6.0 million favorable to budget).

Mr. Jarecki provided an overview of November results and elaborated on the December results. He noted that enrollment declined to 253,735 members. Medi-Cal enrollment has declined since October 2016, largely in the Non-Dual Adult and Child categories of aid, and a continued decline was assumed in the annual budget. CMC membership has grown modestly over the past few months due to continued outreach efforts. Revenue reflected a favorable current month variance of $7.6 million (13.2%) largely due to additional accruals from DHCS. Medical expenses reflected an unfavorable current month variance of $3.9 million (5.2%) due largely to increased utilization and higher pharmacy costs. Administrative expenses reflected a favorable current month variance of $67 thousand (1.5%) and a favorable year-to-date variance of $627 thousand (2.2%). The balance sheet reflected a current ratio of 1.26:1 versus the minimum required by DMHC of 1.0:1. Tangible Net Equity (TNE) was $186.1 million, or 537.4% of the minimum required by DMHC of $34.6 million. YTD Capital Investments of $5.0 million were made and largely represented building renovation costs.

It was moved, seconded, and the November and December 2018 Financial Statements were **unanimously approved.**

7. Reappointment of External Auditor

Mr. Jarecki noted that the Plan's current independent auditing firm is Moss Adams LLP. Moss Adams audits the majority of the local health plans and has a prominent healthcare practice. Moss-Adams is in the third year of its current engagement. Management recommends and seeks the Committee's approval to extend the term of engagement an additional two years with no change to the current pricing.

It was moved, seconded, and the reappointment of Moss Adams as the Plan's External Auditor was **unanimously approved.**

8. Compliance Update

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, discussed the 2018 CMS Program Audit. She presented the CMS Audit Activity Tracker, reflecting progress in completion of the Corrective Action Plans (CAPs) implemented in response to the Immediate Corrective Action Required Conditions (ICARs) and Corrective Action Required Conditions (CARs) identified by CMS.

Most tasks are complete or substantially on track. However, Ms. Larmer has some concerns about the Beacon implementation and some of the reports that are not yet being produced in the required format. . The Plan has implemented work-around processes to ensure that Compliance receives all required data while implementation issues continue to be addressed. Ms. Larmer also noted some other general areas of concern, including staffing, and in particular, the ability of staff to sustain long term the effort required to manage CMS Program Audit remediation along with the demands of simultaneous, multiple state audits and daily work.

Ms. Larmer noted that, as anticipated, the Plan was assessed a civil monetary penalty in the amount of $39 thousand in connection with the CMS Program Audit. The penalty was based on two Conditions, which had the potential to impact a total of 440 and 480 members, respectively. The Plan mitigated the amount of the penalty by demonstrating effective remedial actions that avoided impact for several of the members.

Ms. Larmer further noted that the California State Auditor's office selected three plans for review in its recent audit, and there were no recommendations or findings related to SCFHP.

It was moved, seconded, and the Compliance Update was **unanimously approved.**

9. Network Detection and Prevention Report

Benjamin McLarin, Director of Infrastructure and Support, reported on firewall intrusion, detection, and prevention efforts.

It was moved, seconded, and unanimously approved to accept the Network Detection & Prevention Report.

10. CEO Update

Christine Tomcala, Chief Executive Officer, reported the percentage of membership attributed to the Community Clinics, noting that 50% of the Medi-Cal membership is with Valley Health Plan and within Valley Health Plan, 35% of that membership is with the Community Clinics (approximately 42,000 Medi-Cal members). Valley Medical Center clinics serve 63% (approximately 75,000 members).

Ms. Tomcala announced the Plan has achieved 3-year NCQA Accreditation for the Cal MediConnect line of business. She also noted this is component of the Team Incentive Program compensation for 2018-19, worth a 1% payout to employees next fall.

Ms. Tomcala updated the Committee on the status of locating space for a Satellite Office Community Resource Center.

Ms. Tomcala further noted she and Laurie Nakahira, Chief Medical Officer, are meeting with each of the community clinics to discuss funding requests, and to give Dr. Nakahira the opportunity to visit each clinic and discuss opportunities where we can collaborate.

Dolores Alvarado left the meeting at 1:10 pm.

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

11. Adjournment

The meeting was adjourned at 1:10pm.

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Brian Darrow, Chair

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Eight Months Ended February 28, 2019

Agenda

Santa Clara Family Health Plan.

Financial Highlights

	MTD		YTD	
Revenue	$83 M		$681 M	
Medical Expense (MLR)	$78 M	94.0%	$635 M	93.2%
Administrative Expense (% Rev)	$4.5 M	5.4%	$37.2 M	5.5%
Other Income/Expense	$338,748		$1,771,734	
Net Surplus (Loss)	**$824,146**		**$10,761,915**	
Cash on Hand			$271 M	
Receivables			$492 M	
Total Current Assets			$771 M	
Current Liabilities			$611 M	
Current Ratio			1.26	
Tangible Net Equity			$189 M	
% of DMHC Requirements			**540.4%**	

Financial Highlights

Net Surplus (Loss)	Month: Surplus of $0.8M is -$0.4M or -32.4% unfavorable to budget of $1.2M. YTD: Surplus of $10.8M is $6.9M or 179.5% favorable to budget of $3.9M.
Enrollment	Month: Membership was 251,199 (526 or 0.2% favorable budget of 250,673). YTD: Member months was 2.0M (1.7K or 0.1% favorable budget of 2.0M).
Revenue	Month: $82.8M ($2.3M or 2.8% favorable to budget of $80.6M) YTD: $681.0M ($34.1M or 5.3% favorable to budget of $646.9M)
Medical Expenses	Month: $77.9M (-$3.0M or -4.0% unfavorable to budget of $74.9M) YTD: $634.8M (-$30.3M or -5.0% unfavorable to budget of $604.5M)
Administrative Expenses	Month: $4.5M (-$80.2K or -1.8% unfavorable to budget of $4.4M) YTD: $37.2M ($0.6M or 1.7% favorable to budget of $37.8M)
Tangible Net Equity	TNE was $188.8M (540.4% of minimum DMHC requirements of $34.9M)
Capital Expenditures	YTD Capital Investment of $4.8M vs. $11.3 annual budget was primarily due to building renovations.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment has decreased since June 30, 2018 by 8,276 or -3.2%, in line with budgeted expectation.
- As detailed on page 7, much of the Medi-Cal enrollment decline has been in the Medi-Cal Non-Dual Adult and Child categories of aid. Medi-Cal Dual enrollment has been stable. CMC enrollment has grown due to outreach efforts.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the beginning of the fiscal year by -3.5%. Over the past 12 months, enrollment has decreased 5.6%.
  - CMC membership increased since the beginning of the fiscal year by 4.1%. Over the past 12 months, enrollment has increased 5.4%.
  - Healthy Kids membership increased since the beginning of the fiscal year by 5.6%. Over the past 12 months, enrollment has increased 3.8%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of February 2019			For Eight Months Ending February 28 2019					
	Actual	Budget	Variance	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	240,010	239,964	0.0%	1,950,188	1,951,595	(1,407)	-(0.1%)	2,070,618	-(5.8%)
Cal Medi-Connect	7,814	7,755	0.8%	61,148	60,920	228	0.4%	59,183	3.3%
Healthy Kids	3,375	2,954	14.3%	26,277	23,362	2,915	12.5%	21,009	25.1%
Total	**251,199**	**250,673**	**0.2%**	**2,037,613**	**2,035,877**	**1,736**	**0.1%**	**2,150,810**	**-(5.3%)**

Santa Clara Family Health Plan Enrollment By Network
February 2019

Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	30,151	13%	7,814	100%	400	12%	38,365	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	119,605	50%	-	0%	1,443	43%	121,048	48%
Palo Alto Medical Foundation	7,009	3%	-	0%	92	3%	7,101	3%
Physicians Medical Group	43,107	18%	-	0%	1,179	35%	44,286	18%
Premier Care	14,911	6%	-	0%	261	8%	15,172	6%
Kaiser	25,227	11%	-	0%	-	0%	25,227	10%
Total	**240,010**	**100%**	**7,814**	**100%**	**3,375**	**100%**	**251,199**	**100%**
Enrollment at June 30, 2018	248,776		7,503		3,196		259,475	
Net Δ from Beginning of FY19	-3.5%		4.1%		5.6%		-3.2%	

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

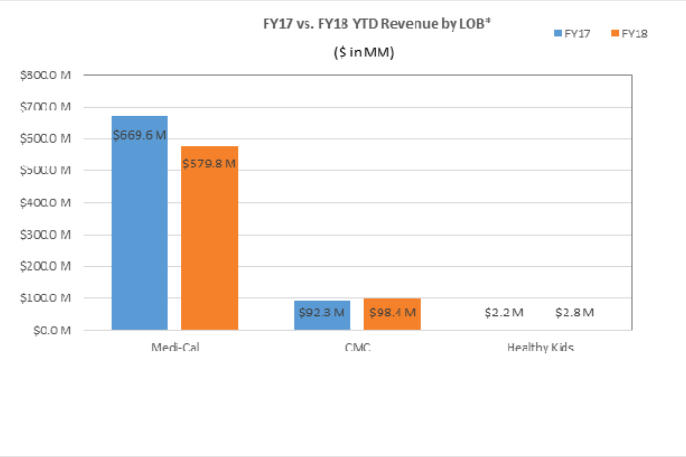
Enrollment By Aid Category

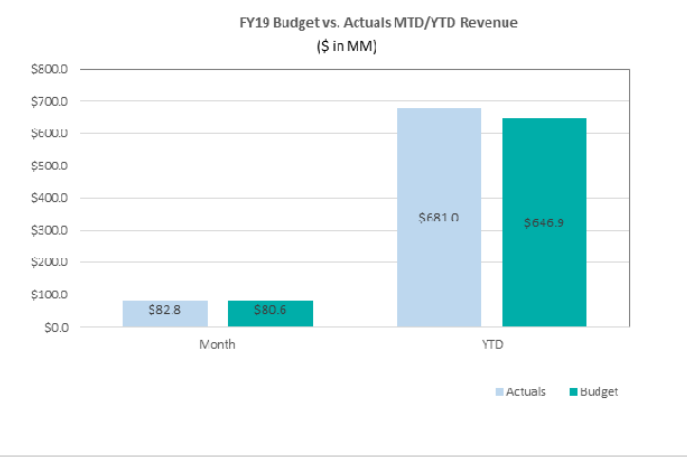
SCFHP TRENDED ENROLLMENT BY COA YTD FEB-19

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01	2019-02
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,185	27,001	26,652	26,568	26,354	26,213	26,175	25,954	25,846
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,238	99,369	98,316	98,255	97,518	96,830	96,330	95,155	95,177
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,963	10,909	10,815	10,887	10,869	10,887	10,923	10,901	10,963
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,750	10,742	10,679	10,635	10,611	10,624	10,631	10,629	10,579
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959	73,601	73,398	73,186	72,075	72,223
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14	13	12	11	11	9	9
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	384	382	384	387	379	377	372	371	376
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**	**219,343**	**218,340**	**217,628**	**215,093**	**215,173**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385	382	385	390	379	373	376
	Aged (21 Over)																					
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,811	22,919	22,928	22,984	22,963	22,897	22,893	22,765	22,728
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485	521	533	538	586	556	529
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2	2	1	1	1	2	1
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,295	1,316	1,323	1,292	1,268	1,233	1,208	1,209	1,203
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**	**25,150**	**25,059**	**25,067**	**24,905**	**24,837**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**	**242,695**	**239,998**	**240,010**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**	**3,345**	**3,252**	**3,375**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386	7,383	7,407	7,484	7,540	7,616
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222	214	218	218	211	210	198
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**	**7,695**	**7,750**	**7,814**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**	**253,735**	**251,000**	**251,199**

Revenue

- Current month revenue of $82.8M is $2.3M or 2.8% favorable to budget of $80.6M. YTD revenue of $681.0M is $34.1M or 5.3% favorable to budget of $646.9M. This month's variances were due to several factors including:
  - FY19 Prop 56 accrual increased revenue by $1.8M (with an offsetting increase to medical expense).
  - Non-Dual revenue higher than budget by $1.5M favorable due to a favorable volume variance and a rate increase retro to July 1.
  - Higher BHT and Maternity kick volumes versus budget yielded a $745K favorable variance.





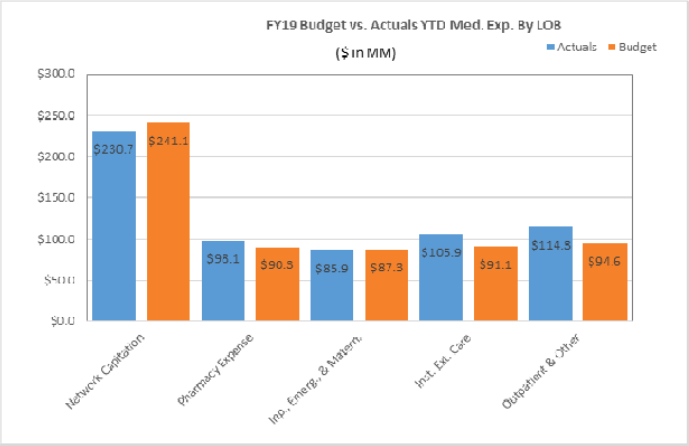
	FY17 vs. FY18 YTD Revenue by LOB*			
	FY17	FY18	Variance	
Medi-Cal	$669.6 M	$579.8 M	($89.8 M)	-13.4%
CMC	$92.3 M	$98.4 M	$6.1 M	6.6%
Healthy Kids	$2.2 M	$2.8 M	$0.6 M	28.9%
Total Revenue	**$764.1 M**	**$681.0 M**	**($77.0 M)**	**-10.1%**

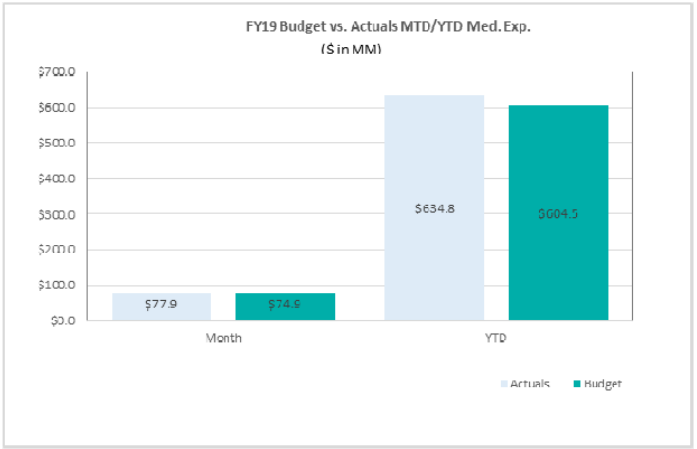
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$82.8	$80.6	$2.3	2.8%
YTD	$681.0	$646.9	$34.1	5.3%

*IHSS was included in FY18 revenue through 12/31/17

Medical Expense

- Current month medical expense of $77.9M is $3.0M or 4.0% unfavorable to budget of $74.9M. YTD medical expense of $634.8M is $30.3M or 5.0% unfavorable to budget of $604.5M.The current month variances were due to a variety of factors, including:
  - FY19 Prop 56 accrual increased medical expense by $1.8M (with offsetting an increase to revenue).
  - Increased Inpatient and LTC expenses yielded an unfavorable variance of $1.1M.
  - Pharmacy costs exceeded budget by $0.3M due to increased utilization, higher specialty drug costs and increased branded usage.





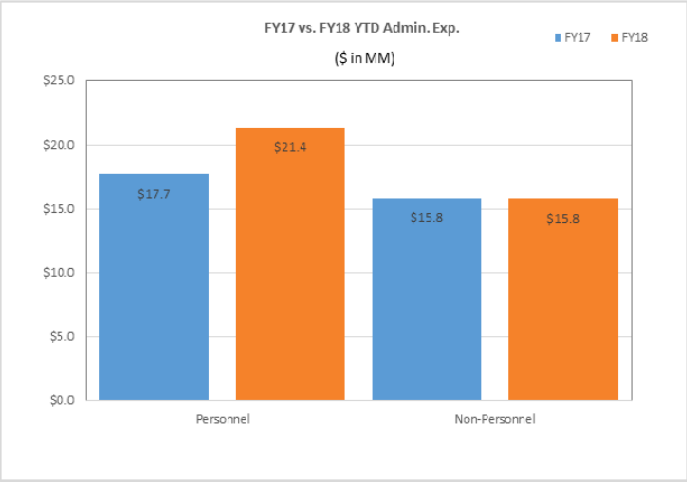
	FY19 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$230.7	$241.1	$10.4	4.5%
Pharmacy	$98.1	$90.3	-$7.8	-7.9%
Inp., Emerg., & Matern.	$85.9	$87.3	$1.4	1.7%
Inst. Ext. Care	$105.9	$91.1	-$14.7	-13.9%
Outpatient & Other	$114.3	$94.6	-$19.7	-17.2%
Total Medical Expense	**$634.8**	**$604.5**	**-$30.3**	**-4.8%**

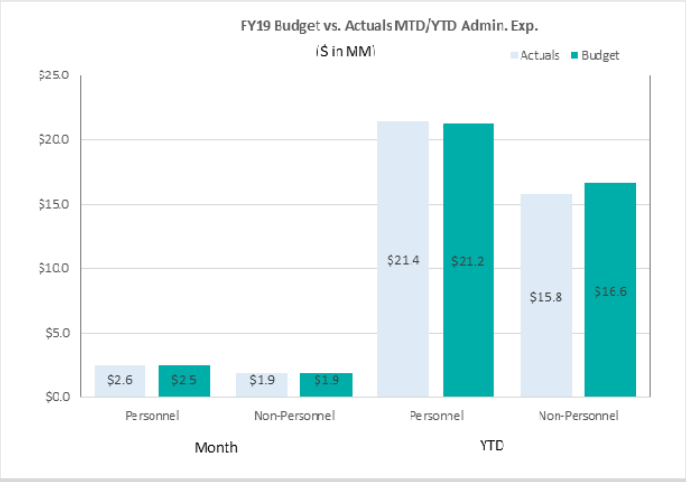
	FY19 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$77.9	$74.9	$3.0	4.0%
YTD	$634.8	$604.5	$30.3	5.0%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $4.5M is $80.2K or 1.8% unfavorable to budget of $4.4M. YTD admin expense of $37.2M is $0.6M or -1.7% favorable to budget of $37.8M. The current month variances were due to a variety of factors, including:
  - Personnel expenses were 0.8% or $100K over budget due to the timing of hiring staff.





	FY17 vs. FY18 YTD Admin. Exp.			
	FY17	FY18	Variance	
Personnel	$17.7	$21.4	$3.7	20.8%
Non-Personnel	$15.8	$15.8	-$0.1	-0.4%
Total Administrative Expense	**$33.6**	**$37.2**	**$3.6**	**10.8%**

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.6	$2.5	$0.1	2.8%
	Non-Personnel	$1.9	$1.9	$0.0	0.5%
	MTD Total	**$4.5**	**$4.4**	**$0.1**	**1.8%**
YTD	Personnel	$21.4	$21.2	$0.2	0.8%
	Non-Personnel	$15.8	$16.6	-$0.8	-4.8%
	YTD Total	**$37.2**	**$37.8**	**-$0.6**	**-1.7%**

Balance Sheet

- Current assets totaled $770.5M compared to current liabilities of $611.2M, yielding a current ratio (Current Assets/Current Liabilities) of 1.26:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash as of February 28, 2019 increased by $47.4M compared to the cash balance as of year-end June 30, 2018.
- Current Cash & Equivalent components and yields were as follows:

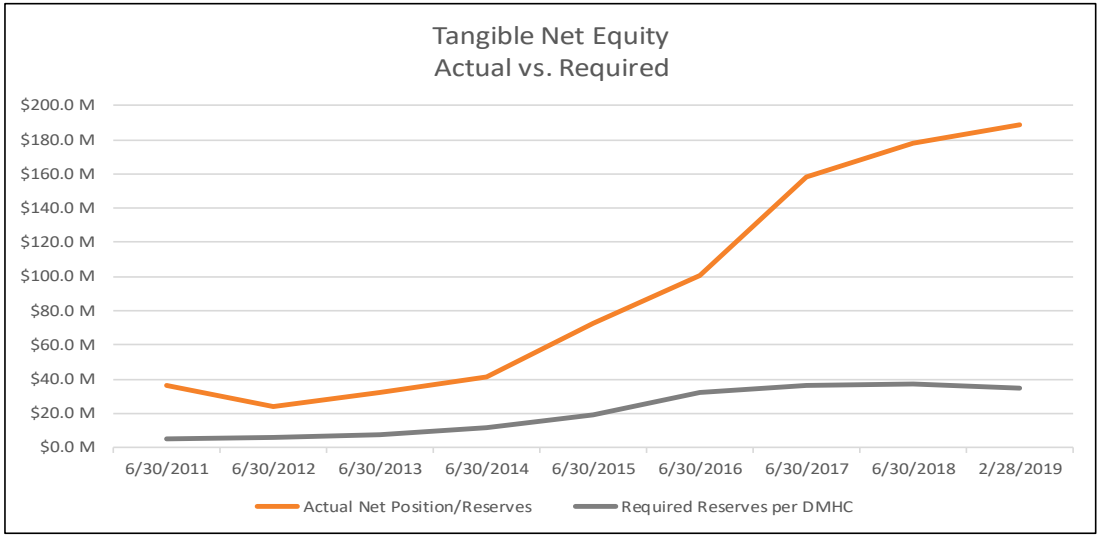
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$78,322,042	1.95%	$100,000	$910,571
Cash & Equivalents				
Bank of the West Money Market	$432,788	1.34%	$5,199	$59,357
Wells Fargo Bank Accounts	$191,749,737	2.27%	$348,785	$1,853,911
	$192,182,525		$353,984	$1,913,269
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$13	$335
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$270,810,416**		**$453,997**	**$2,824,175**

Tangible Net Equity

- TNE was $188.8M in February 2019 or 540.4% of the most recent quarterly DMHC minimum requirement of $34.9M. TNE trends for SCFHP are shown below.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of: February 28, 2019

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	6/30/2018	2/28/2019
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$188.8 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$34.9 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$69.9 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	540.4%



Reserves Analysis

SCFHP RESERVES ANALYSIS February 2019	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	188,777,778
Current Required TNE	34,931,993
Excess TNE	**153,845,785**
Required TNE %	540.4%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	122,261,975
500% of Required TNE (High)	174,659,965
TNE Above/(Below) SCFHP Low Target	**$66,515,802**
TNE Above/(Below) High Target	**$14,117,813**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	270,810,416
Less Pass-Through Liabilities	
Other Pass-Through Liabilities	(15,441,746)
Total Pass-Through Liabilities	**(15,441,746)**
Net Cash Available to SCFHP	$255,368,670
SCFHP Target Liability	
45 Days of Total Operating Expense	(120,210,934)
60 Days of Total Operating Expense	(160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$135,157,736**
Liquidity Above/(Below) High Target	**$95,087,425**

In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Capital Expenditures

- YTD Capital investments of $6M, largely to complete the renovation of the new building, were comprised of the following:

Expenditure	YTD Actual	Annual Budget	
Building	$4,864,446	$ 7,874,631	*
Systems	0	925,000	
Hardware	361,853	1,550,000	
Software	337,000	593,000	
Furniture and Fixtures	0	0	
Automobile	0	0	
Leasehold Improvements	0	0	
TOTAL	**$5,563,299**	**$10,942,631**	

** Includes FY18 budget rollover of $6,628,131*

Financial Statements

Income Statement

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Income Statement for Eight Months Ending February 28, 2019

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 69,722,740	84.2%	$ 67,893,804	84.3%	$ 1,828,935	2.7%	$ 579,757,211	85.1%	$ 548,958,553	84.9%	$ 30,798,658	5.6%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,468,030	3.0%	2,556,768	3.2%	(88,738)	-3.5%	19,121,095	2.8%	20,084,885	3.1%	(963,789)	-4.8%
CMC MEDICARE	10,305,786	12.4%	9,827,779	12.2%	478,007	4.9%	79,303,312	11.6%	75,396,306	11.7%	3,907,006	5.2%
TOTAL CMC	12,773,816	15.4%	12,384,547	15.4%	389,269	3.1%	98,424,408	14.5%	95,481,191	14.8%	2,943,217	3.1%
HEALTHY KIDS	352,700	0.4%	306,921	0.4%	45,779	14.9%	2,802,390	0.4%	2,427,312	0.4%	375,078	15.5%
TOTAL REVENUE	**$ 82,849,255**	**100.0%**	**$ 80,585,271**	**100.0%**	**$ 2,263,984**	**2.8%**	**$ 680,984,008**	**100.0%**	**$ 646,867,055**	**100.0%**	**$ 34,116,953**	**5.3%**
MEDICAL EXPENSE												
MEDI-CAL	$ 66,652,007	80.4%	$ 63,174,678	78.4%	$ (3,477,328)	-5.5%	$ 537,425,528	78.9%	$ 512,711,486	79.3%	$ (24,714,042)	-4.8%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	*2,429,272*	*2.9%*	*2,242,456*	*2.8%*	*(186,816)*	*-8.3%*	*20,079,688*	*2.9%*	*17,615,784*	*2.7%*	*(2,463,904)*	*-14.0%*
CMC MEDICARE	*8,532,944*	*10.3%*	*9,167,938*	*11.4%*	*634,994*	*6.9%*	*74,819,133*	*11.0%*	*71,995,370*	*11.1%*	*(2,823,763)*	*-3.9%*
TOTAL CMC	10,962,215	13.2%	11,410,393	14.2%	448,178	3.9%	94,898,821	13.9%	89,611,154	13.9%	(5,287,667)	-5.9%
HEALTHY KIDS	251,333	0.3%	276,433	0.3%	25,100	9.1%	2,497,459	0.4%	2,186,198	0.3%	(311,261)	-14.2%
TOTAL MEDICAL EXPENSES	**$ 77,865,555**	**94.0%**	**$ 74,861,505**	**92.9%**	**$ (3,004,051)**	**-4.0%**	**$ 634,821,807**	**93.2%**	**$ 604,508,838**	**93.5%**	**$ (30,312,969)**	**-5.0%**
MEDICAL OPERATING MARGIN	**$ 4,983,700**	**6.0%**	**$ 5,723,767**	**7.1%**	**$ (740,067)**	**-32.7%**	**$ 46,162,201**	**6.8%**	**$ 42,358,217**	**6.5%**	**$ 3,803,984**	**11.1%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,556,356	3.1%	$ 2,486,631	3.1%	$ (69,725)	-2.8%	$ 21,379,528	3.1%	$ 21,218,956	3.3%	$ (160,571)	-0.8%
RENTS AND UTILITIES	24,928	0.0%	23,611	0.0%	(1,317)	-5.6%	356,526	0.1%	388,448	0.1%	31,922	8.2%
PRINTING AND ADVERTISING	152,523	0.2%	139,150	0.2%	(13,373)	-9.6%	695,272	0.1%	1,165,200	0.2%	469,928	40.3%
INFORMATION SYSTEMS	189,780	0.2%	226,473	0.3%	36,693	16.2%	1,484,441	0.2%	1,811,785	0.3%	327,343	18.1%
PROF FEES/CONSULTING/TEMP STAFFING	980,002	1.2%	885,079	1.1%	(94,923)	-10.7%	8,694,029	1.3%	7,227,666	1.1%	(1,466,363)	-20.3%
DEPRECIATION/INSURANCE/EQUIPMENT	370,055	0.4%	457,566	0.6%	87,512	19.1%	2,946,503	0.4%	3,701,031	0.6%	754,527	20.4%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	86,976	0.1%	70,930	0.1%	(16,046)	-22.6%	688,391	0.1%	1,219,182	0.2%	530,791	43.5%
MEETINGS/TRAVEL/DUES	94,561	0.1%	110,826	0.1%	16,265	14.7%	697,306	0.1%	866,467	0.1%	169,161	19.5%
OTHER	43,121	0.1%	17,804	0.0%	(25,317)	-142.2%	230,024	0.0%	212,015	0.0%	(18,008)	-8.5%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,498,302**	**5.4%**	**$ 4,418,071**	**5.5%**	**$ (80,231)**	**-1.8%**	**$ 37,172,020**	**5.5%**	**$ 37,810,750**	**5.8%**	**$ 638,730**	**1.7%**
OPERATING SURPLUS (LOSS)	$ 485,398	0.6%	$ 1,305,696	1.6%	$ (820,298)	-62.8%	$ 8,990,181	1.3%	$ 4,547,468	0.7%	$ 4,442,714	97.7%
OTHER INCOME/EXPENSE												
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(478,237)	-0.1%	(478,240)	-0.1%	3	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(600,000)	-0.1%	(600,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	473,527	0.6%	47,605	0.1%	425,922	894.7%	2,849,971	0.4%	380,840	0.1%	2,469,131	648.3%
OTHER INCOME/EXPENSE	**338,748**	**0.4%**	**(87,175)**	**-0.1%**	**425,923**	**-488.6%**	**1,771,734**	**0.3%**	**(697,400)**	**-0.1%**	**2,469,134**	**-354.0%**
NET SURPLUS (LOSS)	**$ 824,146**	**1.0%**	**$ 1,218,521**	**1.5%**	**$ (394,375)**	**-32.4%**	**$ 10,761,915**	**1.6%**	**$ 3,850,067**	**0.6%**	**$ 6,911,848**	**179.5%**

Balance Sheet

SANTA CLARA COUNTY HEALTH AUTHORITY

For the Eight Months Ending February 28, 2019

	February 2019	January 2019	December 2018	June 2018
Assets				
Current Assets				
Cash and Marketable Securities	$270,810,416	$206,033,993	$208,026,081	$224,156,209
Receivables	492,373,644	550,751,893	534,641,224	493,307,425
Prepaid Expenses and Other Current Assets	7,358,731	8,648,220	8,623,739	7,024,982
Total Current Assets	**770,542,791**	**765,434,106**	**751,291,045**	**724,488,615**
Long Term Assets				
Property and Equipment	43,382,948	43,842,601	43,554,399	38,579,130
Accumulated Depreciation	(16,084,786)	(16,511,470)	(16,186,309)	(14,309,761)
Total Long Term Assets	27,298,162	27,331,131	27,368,090	24,269,369
Total Assets	**797,840,954**	**792,765,237**	**778,659,134**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,535,240**
Total Deferred Outflows and Assets	**812,376,194**	**807,300,477**	**793,194,374**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	4,263,225	4,494,896	3,986,497	8,351,090
Deferred Rent	(0)	(0)	(0)	17,011
Employee Benefits	1,738,577	1,686,776	1,725,742	1,473,524
Retirement Obligation per GASB 45	4,029,032	3,969,253	3,909,473	4,882,795
Advance Premium - Healthy Kids	95,070	87,512	78,886	66,195
Deferred Revenue - Medicare	-	-	-	9,928,268
Whole Person Care/Prop 56	15,198,657	15,583,165	13,847,960	9,263,004
Payable to Hospitals	243,089	-	-	0
Due to Santa Clara County Valley Health Plan and Kaiser	14,159,501	12,593,341	10,370,443	6,691,979
MCO Tax Payable - State Board of Equalization	17,569,814	8,784,630	26,353,890	(0)
Due to DHCS	52,268,200	57,457,558	35,038,446	24,429,978
Liability for In Home Support Services (IHSS)	416,092,527	416,092,527	413,549,552	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	83,187,262	83,918,726	83,657,353	92,470,504
Total Current Liabilities	**611,219,480**	**607,042,908**	**594,892,767**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,424,796	2,349,796	2,274,796	1,824,796
Total Non-Current Liabilities	**8,344,296**	**8,269,296**	**8,194,296**	**7,744,296**
Total Liabilities	**619,563,776**	**615,312,204**	**603,087,063**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	27,298,162	27,331,131	27,368,090	24,269,369
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	150,412,350	150,379,382	150,342,423	133,805,841
Current YTD Income (Loss)	10,761,915	9,937,769	8,056,809	19,635,303
Total Net Assets / Reserves	188,777,778	187,953,632	186,072,672	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**812,376,194**	**807,300,477**	**793,194,374**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	727,325,825
Medical Expenses Paid	(634,094,553)
Adminstrative Expenses Paid	(43,863,737)
Net Cash from Operating Activities	**$49,367,536**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(4,803,818)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	2,849,971
Net Increase/(Decrease) in Cash & Cash Equivalents	**47,413,689**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Feb 19)	**$270,810,416**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**$10,761,915**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	2,534,506
Changes in Operating Assets/Liabilities	
Premiums Receivable	933,781
Other Receivable	(2,849,971)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(333,749)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(8,414,237)
State Payable	45,408,036
Santa Clara Valley Health Plan & Kaiser Payable	7,467,522
Net Pension Liability	600,000
Medical Cost Reserves & PDR	(9,283,242)
IHSS Payable	2,542,975
Deferred Inflow of Resources	-
Total Adjustments	**36,071,115**
Net Cash from Operating Activities	**$49,367,536**

Statement of Operations - YTD

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Eight Months Ending February 28 2019

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 579,757,211	$ 19,121,095	$ 79,303,312	$ 98,424,408	$ 2,802,390	**$ 680,984,008**
MEDICAL EXPENSE	$ 537,425,528	$ 20,079,688	$ 74,819,133	$ 94,898,821	$ 2,497,459	**$ 634,821,807**
(MLR)	92.7%	105.0%	94.3%	96.4%	89.1%	**93.2%**
GROSS MARGIN	$ 42,331,683	$ (958,593)	$ 4,484,180	$ 3,525,587	$ 304,931	**$ 46,162,201**
ADMINISTRATIVE EXPENSE	$ 31,646,480	$ 1,043,739	$ 4,328,830	$ 5,372,570	$ 152,971	**$ 37,172,020**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 10,685,203	$ (2,002,332)	$ 155,349	$ (1,846,983)	$ 151,961	**$ 8,990,181**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 1,508,369	$ 49,748	$ 206,325	$ 256,073	$ 7,291	**$ 1,771,734**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 12,193,573	$ (1,952,584)	$ 361,675	$ (1,590,909)	$ 159,252	**$ 10,761,915**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 297.28	$ 335.31	$ 1,296.91	$ 1,609.61	$ 106.65	**$ 334.21**
MEDICAL EXPENSES	$ 275.58	$ 352.12	$ 1,223.57	$ 1,551.95	$ 95.04	**$ 311.55**
GROSS MARGIN	$ 21.71	$ (16.81)	$ 73.33	$ 57.66	$ 11.60	**$ 22.66**
ADMINISTRATIVE EXPENSES	$ 16.23	$ 18.30	$ 70.79	$ 87.86	$ 5.82	**$ 18.24**
OPERATING INCOME/(LOSS)	$ 5.48	$ (35.11)	$ 2.54	$ (30.21)	$ 5.78	**$ 4.41**
OTHER INCOME/(EXPENSE)	$ 0.77	$ 0.87	$ 3.37	$ 4.19	$ 0.28	**$ 0.87**
NET INCOME/(LOSS)	$ 6.25	$ (34.24)	$ 5.91	$ (26.02)	$ 6.06	**$ 5.28**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	1,950,188	57,025	61,148	61,148	26,277	2,037,613
REVENUE BY LOB	85.1%	2.8%	11.6%	14.5%	0.4%	100.0%

Santa Clara Family Health Plan™

Microsoft License Renewal

April 2019

Microsoft Renewal

Renewal of Microsoft Enterprise Software License

- The current Microsoft Enterprise Agreement expired on March 31, 2019
- The previous agreement was for a three year term (2016-2018) at a total cost of $672,000 paid annually at a rate of $224,000 per year
- The new proposed agreement is for a three year term as well (2019-2021)
- The total cost is quoted at $604,726 paid annually at a rate of $201,575 per year
- Total savings over 3 years is $67,274

Microsoft Renewal

Possible Action

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with Microsoft in an amount not to exceed $605,000 for licensing


Santa Clara Family
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Santa Clara Family Health Plan™

Server Infrastructure Revitalization

April 2019

Server Infrastructure

Revitalize and Upgrade Server Infrastructure to Meet Business Needs

- Current network and phone system servers are over 5 years old and near end of life
- Plan to upgrade server infrastructure to replace aging equipment and to meet anticipated future needs over the next 5 years
- This includes servers to support all production system environments, disaster recovery environment in Denver, and our phone system servers
- ePlus will be our purchasing partner and provide implementation support, including hardware configuration and testing

Server Infrastructure

Possible Action

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate contracts with Cisco and ePlus in an amount not to exceed $660,000 for hardware and implementation


Santa Clara Family
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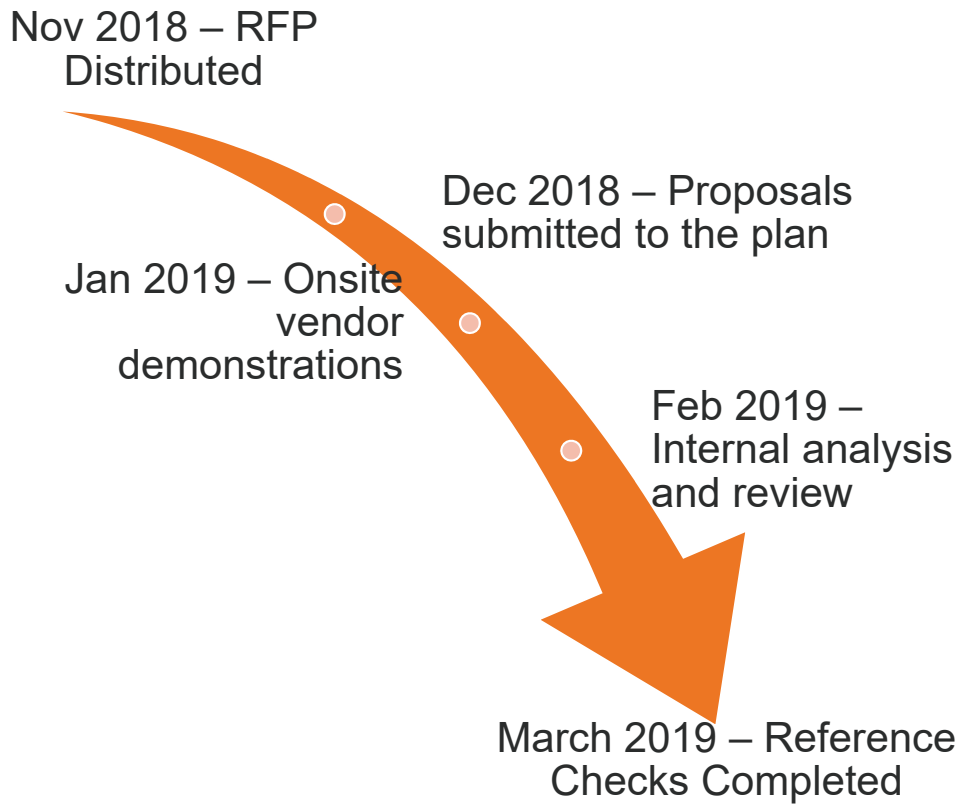
HEDIS Request for Proposal (RFP)

April 25, 2019

HEDIS RFP

Vendor Selection Timeline:

- Contract with existing vendor terms on December 31, 2019
- 7 vendors bid for certified engine – 5 vendors were selected for onsite demo
- 6 vendors bid for medical records review – 3 were selected for onsite demo
- Recommendation to migrate from existing vendor, Cotiviti, to new vendors, CitiusTech and Guardian Angel



HEDIS RFP

HEDIS Certified Engine Software Selection – CitiusTech Inc.

- CitiusTech works with 80+ customers including the Mayo Clinic, Blue Shield Blue Cross of South Carolina and Florida Blue.
- Data analytics tool is dynamic allowing drill down to member and provider levels.
- HEDIS rates and gaps in care lists can be refreshed more frequently providing current data without incurring any additional costs.
- 3 year contract

HEDIS RFP

HEDIS Medical Record Selection – Guardian Angel Consulting, Inc.

- Guardian Angel Consulting has two clients in California, including Valley Health Plan and Inland Empire Health Plan.
  - Guardian Angel is familiar with Santa Clara County providers and has established relationships with the community clinics and VMC.
- Uses CareSeed's MRR software, Harvest™, has been in production since the HEDIS 2015 reporting season.
- 1 year contract

Proposed Action:

Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with selected HEDIS vendors in an amount not to exceed $665,000 for licensing and implementation.

Santa Clara Family Health Plan™

Collective Medical Technology

Presented by: Dr. Laurie Nakahira and Jonathan Tamayo

Current State of Health Information Technology

- Inpatient and Emergency Department Admission
  - Notification of an Inpatient Admission may take greater than 24 hours for faxed notification
  - Notification of an Emergency Room visit may take about 1 week for service claims and/or encounters
- Care Management Summaries
  - If requested, some care summaries are faxed by the facilities (i.e. hospitals, skilled nursing) and providers to the health plan
  - Care summaries are not routinely shared with any case management team to coordinate care and services

Collective Medical Technology (CMT)

- Collective Medical Technology is a software application that provides a platform to exchange real-time health information.
- CMT allows healthcare entities a pathway to exchange protected health information (PHI) to improved treatment planning, claims adjudication and health care operations.
- CMT can share health information

Collective Medical Technology's Network

- Kaiser North West Oregon
- Sutter Health
- San Francisco Health Plan
- UCSF
- Health Plan of San Mateo
- Alameda Health System
- AHS John George Psychiatric hospital
- Washington Hospital Systems

Collective Medical Technology

Client Quality Improvement analysis:

- High Emergency Room (ER) utilization

Results from a client using Collective Medical Technology Platform:

- Reduction of 15% in ER utilization per 1,000 patients
- Reduction of 7% in avoidable ER admissions
- Increase by 16% in patient satisfaction for urgent appointments
- Increase by 13% in provider engagement scores

Proposal:

- Utilize CMT platform for:
  - Health Homes Program members
  - Non-VHP and non-Kaiser members
- Anticipated benefits of CMT platform include:
  - Efficient medical information sharing
  - Receive real-time patient information for ER and Inpatient utilization
  - Improve coordination of care between case management teams and providers
  - Improve risk stratification

Proposed Action:

- Authorize Chief Executive Officer to negotiate, execute, amend, and terminate a contract with Collective Medical Technology in an amount not to exceed $250,000 for licensing, implementation and training.


Santa Clara Family
Health Plan™

POLICY

Santa Clara Family Health Plan™

Procedure Title:	**Investments**	**Procedure No.:**	**FA-07**
Replaces Procedure Title (if applicable):		**Replaces Procedure No. (if applicable):**	
Issuing Department:	Finance	**Procedure Review Frequency:**	**Annually**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. PURPOSE

This Annual Investment Policy (AIP) sets for the investment guidelines and structure for the investment of short term operating funds and any Board-designated reserve funds invested on and after April 26, 2018, of the Santa Clara Family Health Plan (SCFHP) which was established by the Santa Clara County Board of Supervisors under Ordinance 300.576 and licensed by the State of California under the Knox-Keene Act of 1975 in 1996.

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

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

II. OBJECTIVES

The objectives of this Policy are to ensure that SCFHP funds not required for the immediate needs of SCFHP are prudently invested to:

i. Preserve principal: investments shall be undertaken in a manner that seeks to ensure the preservation of capital,
ii. Maintain sufficient liquidity to meet the operating requirements for six months,
iii. Achieve a market-average rate of return (yield) through budgetary and economic cycles, considering SCFHP's regulatory constraints and cash flow characteristics. Investments will be limited to low risk securities in anticipation of earning a fair return relative to the risk being assumed.
iv. Provide diversification of the portfolio to avoid incurring unreasonable market and credit risks."

POLICY

III. ETHICS AND CONFLICTS OF INTEREST

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

IV. DELEGATION OF AUTHORITY

A. Santa Clara Commingled Investment Pool

The Board of Directors of the SCFHP is responsible for the management and oversight of SCFHP's investment program. The Board has directed that available excess funds be deposited with the County Treasurer into the County of Santa Clara Commingled Investment Pool which will be invested by the County Treasurer in accordance with the policies contained in the County of Santa Clara Treasury Investment Policy, now in effect, and which may be revised from time to time. As per the deposit requirements for county health plans under California Health and Safety Code Section 1346 and 1376.1, depositing SCFHP's excess funds with the County of Santa Clara is permitted if:

(1) All of the evidence of indebtedness of the county, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.

(2) The County has cash or cash equivalents in an amount equal to fifty million dollars or more, based on its audited financial statements for the immediately preceding fiscal year.

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

B. Depository (Financial) Institutions

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

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

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

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

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

POLICY

C. Permitted Investments

SCFHP shall invest only in instruments as permitted by the Code, subject to the limitations of this AIP.

(1) Permitted investments under the short-term operating fund, unless otherwise specified, are subject to a maximum stated term of four hundred fifty (450) days.

(2) Permitted investments under a Board-designated reserve fund, unless otherwise specified, are subject to a maximum stated term of five years.

(3) The Board of Directors must grant express written authority to make an investment not permitted by this Policy, or to establish an investment program of a longer term which may include directing SCFHP's staff to enter into a contract with a Board-approved Investment Manager. Any such Board-approved Investment Manager shall be provided with a copy of this AIP and be subject to periodic review for compliance to the AIP. Any Board- approved changes in Permitted Investments shall be in accordance with the Code Section 53600 et seq. and as provided on pages 5-6 of this AIP.

(4) Permitted investments shall include:

a. Joint Powers Authority Pool – A joint powers authority formed pursuant to California Government Code, Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of following criteria:

1. Registered or exempt from registration with the Securities and Exchange Commission;
2. No less than five (5) years of experience investing in the securities and obligations authorized by the Code; and
3. Assets under management in excess of five hundred million dollars ($500,000,000).
4. Such investment may not represent more than ten percent (10%) of the joint powers authority pool's assets.
5. A joint powers authority pool shall be rated at least A+f by a nationally recognized rating service.

b. Local Agency California Investment Fund (LAIF) - Funds may be invested in LAIF, a State of California managed investment pool up to the maximum dollar amounts in conformance with the account balance limits authorized by the State Treasurer.

c. Money Market Funds – Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

1. Which are rated AAA (or equivalent highest ranking) by two of the three largest nationally recognized rating services; and
2. Such investment may not represent more than ten percent of the money market fund's assets.

V. DOCUMENTS

The following documents have been reviewed by County counsel and approved by the SCFHP Board of Directors to support the investment relationship between the County of Santa Clara and SCFHP:

- County of Santa Clara Investment Pool Disclosure and Agreement for Voluntary Deposits:
  This document states that SCFHP has provided funds to Santa Clara County for investment, and that these funds are owned and available to SCFHP for the purpose of SCFHP's use. This agreement spells out the rules for participating in the Pool and establishes the frequency and amount of funds that can be removed from the Pool at a particular time.

- County of Santa Clara Treasury Investment Policy:

POLICY

The County of Santa Clara Treasury Investment Policy, as approved annually by the Santa Clara Board of Supervisors, details the investment policy, practices, and goals of the County of Santa Clara based on compliance with State law and prudent money management. The policy includes sections on the Standards of Care, the County Treasury Oversight Committee, Eligible, Authorized and Suitable Investments, Internal Controls and Accounting, and Reporting. It is the responsibility of the County Treasury Oversight Committee to approve the investment policy prepared annually by the County Treasurer, to review and monitor the quarterly investment reports prepared by the County Treasurer, to review depositories for County fund and broker/dealers and banks as approved by the County Treasurer, and to cause an annual audit to be conducted to determine the County Treasury's compliance with all relevant California Government Code statutes and County of Santa Clara ordinances and the County Treasury Investment Policy.

- County of Santa Clara Treasury Quarterly Report

  This quarterly investment report is provided to SCFHP as a voluntary participant and other participants whose funds are maintained and invested by the Treasurer of the County of Santa Clara, This report discloses a quarter end listing of the Pool's investment holdings, a portfolio summary of cost values versus market values and yields, a summary of portfolio strategy, diversification and credit compliance of permitted investments,, and a listing of all transactions that have taken place during the reporting period.

- SAP Balance and Interest Earnings of SCFHP Invested Funds

  SCFHP periodically receives from the County of Santa Clara SAP reports that list the fund balance as well as interest earnings which is apportioned by the County Treasurer to all Pool participants based upon the average daily balance of SCFHP funds on deposit for each quarter.

VI. REVIEW OF INVESTMENT POLICY

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

Any modifications to this Investment Policy, including withdrawal from the County of Santa Clara Commingled Investment Pool, will be made in accordance with California Government Code Sections 27130 et seq., Sections 53635 and/or 53601 et seq., Section 1346 of the Knox Keene Act of 1975 as well as the prudent investment standard. Any request for withdrawal of funds from the County Pool shall require prior written approval from the County Treasurer to ensure that the interests of the other depositors in the County Pool will not be adversely affected.

POLICY

ALLOWABLE INVESTMENT INSTRUMENTS PER STATE Government Code (AS OF JANUARY 1, 2017)[A] APPLICABLE TO ALL LOCAL AGENCIES[B]			
INVESTMENT TYPE	MAXIMUM MATURITY[C]	MAXIMUM SPECIFIED % OF PORTFOLIO[D]	MINIMUM QUALITY REQUIREMENTS
Local Agency Bonds	5 years	None	None
U.S. Treasury Obligations	5 years	None	None
State Obligations - CA and Others	5 years	None	None
CA Local Agency Obligations	5 years	None	None
U.S. Agency Obligations	5 years	None	None
Bankers'Acceptances	180 days	40%[E]	None
Commercial Paper-Pooled Funds	270 days	40% of the agency's money[G]	Highest letter and number rating by an NRSRO [H]
Commercial Paper-Non-Pooled Funds[F]	270 days	25% of the agency's money[G]	Highest letter and number rating by an NRSRO [H]
Negotiable Certificates of Deposit	5 years	30%[J]	None
Non-negotiable Certificates of Deposit	5 years	None	None
Placement Service Deposits	5 years	30% [K]	None
Placement Service Certificates of Deposit	5 years	30% [K]	
Repurchase Agreements	1 year	None	None
Reverse Repurchase Agreements and Securities Lending Agreements	92 days	20% of the bas value of the portfolio	None
Medium-Term Notes[N]	5 years	30%	"A" Rating category or its equivalent or better
Mutual Funds and Money Market Mutual Funds	N/A	20%	Multiple [PQ]
Collateralized Bank Deposits	5 years	None	None
Mortgage Pass-Through Securities	5 years	None	"AA" rating category or its equivalent or better[R]
County Pooled Investment Funds	N/A	None	None
Joint Powers Authority Pool	N/A	None	Multiple[S]
Local Agency Investment Fund (LAIF)	N/A	None	None
Voluntary Investment Program Fund	N/A	None	None
Supranational Obligations [U]	5 years	30%	"AA" Rating category or its equivalent or better

California Debt and Investment Advisory Commission, Local Agency Investment Guidelines, 17.01 changes as of January 1, 2017

POLICY

TABLE OF NOTES FOR CA GOVERNMENT CODE

A Sources: Sections 16340, 16429.1, 53601, 53601.8, 53635, 53635.2, 53635.8m and 53638.

B Municipal Utilites Districts have the authority uner the Public Utilites Code Section 12871 to invest in certain securities not addressed here.

C Section 53601 provides that the maximum term of any investment authorized uner this section, unless otherwise stated, is five years. However, the legislative body may grant express authority to make investments either specifically or as a part of an investment program approved by the legislative body that exceeds the five year maturity limit. Such approval must be issued no less than three months prior to the purchase of any security exceeding the five-year limit.

D Percentages apply to all portfolio investments regardless of source of funds. For instancer, cash from a reverse repurchase agreement would be subject to the restrictions.

E No more than 30 percent of the agency's money may be in bankers' acceptances of any one commercial bank.

F "Select Agencies" are defined as a "city, a district, or other local agency that do[es] not pool money in deposits or investment with other local agenies, other than local agencies that have the same governing body."

G Local agencies, other than counties or a city and county, may purchase no more than 10 percent of the outstanding commerical paper of any single issuer.

H Issuing corporation must be organized and operating within the U.S., have assets in excess of $500 million, and debt other than commercial paper must be rated "A" or the issuing corporation must be organized within the U.S. as a special purpose corporation, trust, or LLC, has program wide credit enhancements, and has commercial paper that is rated "A-1" or higher, or the equivalent, by a nationally recognized rating agency.

I "Other Agencies" are counties, a city and county, or other local agency "that pools money in deposits or investments with other local agencies, including local agencies that have the same governing body." Local agencies that pool exclusively with other local agencies that have the same governing body must adhere to the limits set for "Select Agencids," above.

J No more than 30 percent of the agency's money may be in negotiable certificates of deposit that are authorized under Section 53601(i).

K No more than 30 percent of the agency's money may be invested in deposits, including certificates of deposit, through a placement service (excludes negotiable certificates of deposit authorzied under Section 53601(i).

L Reverse repurchase agreements or securities lending agreements may exceed the 92-day term if the agreement includes a written codicil guaranteeing a minimum earning or spread for the entire period between the sale of a security using a revers repurchase agreement or securiteis lending agreement and the final maturity dates of the same security.

M Reverse repurchase agreements must be made with primary dealers of the Federal Reserve Bank of New York or with a nationally or state chartered bank that has a significant relationship with the local agency. The local agency must have held the securities used for the agreements for at least 30 days.

N "Medium-term notes" are defined in Section 53601 as "all cororate and depository institution debt securities with a maximum remaining maturity of five years or less, issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States."

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

R Issuer must be rated "A" or higher as provided by a nationally recognized rating agency.

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

T Local entities can deposit between $200 million and $10 billion into the Voluntary Investment Program Fund, upon approval by their governing bodies. Deposits in the fund will be invested in the Pooled Money Investment Account.

U Only those obligations issued or unconditionally guaranteed by the International Bank for Reconstruction and Development (BRD), International Finance Corporation (IFC), and Inter-American Development Bank (IADB).

VII. REFERENCES

None.

VIII. MONITORING

Investment policy, investments and yield will be reviewed on an annual basis by the Controller and Chief Financial Officer

IX. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 26, 2018 Date	Dave Cameron, CFO April 26, 2018 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 26, 2018 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee	Approved 04/26/18	Approved 06/28/18
V1	Reviewed	Executive/Finance Committee		

April 2, 2019

Neal Jarecki, Controller
Santa Clara Family Health Plan
6201 San Ignacio Avenue
San Jose, CA 95119

Via Email: njarecki@scfhp.com

Dear Neal,

Pursuant to your request, this letter will serve to outline a **Scope of Work re: Investment Policy Oversight Services**:

Sperry Capital will provide an independent review of the 2018 SCFHP Investment Policy, a review of current investment practices and a compliance review that such investments are in accordance with the Policy. We will review FY18 and FY19 investment statements from the 1) County Investment Pool, 2) Wells Fargo Bank and 3) Bank of the West to determine:

a. that all liquid assets are currently invested in accordance with the SCFHP Investment Policy and California Government Code's investment guidelines for local agencies,

b. that oversight procedures have been followed pursuant to the Investment Policy,

c. if any updates to the California Government Code need be included in the Investment Policy,

d. if that liquidity needs have been sufficiently met, and

e. if any noteworthy events for the three depositories require additional review for consideration as a viable investment option for the SCFHP.

Fee Proposal

- Our fee for this Scope of Work will be based on our hourly rate of $325/hour.
- Time budget: approximately 20 hours of work
- Cap: Not to exceed $6,500

Delivery of Report: provided by April 8, 2019 or other date as mutually agreed upon.

We welcome the opportunity to assist you in the annual review of the SCFHP's investment policy. If this Scope of Work meets with your approval, please execute below and email a scanned version of the signature page.

Sperry

Three Harbor Drive, Suite 101
Sausalito, CA 94965
Tel: 415.339.9202 Fax: 415.339.6030
MVujovich@SperryCapital.com

Thank you.

Sincerely,

Martha J. Vujovich
Principal

Accepted by:

Santa Clara Family Health Plan

CONTROLLER

Its 4.2.19

Date

Sperry

Three Harbor Drive, Suite 101
Sausalito, CA 94965
Tel: 415.339.9202 Fax: 415.339.6030
MVujovich@SperryCapital.com

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Finance - General**	**Policy No.:**	**FA-01**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Cash & Cash Receipts**	**Policy No.:**	**FA-02**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

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V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Accounts Receivable and Revenue**	**Policy No.:**	**FA-04**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures:

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

III. Responsibilities

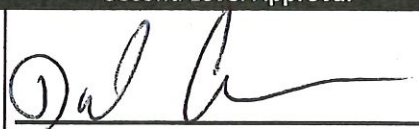
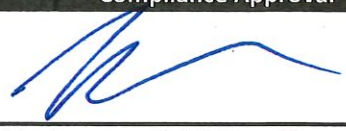
The Chief Financial Officer has overall responsibility for this policy. The Controller has responsibility for implementation, periodic updates, and oversight of the Finance's staff adherence to this policy and all related procedures.

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
		
Neal Jarecki, Controller	Dave Cameron, CFO	Robin Larmer, Chief Compliance & Regulatory Affairs Officer
April 15, 2019	April 15, 2019	April 15, 2019
Date	Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Payroll & Employee Expenses**	**Policy No.:**	**FA-05**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Fixed Assets & Depreciation Expense**	**Policy No.:**	**FA-06**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Treasury & Debt**	**Policy No.:**	**FA-08**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Financial Close & Reporting**	**Policy No.:**	**FA-09**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Medical Expense & IBNP**	**Policy No.:**	**FA-10**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Neal Jarecki, Controller April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

POLICY

Santa Clara Family Health Plan™

Policy Title:	**Healthcare Economics**	**Policy No.:**	**FA-11**
Replaces Policy Title (if applicable):	**N/A**	**Replaces Policy No. (if applicable):**	**N/A**
Issuing Department:	**Finance**	**Policy Review Frequency:**	**Periodically As Warranted**
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

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

This policy will be supported by specific detailed procedures on:

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

III. Responsibilities

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

IV. References

None.

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Compliance Approval
Ngoc Bui-Tong, Director of Healthcare Analytics April 15, 2019 Date	Dave Cameron, CFO April 15, 2019 Date	Robin Larmer, Chief Compliance & Regulatory Affairs Officer April 15, 2019 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Executive/Finance Committee		

Enrollment and Retention

- Environment
  - Medi-Cal
    - Total enrollment in SCC has been decreasing since 2016 (SCFHP, Anthem, FFS) and is projected to continue decreasing
    - SCFHP Medi-Cal market share as of February 2019 is 78.3%, up .5% from February 2018
  - Cal MediConnect
    - SCFHP Cal MediConnect market share as of December 2018 is 74.5%, up from 71.5% in December 2017
    - SCFHP total enrollment increased by 6.4% from March 2018 to March 2019
- Key factors determining new member enrollment
  - Plan choice, including physician influence
  - Auto-assignment
- Key factors affecting member retention
  - Eligibility
  - Member experience
  - Physician influence

Cal MediConnect

Enrollment

- Only plan choice, no auto-assignment
- Medicare Outreach Team
  - Manager and four agents
  - Outreach to SCFHP Medi-Cal duals via phone, community and SCFHP events, direct mail
  - Provider outreach to educate about benefits of CMC to patients and providers
- Implementing new direct mail lead generation campaign
- Providing assistance with Low Income Subsidy (LIS) qualification
- Establishing service to assist with disability reclassification for Medi-Cal members who are likely eligible for State and/or Federal Disability

Retention

- Outreach to beneficiaries “deemed” ineligible for Medi-Cal via direct mail and phone
- Focus on clinical and service quality improvement to enhance overall member experience
- Three-year NCQA accreditation
- Launch of member portal for member self-service (e.g., to request transportation)
- Disenrollment survey via direct mail and phone

Medi-Cal

Enrollment

- Community outreach to increase awareness
  - Community Outreach Program Manager hired January 2019
  - Arranged participation in 28 community events calendar year to date
  - Established connections with 22 Community Based Organizations (since January 2019) who serve the same populations. Examples:
    - Participation at senior nutrition sites throughout the county, through SCC Department of Aging and Adult Services
    - Increase in brand awareness through providing SCFHP items to give to their clients (e.g., toothbrushes, reusable bags)
- Focus on clinical quality improvement to raise HEDIS scores to improve auto-assignment rate

Medi-Cal

Retention

- Increase clinical and service quality to enhance member experience
- Improve accuracy of member contact information
  - Process improvements
    - For returned undeliverable mail, conduct outreach for new addresses and phone numbers
    - Implement core system enhancements to retain updated information and not override with out of date state data
    - Lead workgroup with CHP and Community Clinics to implement process to get patient address updates from clinics to SCFHP
    - Communicate updated member information to SCC Social Services
  - Impact on retention
    - Facilitates timely communication of plan information to member, enhancing member satisfaction with SCFHP
    - Increases likelihood of member receiving redetermination packet
- Planning to mail notices to members:
  - Who receive a redetermination packet to encourage completion
  - In an eligibility “hold” status (ineligible) due to failure to complete their redetermination
- Established internal member retention workgroup to document member touchpoints
- Launched member portal for member self-service (e.g., to request transportation)

Santa Clara Family Health Plan

	Dec-13	Jan-14	Oct-16	Mar-19	Change from Dec 13 to March 19		Change from Dec 13 to October 16		Change from Oct 16 to March 19	
SCVMC & CHP Clinics	**Medi-Cal**	**Medi-Cal**	**Medi-Cal**	**Medi-Cal**						
VMC	40,834	53,241	87,592	77,960	37,126	91%	46,758	115%	(9,632)	-11%
CHP	29,092	31,475	57,822	41,660	12,568	43%	28,730	99%	(16,162)	-28%
Total Enrollment	69,926	84,716	145,414	119,620	49,694	71%	75,488	108%	(25,794)	-18%

ACA Implemented	Peak Enrollment	Current Enrollment

Enrollment has increased 71% since 12-31-13

Enrollment increased 108% from 12-31-13 to 10-31-16 (34 months)

Enrollment decreased 18% from 10-31-16 to 3-31-19 (29 months)

% of Membership	**Dec-13**	**Jan-14**	**Oct-16**	**Mar-19**
SCVMC & CHP Clinics	**Medi-Cal**	**Medi-Cal**	**Medi-Cal**	**Medi-Cal**
VMC	58%	63%	60%	65%
CHP	42%	37%	40%	35%

Department of Health Care Services

Although Its Oversight of Managed Care Health Plans Is Generally Sufficient, It Needs to Ensure That Their Administrative Expenses Are Reasonable and Necessary

April 2019

REPORT 2018-115

CALIFORNIA STATE AUDITOR
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April 4, 2019
2018-115

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this report detailing our audit of the Department of Health Care Services' (DHCS) oversight of the Health Plan of San Joaquin (San Joaquin) and other similar Medi-Cal managed care health plans (health plans) with which DHCS contracts for the provision of quality health care to Medi-Cal beneficiaries. This report concludes that DHCS provides sufficient oversight to ensure that health plans meet state and federal quality of care requirements. However, DHCS does not provide some important oversight and guidance to health plans, such as guidance concerning which administrative expenses are reasonable and necessary.

We found that DHCS' processes for ensuring that health plans provide quality of care at a level consistent with state and federal requirements are appropriate. DHCS requires health plans to engage in an improvement process known as a quality corrective action plan (quality CAP) when they fail to meet quality of care standards specified in state regulations. DHCS properly identified those health plans that met its criteria to be placed on a quality CAP, required them to conduct activities aimed at improving quality, conducted appropriate monitoring activities to ensure that the health plans' actions addressed the identified deficiencies, and took appropriate steps when they did not achieve the goals of the quality CAPs.

However, we did find several aspects of DHCS' oversight that it could improve. It does not consistently ensure that health plans have proper processes in place to prevent, identify, and address fraud, and it does not evaluate whether health plans have controls in place to prevent conflicts of interest. Additionally, DHCS does not provide health plans with guidance on what types of administrative expenses are reasonable and necessary, which likely contributed to the health plans we reviewed making some questionable expenditures. Finally, we reviewed the employee bonuses paid by three health plans and found that, although health plans are allowed to use Medi-Cal funds to pay reasonable employee bonuses, DHCS does not oversee whether such bonuses are reasonable.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CAP	corrective action plan
EQRO	external quality review organization
HEDIS	Healthcare Effectiveness Data and Information Set
MPL	minimum performance level

Contents

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SUMMARY

The Department of Health Care Services (DHCS) is responsible for administering the California Medical Assistance Program, known as Medi-Cal. Managed care is one method DHCS uses to provide Medi-Cal benefits, and to do so, it contracts with Medi-Cal managed care health plans (health plans) and pays them a monthly premium to provide quality health care services to Medi-Cal beneficiaries. These contracts require health plans to meet quality of care standards specified in state regulations. When health plans fail to meet the quality of care standards, such as not providing required or timely medical treatments for diabetes and postpartum care, DHCS requires them to engage in an improvement process to correct deficiencies known as a quality corrective action plan (quality CAP). State regulations also generally require DHCS to ensure that a health plan's overall administrative expenses do not exceed 15 percent of its revenue and are reasonable and necessary. For this audit, we reviewed DHCS' oversight of the Health Plan of San Joaquin (San Joaquin) and a selection of other health plans as it relates to their quality of care and administrative expenses. This report draws the following conclusions:

DHCS' Processes to Oversee Health Plans' Quality of Care Are Generally Sufficient

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DHCS provides sufficient oversight to ensure that health plans meet state and federal quality of care requirements. DHCS properly placed four poorly performing health plans on quality CAPs between 2013 and 2017, ensured that the health plans' actions addressed identified deficiencies, and adequately monitored each plan's progress in implementing its CAP. For example, as part of its quality CAP process, DHCS conducts several monitoring activities—such as holding periodic meetings with health plans to gauge their progress in achieving specified goals—to ensure that health plans address quality of care deficiencies. Although two of the four health plans on quality CAPs successfully fulfilled the respective requirements, and the remaining two health plans did not, we found that DHCS took the appropriate steps—which included imposing financial sanctions—to address these health plans' shortcomings. However, DHCS is missing an opportunity to identify successful actions taken by health plans to address deficiencies that it can share with all health plans. Specifically, DHCS requires health plans to conduct activities, known as performance improvement projects, as part of their quality CAPs to increase performance in areas in which they are deficient, but it does not follow up to identify successful projects or periodically share these projects with other health plans.

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DHCS Does Not Ensure That Health Plans' Administrative Expenses Are Reasonable and Necessary

Contrary to federal and state regulations, DHCS does not provide health plans with guidance on what types of administrative expenses are reasonable and necessary, and it limits its oversight of health plans' administrative expenses to generally ensuring that they do not exceed the maximum of 15 percent of the Medi-Cal funds health plans receive that state regulations typically allow. Our review determined that each of the health plans had questionable expenditures among their administrative expenses, such as events for their employees, that used Medi-Cal funding. DHCS also does not oversee, or provide guidance on, health plans' bonus programs to ensure that they are reasonable. Thus, without providing specific direction to the health plans, DHCS risks that health plans are making administrative expenditures that are not reasonable and necessary.

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DHCS Properly Recouped Excess Funds From Health Plans

We also reviewed whether DHCS complied with federal requirements in recouping excess funds it paid to health plans during the first three years of expanded coverage resulting from the federal Patient Protection and Affordable Care Act. We determined that DHCS' actions to recoup nearly $2.6 billion in Medi-Cal overpayments to health plans complied with the federally approved methodology.

Summary of Recommendations

To help identify successful performance improvement projects, DHCS should identify best practices by December 2019 and follow up on whether health plans implement and expand successful projects.

DHCS should develop and issue binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses. Further, it should provide guidance to the health plans on what is a reasonable bonus program.

Agency Comments

DHCS largely agreed with our recommendations, but did not fully agree to implement our recommendation that it develop and issue guidance to the health plans on what constitutes reasonable and necessary administrative expenses, or that it issue guidance regarding what is a reasonable bonus program. Although we did not make any recommendations to the Santa Clara Family Health Plan, it chose to submit a response in which it disagreed with our conclusion that some of its administrative expenses were questionable.

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INTRODUCTION

Background

The federal Medicaid program, overseen by the Centers for Medicare & Medicaid Services (CMS), provides health coverage to certain low-income individuals and families who meet federal and state eligibility requirements. California participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal. The Department of Health Care Services (DHCS) is the single state agency responsible for administering Medi-Cal. As of October 2018, the Medi-Cal program provided services to nearly 12 million beneficiaries—nearly one-third of Californians. DHCS received more than $110 billion in federal and state funds during fiscal year 2017–18 to administer the Medi-Cal program, with $19 billion of that total coming from California's General Fund.

The State provides Medi-Cal benefits through two delivery systems: fee-for-service and managed care. Under fee-for-service, medical providers bill DHCS directly for approved services they provide to Medi-Cal beneficiaries. In Medi-Cal managed care, DHCS contracts with Medi-Cal managed care health plans (health plans) and pays each a monthly capitation payment (premium)—an amount per person covered—to provide health care to Medi-Cal beneficiaries. During the entire period covering fiscal years 2013–14 through 2017–18, DHCS contracted with 22 health plans. These contracts require health plans to meet quality of care and financial operating standards specified in state regulations. Each health plan uses the premium to fund both health care services and its administrative expenses, such as salaries and facility maintenance. Additionally, DHCS issues guidance to health plans, such as that related to contract or legal requirements, in the form of All-Plan Letters. These letters undergo a similar review and approval process as state regulations in that DHCS is required to solicit feedback from the health plans and the public before issuing the guidance.

DHCS Is Responsible for Overseeing Health Plans' Quality of Care

Federal and state regulations require DHCS to measure and report on the quality of care that the health plans provide to Medi-Cal beneficiaries. To fulfill this requirement, DHCS contracts with an external quality review organization (EQRO) to perform annual independent reviews of the services health plans provide. For these external quality reviews, the EQRO evaluates the health plans annually using a subset of the performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS).[1] HEDIS is a nationally recognized set of more than 90 performance measures used to evaluate health plans' performance on providing important health care services, such as the type and frequency of medical exams for diabetes care. In its evaluation, the EQRO determines the health plan's performance for each of the HEDIS measures it reviews. More than 90 percent of U.S. health plans use these performance measures. By using this standardized national measure of quality of care that is independently evaluated, DHCS can compare a health plan's performance against other health plans in California as well as those in other states.

[1] The National Committee for Quality Assurance, an independent nonprofit organization, develops the HEDIS measures and conducts accreditation assessments of health plans.

Additionally, state regulations require DHCS to conduct its own review to assess the quality of care that each health plan provides. In its annual quality review, DHCS selects roughly 20 of the more than 90 HEDIS performance measures and uses them to evaluate the quality of care that health plans deliver to beneficiaries.

DHCS updates its selection of HEDIS performance measures to use in quality of care assessments each year after consulting with the health plans, the EQRO, and various stakeholders. These performance measures include what are known as quality indicators to evaluate a health plan's performance on each measure. Some examples of quality indicators include assessing whether beneficiaries with diabetes receive required eye exams and blood tests, or evaluating whether beneficiaries who have recently given birth receive timely postpartum care. To create a standard for assessing health plans' quality performance, DHCS creates a minimum performance level (MPL), which is based on how health plans nationally are performing, for each of the quality indicators it selects. DHCS considers health plans that score higher on a quality indicator than at least 25 percent of health plans nationwide to be performing above the MPL on the performance measure. If the health plan demonstrates one or more of the deficiencies shown in the text box, DHCS requires the health plan to engage in a process known as a corrective action plan (CAP), referred to as a *quality CAP*, to improve the quality of care it provides.

DHCS Places Health Plans on Quality CAPs if One or More of the Following Situations Occur:

- The plan has 50 percent or more of its quality indicators below the MPL in a given year.
- The plan has three or more of the same quality indicators below the MPL for three or more consecutive years.
- DHCS determines, based on other factors it finds concerning, that a health plan's performance warrants a quality CAP.

Source: DHCS' policies and procedures for its quality CAP process.

As part of the quality CAP process, DHCS requires the health plan to describe key staff, resources, and initiatives it will use to improve its performance for each quality indicator identified in the quality CAP. Additionally, the quality CAP process includes the health plan meeting with DHCS management periodically to discuss the plan's progress on implementing the quality CAP to ensure compliance. The EQRO approves and provides technical assistance on certain quality improvement activities—including performance improvement projects—the health plans undertake as part of their quality CAPs. Performance improvement projects consist of a health plan evaluating the effectiveness of small changes to improve quality of care. In addition to DHCS requiring a health plan to implement performance improvement projects as part of the quality CAP, it also requires the health plan to meet annual quality improvement milestones. DHCS may extend the duration of the quality CAP and also may impose consequences that include monetary sanctions if a health plan fails to meet one or more of the yearly quality improvement milestones it agreed to as part of the quality CAP.

As part of this audit, we reviewed DHCS' oversight of the four health plans that were on quality CAPs between 2013 and 2017: Anthem Blue Cross Partnership Plan (Anthem), Health Net Community Solutions, Inc. (Health Net), Health Plan of San Joaquin (San Joaquin), and Molina Healthcare of California Partnership Plan, Inc. (Molina). In addition, we selected two health plans—Kern Health Systems (Kern) and Santa Clara Family Health Plan (Santa Clara)—that were not on quality CAPs but have organizational structures similar to that of San Joaquin. We visited these two health plans as well as San Joaquin to review whether their administrative expenses were reasonable and necessary. Figure 1 on the following page shows all six health plans we reviewed and the counties they serve throughout California.

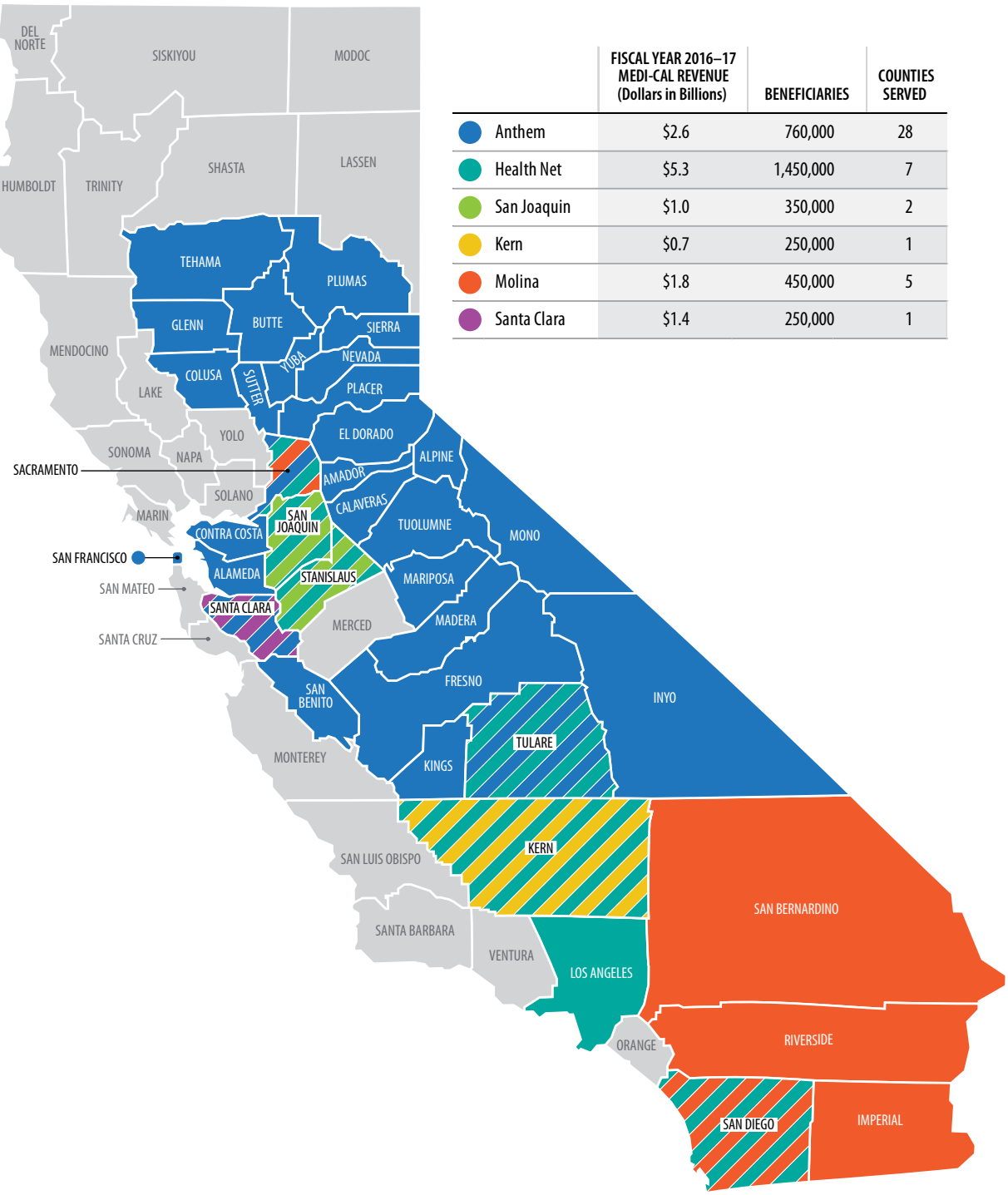
State law requires DHCS to perform annual medical audits of prepaid health plans, which include the Medi-Cal managed care health plans we reviewed, for compliance with requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), which sets operating standards for the licensing of most California managed care plans. The text box identifies the seven audit categories that DHCS uses to evaluate the health plans' compliance with key requirements during its annual medical audits. For example, the category of "administrative and organizational capacity" includes steps to review a health plan's fraud detection procedures—a Knox-Keene Act requirement. Deficiencies discovered in an audit can also result in health plans being placed on a CAP, which for the purposes of this report we refer to as an *audit CAP*. Similar to its requirements for the quality reviews, DHCS requires a health plan to submit an audit CAP detailing how it will address the deficiencies identified through the audit. DHCS requires health plans to either correct audit deficiencies within 30 calendar days from completion of the audit report or specify the intended date of completion in the audit CAP. DHCS may impose administrative or financial sanctions on health plans that fail to address the deficiencies listed in the audit CAP. Further, DHCS indicated that it monitors a health plan's compliance with an audit CAP through regular communication and by verifying supporting documentation the health plan supplies to show how it is addressing the audit deficiencies.

DHCS Reviews Seven Categories as Part of Its Annual Medical Audits

- Utilization management
- Case management and coordination of care
- Access and availability of care
- Member rights
- Quality management
- Administrative and organizational capacity
- State supported services

Source: DHCS.

Figure 1
The Health Plans We Reviewed Serve Counties Throughout California



	FISCAL YEAR 2016–17 MEDI-CAL REVENUE (Dollars in Billions)	BENEFICIARIES	COUNTIES SERVED
Anthem	$2.6	760,000	28
Health Net	$5.3	1,450,000	7
San Joaquin	$1.0	350,000	2
Kern	$0.7	250,000	1
Molina	$1.8	450,000	5
Santa Clara	$1.4	250,000	1

Source: DHCS' September 2018 health plan data.
Note: The health plans we reviewed do not serve the counties shaded in gray.

Health Plans Must Meet Certain Requirements Related to Their Administrative Expenses

State regulations generally require DHCS to ensure that a health plan's overall administrative expenses do not exceed 15 percent of the Medi-Cal funds it receives. Administrative expenses are generally considered to be any costs not directly related to providing health care services to beneficiaries. Although state regulations require that administrative expenses be reasonable and necessary, and define some general categories of administrative expenses—such as salaries and bonuses, marketing, and legal expenses—state regulations do not provide specific guidance on what constitutes a reasonable and necessary administrative expense. This leaves health plans to rely on their own judgment to determine whether their administrative expenses are "reasonable and necessary."

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DHCS' Processes to Oversee Health Plans' Quality of Care Are Generally Sufficient

Key Points

- DHCS has sufficient processes to monitor the quality of care that health plans provide and to address health plans that are performing poorly.
- The majority of all health plans in the State perform at levels that meet or exceed those established by DHCS for quality of care. Although two of the four health plans on quality CAPs have not demonstrated sufficient improvement, DHCS has taken appropriate steps to address these health plans' inadequate performance.
- DHCS does not consistently ensure that health plans have proper processes in place to prevent, identify, and address fraud. Additionally, DHCS does not evaluate whether health plans have controls in place to prevent conflicts of interest.

DHCS Has Adequate Processes to Oversee Health Plans' Quality of Care

DHCS' processes for ensuring that health plans provide quality of care at a level consistent with state and federal requirements are appropriate. State regulations require health plans to provide quality care and DHCS requires health plans to meet or exceed the MPL it establishes for each quality indicator. In addition, federal regulations require DHCS to annually review the health plans' quality assessment and efforts that the plans make to improve performance in the way they deliver services to beneficiaries. Federal regulations also direct DHCS to require health plans to complete performance improvement projects when it identifies poor performance.

As described in the Introduction, DHCS monitors whether health plans meet or exceed the established MPLs. When it identifies that a plan is consistently performing below the MPLs, DHCS generally places it on a quality CAP and then monitors its performance until the health plan meets the requirements of the CAP. Of the 22 health plans in the State that offered Medi-Cal coverage during fiscal year 2016–17, four—Anthem, Health Net, Molina, and San Joaquin—were on quality CAPs. Based on our review of the four health plans' performances in meeting or exceeding the MPLs during 2013 through 2017, we found that DHCS properly identified that these health plans met its criteria to be placed on a quality CAP. For instance, DHCS placed San Joaquin on a quality CAP in 2016 because it failed to meet 50 percent of the MPLs for the 22 quality indicators DHCS established for 2015.

Once DHCS identifies that it should place a health plan on a quality CAP, it identifies the milestones the health plan needs to achieve and requires that the health plan submit a response to the quality CAP that includes the specific activities it will take to address the poor performance. Based on a selection of these activities, we found that DHCS ensured that each of the four health plans conducted the quality improvement activities

their quality CAPs required in order to meet or exceed the MPLs. These activities included the health plans conducting two types of performance improvement projects. Although one type of these projects is lengthier than the other and involves a thorough review by the EQRO, they share the common goal of improving health care outcomes and processes by piloting small changes rather than implementing one large transformation.

For the lengthier type of improvement projects that we reviewed, DHCS provided documentation demonstrating that the EQRO reviewed and approved them. For example, in 2016 Molina submitted a proposal for an improvement project with the objective of increasing its performance related to annual monitoring of patients on persistent medications (monitoring persistent medications). According to DHCS, this monitoring addresses patient safety by assessing the percentage of adult beneficiaries who were prescribed one of several different medications commonly associated with conditions such as high blood pressure and diabetes for at least six months during the year and who also received at least one monitoring lab test during the year. Health plans perform this monitoring to reduce the likelihood of patient injury and limit increased health care costs that might occur due to complications from the medications. The EQRO did not initially approve Molina's proposal and required it to clarify the steps it proposed to increase the percentage of beneficiaries tested for adverse drug reactions before the EQRO ultimately approved the proposal. By including the EQRO's evaluation of the proposed actions included in a health plan's quality CAP, we found that DHCS has increased assurance that the activities the health plan undertakes to improve the quality of care are appropriate.

We also found that DHCS appropriately monitored the progress all four health plans made in developing and implementing the specified activities in their quality CAPs. From September 2015 through September 2017, DHCS' quality CAP process required health plans to participate in monthly meetings with a DHCS nurse consultant to discuss progress and provide technical assistance. In October 2017, DHCS began requiring health plans to also participate in quarterly in-person meetings with DHCS leadership to discuss and receive updates from the health plans on their progress in achieving the requirements of their CAPs.

Prior to attending these quarterly meetings, health plans must submit written reports to DHCS that discuss the progress they have made, any barriers to success, and the next steps that will be taken in the CAP process. DHCS explained that it uses these progress reports to update DHCS staff and executives on the health plan's progress and to inform the discussion at quarterly meetings. DHCS also uses the reports to prompt health plans to consider how staffing and other considerations may affect their planned efforts to improve quality of care. DHCS

stated that it had been holding quarterly meetings and requiring health plans to submit similar progress reports before it formally incorporated these steps as requirements in its October 2017 policy.

Based on our review of the quarterly meetings and progress reports for each of the four health plans, we found that DHCS held the required meetings and was able to demonstrate that the health plans submitted the required progress reports. Although DHCS is following its quality CAP process and the process is sufficient, it does not always guarantee success. As we describe in the next section, two of the four health plans—Health Net and San Joaquin—failed to achieve the requirements included in their 2017 quality CAPs.

We also reviewed another oversight mechanism, annual medical audits, that DHCS uses to determine whether health plans are complying with contract requirements. We found that DHCS' medical audit processes for having health plans address deficiencies and for working with plans to ensure a high level of care are adequate. During the required medical audits that DHCS conducted of the four health plans for the review period beginning in 2014 and ending in 2017, DHCS identified 16 findings related to quality of care. When we reviewed a selection of seven of these findings for which the audit CAP process was complete, we found that DHCS appropriately required the respective health plans to submit an audit CAP to address these findings. Further, DHCS' policies require that it assess whether a health plan's proposed actions will address its findings and meet applicable requirements. We found that each of the health plans' proposed actions addressed the findings, and DHCS subsequently closed the audit CAPs.

Some Health Plans on Quality CAPs Have Demonstrated Improvement in Their Quality of Care

The majority of health plans in the State generally met or exceeded most, if not all, of the MPLs for DHCS' established quality indicators in 2017. Based on the most recent data available as of January 2019, we determined that 16 of 22 health plans met or exceeded the MPLs on more than 85 percent of the 21 quality indicators during 2017.[2] One of these 16 health plans was Molina, which improved its performance and successfully completed its quality CAP in September 2018. In addition, because it improved its performance in certain locations that DHCS specified in its quality CAP, Anthem also successfully completed its quality CAP in September 2018. The improved performance by these health plans suggests that the

[2] Several health plans have multiple locations, and each location's performance can vary. This analysis is based on the average of a health plan's performance across all of its locations.

quality CAP process may be effective in increasing quality of care. Nonetheless, two other health plans—Health Net and San Joaquin—did not demonstrate similar improvement in their performance and remained on quality CAPs as of January 2019.

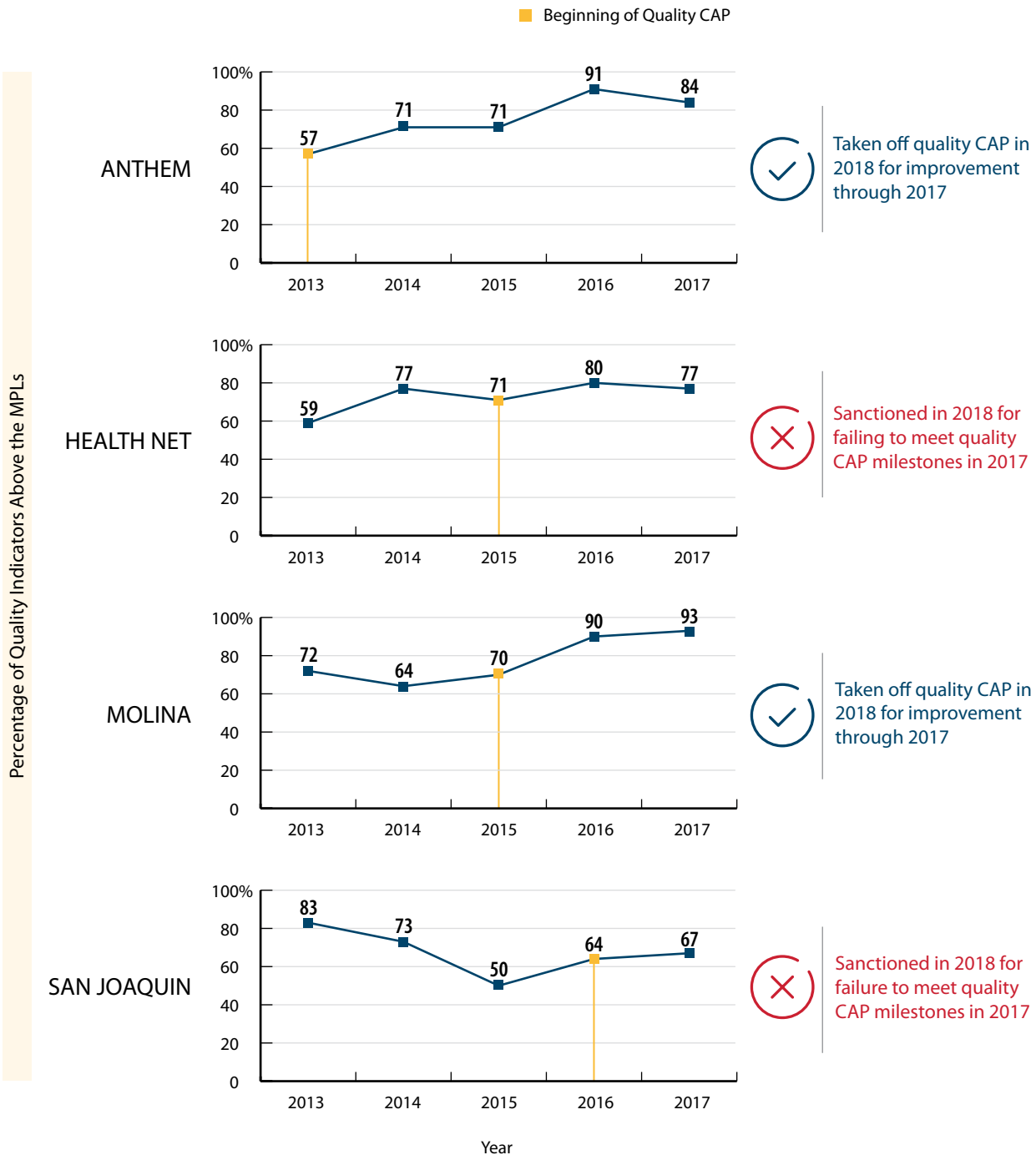
According to DHCS, when Anthem was placed on a quality CAP in 2013 a formal process had not yet been established for identifying poorly performing health plans and placing them on quality CAPs. DHCS formalized its quality CAP process in September 2015, and in December 2015 DHCS also placed Molina on a quality CAP. Figure 2 shows that Anthem and Molina improved their performance by 2017. Subsequently, DHCS removed them from the quality CAP.

In contrast, although Health Net and San Joaquin demonstrated some improvement after DHCS placed them on quality CAPs, both health plans fell short of meeting their quality CAP requirements. In the case of Health Net, it did not achieve the milestone for 2017 that it meet or exceed the MPLs for 82 percent of the quality indicators. Similarly, in 2017 San Joaquin fell short of its milestone that it meet or exceed the MPLs for 77 percent of the quality indicators. According to DHCS, both of these health plans operate in difficult-to-serve areas, and improvement projects that had worked elsewhere failed in these particular locations, making it difficult for the plans to improve their quality indicators sufficiently.

Although Health Net and San Joaquin demonstrated some improvement after DHCS placed them on quality CAPs, both health plans fell short of meeting their quality CAP requirements.

Because the health plans did not meet the quality CAP requirements, DHCS imposed monetary sanctions in October 2018 of $335,000 on Health Net and $135,000 on San Joaquin. State law allows DHCS to sanction the health plans $5,000 for the first contract violation—an example of which is failing to maintain quality indicators above the MPLs—and $10,000 for each subsequent violation. DHCS calculated the sanction amounts based on the number of quality indicators for which the health plans failed to meet or exceed the respective MPLs. In addition, DHCS required both health plans to submit revised quality CAPs detailing how they will meet or exceed the required milestones in 2019. DHCS will continue to monitor both plans until they achieve their quality CAP requirements.

Figure 2
Anthem and Molina Generally Improved Their Performance While on a Quality CAP



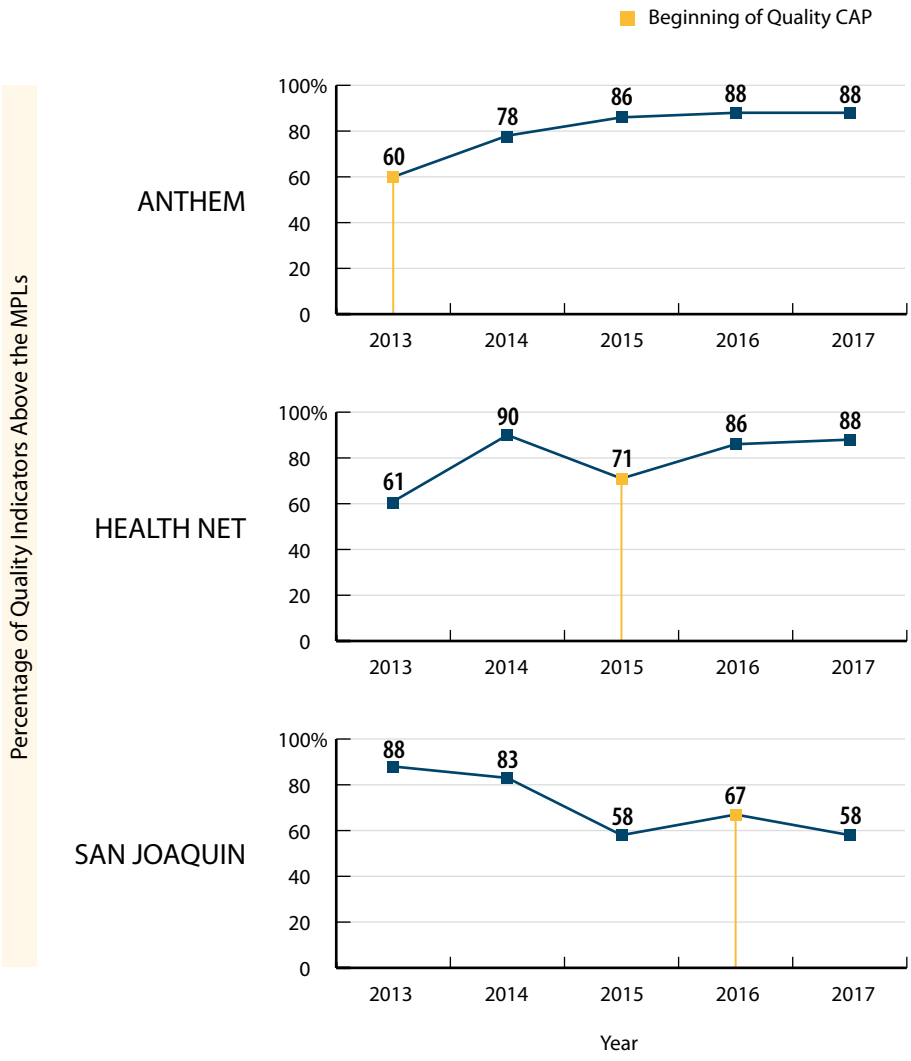
Source: Documentation related to quality CAPs and sanctions, and data provided by DHCS.
Note: DHCS places health plans on a quality CAP based on their previous performance.

In addition to reviewing health plans' overall performance, we also reviewed their performance on quality indicators related to three specific areas of care. The Joint Legislative Audit Committee (Audit Committee) specifically asked us to review quality of care standards related to postpartum care and diabetes treatments. We also selected for review the quality of care standards related to the area of monitoring persistent medications. Although our review found that health plans improved their performance in some of these areas, it is important to note that DHCS generally bases its decision to place health plans on, and remove them from, quality CAPs on overall performance rather than performance on quality indicators related to specific areas of care. DHCS placed three health plans—Anthem, Health Net, and San Joaquin—on quality CAPs, in part for their poor performance on certain quality indicators in the area of diabetes care. In 2013, DHCS held health plans accountable for eight quality indicators related to diabetes care. During the next four years, from 2014 through 2017, DHCS held the health plans accountable for six quality indicators related to diabetes care. Figure 3, which depicts the health plans' performance across these indicators, shows that both Anthem and Health Net improved their performance in this area over the course of their quality CAPs.

All three health plans conducted improvement projects to increase their performance on some of these diabetes-related quality indicators. For example, in 2016 Health Net implemented a successful outreach effort in a Sacramento clinic that led to an increase in beneficiaries with diabetes who received necessary blood tests. Health Net stated that it intended to adopt the use of this process at this location. Similarly, although San Joaquin's performance generally declined in the area of diabetes care, the health plan conducted a successful improvement project that increased one of its clinics' rate of beneficiaries with diabetes who received an eye exam, which led to it exceeding its intended goal for this project. This improvement project likely played a role in San Joaquin's performance on this quality indicator increasing from below the MPL to above the MPL in 2017 in the county in which it conducted the improvement project.

Of the three health plans that were on quality CAPs related to postpartum care—Anthem, Molina, and Health Net—two demonstrated improvement in providing timely postpartum care. Most notably, at the beginning of its quality CAP in 2013, Anthem met or exceeded the MPLs for just 33 percent of the quality indicators in this area. However, as Figure 4 on page 18 shows, Anthem improved its performance and in 2017 met or exceeded the MPLs for 92 percent of the quality indicators in providing timely postpartum care. Further, Figure 4 shows that Molina also demonstrated some improvement while on a quality CAP. Conversely, Health Net's performance decreased in 2017, despite being on a quality CAP.

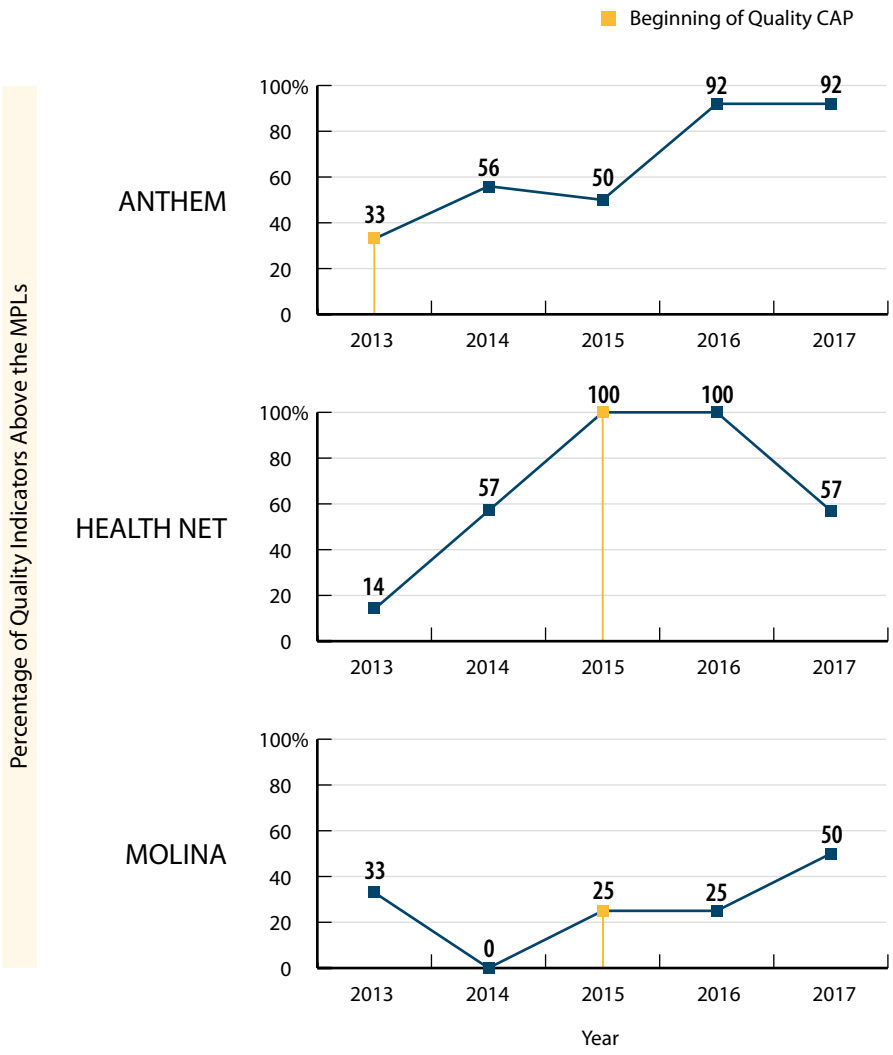
Figure 3
Two of the Health Plans on a Quality CAP for Poor Performance in Quality Indicators Related to Diabetes Demonstrated Improvement



Source: Documentation related to quality CAPs and data provided by DHCS.
Note: DHCS places health plans on a quality CAP based on their previous performance.

Each of these plans implemented improvement projects aimed at increasing their performance in providing timely postpartum care. In a project conducted from 2016 through 2017 at four of its Sacramento clinics, Molina contacted new mothers to schedule and complete in-home assessment visits to help ensure that they received timely postpartum care. After implementing the project, Molina surpassed its initial goal for increasing the number of women completing timely postpartum visits. Molina stated that it planned to make the program permanent in this group of Sacramento clinics and would consider expanding the project to another clinic group in Sacramento County.

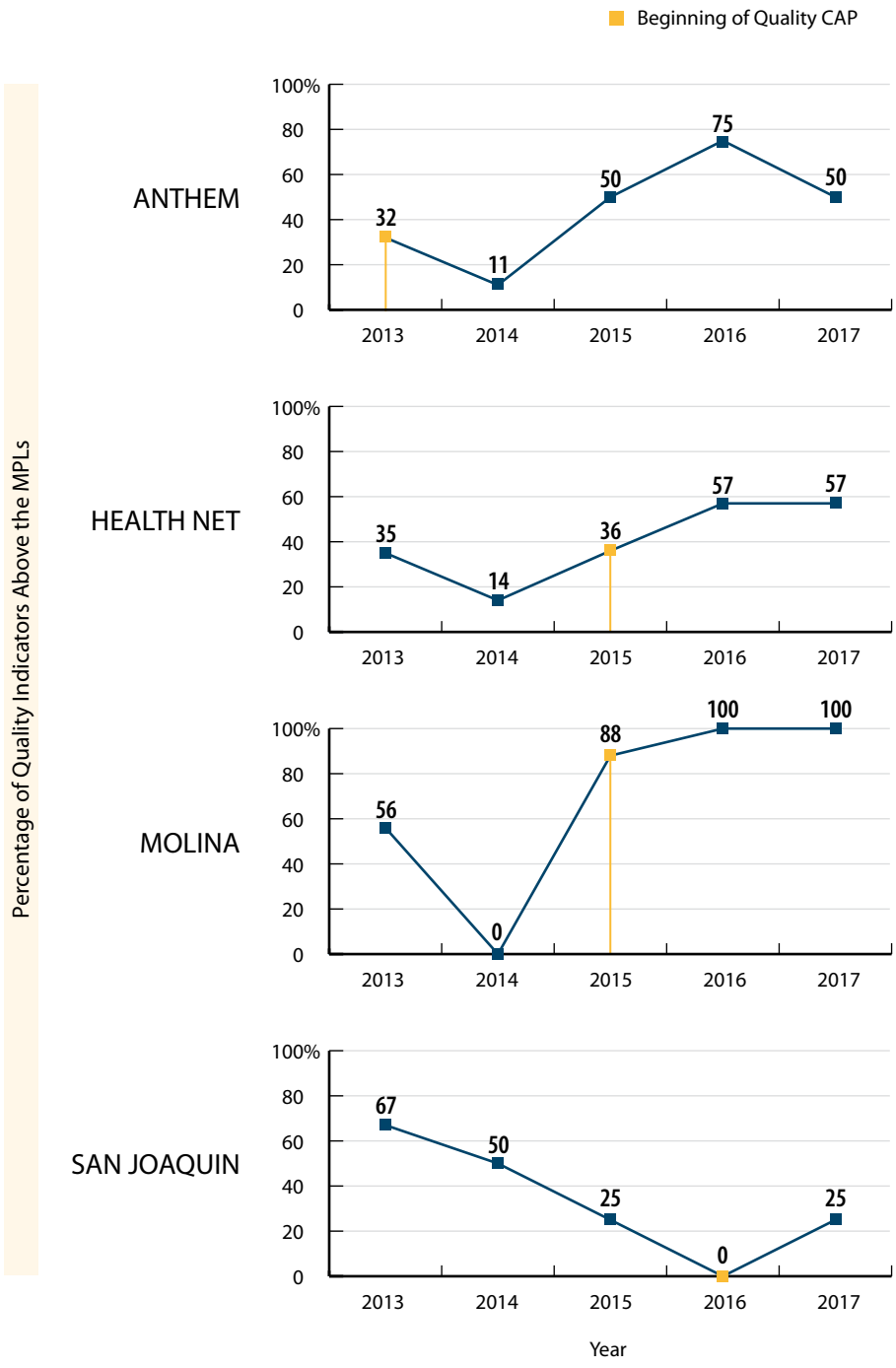
Figure 4
Two of Three of the Health Plans on Quality CAPs for Poor Performance on Timely Postpartum Care Demonstrated Improvement



Source: Documentation related to quality CAPs and data provided by DHCS.
Note: DHCS places health plans on a quality CAP based on their previous performance.

The four health plans on quality CAPs for monitoring persistent medications showed some improved performance in meeting the MPLs. For example, Figure 5 shows that Health Net's performance in this area increased from 14 percent of quality indicators above the MPLs in 2014—the year that triggered the quality CAP—to 57 percent of quality indicators above the MPLs in 2017. Although Figure 5 shows that San Joaquin's performance related to monitoring persistent medications improved from 2016 to 2017, San Joaquin will continue on a quality CAP and DHCS will require that it complete additional improvement projects in this area.

Figure 5
The Four Health Plans Demonstrated Improvement on Their Quality Indicators Related to Monitoring Persistent Medications Since Being Placed on a Quality CAP



Source: Documentation related to quality CAPs and data provided by DHCS.
Note: DHCS places health plans on a quality CAP based on their previous performance.

As part of their quality CAPs, these four health plans performed a variety of improvement projects for monitoring persistent medications, and those that were successful likely contributed to improvements in this area. For example, Anthem completed an improvement project that focused on outreach and intervention in two of its facilities in Tulare County that led to an increased percentage of beneficiaries who received necessary laboratory tests. As a result of its success, Anthem stated that it plans to expand the improvement project to other facilities and providers in Tulare County. In another successful example, in 2017 Health Net conducted an improvement project focused on increasing the number of beneficiaries of a clinic in Sacramento County who had completed their annual laboratory testing. Based on the outreach efforts performed, Health Net stated that it increased the number of beneficiaries who completed annual laboratory testing, and it concluded that the improvement project was a success and one that it would continue.

Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality CAPs, it is missing an opportunity to ensure that health plans formally adopt successful projects and to share these with other plans. Specifically, once an improvement project reaches its completion, the health plan can choose to adopt or abandon the project. If a health plan chooses to adopt the improvement project, it may do so at only the location where it was completed or it may expand the project to other locations. In instances in which improvement projects are successful and the health plans indicate they will adopt the projects, DHCS acknowledged that it does not formally follow up on whether the health plans do so. DHCS explained that it has considered a formal follow-up process to determine whether health plans implement successful improvement projects on a wider scale but cited various limitations, including that expanding these projects to other clinics takes significant time and could involve years of continued reporting by the health plan to DHCS.

Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality CAPs, it is missing an opportunity to ensure that health plans formally adopt successful projects and to share these with other plans.

Although we agree that type of monitoring could be extensive, we do not expect DHCS to wait years to share successful improvement projects. Instead, we believe that DHCS could compile a list of improvement projects that it determined were successful and share it with other health plans on a periodic basis. In addition, DHCS could require the health plan to annually report to it on the results of those projects the health plan intends to adopt or expand at other locations. Using this information, DHCS could identify successful improvement projects, particularly those proven effective on a wider scale, and then include these projects on the list of successful improvement projects that we describe above. DHCS agreed that adding this provision to its quality CAP process would be feasible.

DHCS Does Not Adequately Oversee Health Plans' Processes to Prevent Fraud or Conflicts of Interest

DHCS should improve its efforts to ensure that health plans have adequate processes in place to prevent or detect fraud. Federal regulations mandate that DHCS' contracts with managed care plans require the plans to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse. DHCS' contracts with the plans we reviewed comply with this requirement. Each plan's fraud, waste, and abuse procedures must include establishment of a compliance committee and a system for training specified employees. Although DHCS' annual medical audits include steps for evaluating whether health plans have a fraud and abuse program that includes processes to detect and prevent fraud, we found that they did not identify shortcomings in this area for three of the nine audit reports we reviewed.

Each plan's fraud, waste, and abuse procedures must include establishment of a compliance committee and a system for training specified employees.

DHCS' audit procedures describe how to evaluate health plan compliance with various contract provisions, such as determining whether a health plan has policies and procedures for its fraud and abuse program, including training records and meeting minutes from its compliance committee. However, our review of nine annual medical audits of Kern, San Joaquin, and Santa Clara that DHCS issued each year from 2016 through 2018 found that DHCS consistently failed to identify a shortcoming in Kern's approach to

preventing and identifying fraud. Specifically, DHCS concluded that Kern satisfied the contract requirements related to fraud and abuse in each of its three consecutive medical audits even though the health plan never established a compliance committee as required by the contract. One intent of requiring health plans to establish a compliance committee is to ensure that the plans' processes, including their training and steps to submit and review fraud complaints, are as effective as possible at preventing and detecting fraud. Although DHCS acknowledged that its staff overlooked this shortcoming and that management should have identified it as a reportable issue during the review process, by repeatedly failing to identify this noncompliance, DHCS demonstrated that it does not consistently follow its established audit procedures.

Further, DHCS does not verify the steps health plans take to identify and prevent conflicts of interest. DHCS' contracts with the health plans we reviewed require them to adhere to specified state conflict-of-interest regulations and requirements, which include prohibiting health plans from contracting with certain individuals who have a substantial financial interest in the health plan. However, we found that DHCS does not determine through its annual medical audits whether health plans adhere to the State's conflict-of-interest requirements. To determine which contract sections to review as part of the annual medical audits, DHCS indicated that it conducted a risk assessment in 2012 and organized the contract sections it identified as high-risk areas into seven broad audit categories. It also stated that it performs annual risk assessments to include any additional areas of risk within these established audit categories. DHCS asserted that it excluded a review of a health plan's conflict-of-interest controls from these audit categories because it has not considered these controls a high-risk area. In addition, DHCS stated that it does not audit all contractual requirements each year because the scope of its annual audits is specific to the seven audit categories it established based on its 2012 risk assessment. Therefore, DHCS would not audit other contractual requirements, such as those related to conflicts of interest, unless it performed another comprehensive risk assessment and selected these requirements as part of its annual medical audits. However, DHCS indicated that it will consider updating its audit program to include conflict-of-interest controls in the future. When DHCS fails to determine whether health plans are taking steps to identify and prevent conflicts of interest, it risks that health plans are not compliant with applicable requirements and lessens assurance in a plan's ability to confirm that its staff are aware of the need to avoid contracting with providers who may have a financial interest in the plan.

Recommendations

To help identify successful improvement projects, by September 2019 DHCS should require health plans to annually report the results of those projects they plan to continue or expand to other locations. Using this information, by December 2019 DHCS should compile a list of successful improvement projects to share with other health plans on a periodic basis, but at least annually.

To ensure that DHCS consistently identifies health plans that do not have required processes to detect and prevent fraud, it should immediately reevaluate its audit program for medical audits and revise it as necessary to ensure that staff follow the audit procedures regarding fraud and abuse programs.

By September 2019, and periodically thereafter, DHCS should conduct another risk assessment and ensure that it includes a comprehensive evaluation of which contract areas—including conflicts of interest—it should focus on in its annual medical audits. Going forward, it should conduct this type of comprehensive risk assessment and ensure that it reviews health plans' conflict-of-interest controls at least once every three years.

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DHCS Does Not Ensure That Health Plans' Administrative Expenses Are Reasonable And Necessary

Key Points

- DHCS does not provide guidance on what types of administrative expenses are reasonable and necessary, which likely contributed to three health plans making some questionable administrative expenditures.
- DHCS does not oversee, or provide guidance on, health plans' bonus programs. San Joaquin and Santa Clara paid bonuses to their employees, whereas Kern did not.

DHCS Oversight of Health Plans' Administrative Expenses Is Lacking, Leading to Some Questionable Costs

DHCS' lack of guidance likely contributed to questionable administrative expenses that we identified at the three health plans we visited. Federal and state regulations generally require that health plans' administrative expenses be below 15 percent of the Medi-Cal funds they receive, and be reasonable. State regulations also require administrative expenses to be necessary. DHCS is the oversight entity to ensure compliance with applicable provisions of state and federal Medi-Cal laws. However, DHCS does not do enough to ensure, as its contracts and regulations require, that health plans' administrative expenses are reasonable and necessary. As described in the Introduction, DHCS issues guidance to health plans regarding contract and legal requirements in All-Plan Letters; however, it has not issued such guidance as it relates to reasonable and necessary administrative expenses. Further, it has not specifically defined what constitutes reasonable and necessary administrative expenses under state regulations. Without this oversight, it is not surprising that we found that Kern, San Joaquin, and Santa Clara each had some questionable administrative expenses from 2015 through 2018.

All three health plans' administrative expenses were below the 15 percent threshold, but we found that they used Medi-Cal funding for questionable purposes, including events for their employees. Both Kern and San Joaquin confirmed that they made these purchases with Medi-Cal funds. Santa Clara pays its administrative expenses from a single account using multiple revenue sources, more than 90 percent of which is Medi-Cal, with substantially all of the remainder consisting of other federal funds. Table 1 shows that, based on a selection of administrative expenses, each of the three health plans spent between $4,600 and $47,000 annually on expenses related to events for their employees and sometimes guests. In addition, Kern spent $7,200 annually on an automobile allowance for its chief executive officer (CEO). Further, San Joaquin provided coffee for its employees—an expenditure approved by its board—at an annual cost of $22,400 or more. The health plans indicated that these expenses were for increasing employee morale and retention. Although the three health plans' respective boards approve their budgets, which include total budgeted amounts for administrative expenses, the boards do not review or approve individual expenses unless they exceed certain thresholds.

Table 1
Three Health Plans Spent Thousands of Dollars on Questionable Purposes

HEALTH PLAN	ADMINISTRATIVE EXPENSE DESCRIPTION	COST	YEAR
Kern	Retirement luncheon	$4,600	2015
	CEO annual automobile allowance	7,200	2015
	Employee recognition event	8,000	2015
	CEO annual automobile allowance	7,200	2016
	Employee and family event at county fair	6,300	2016
	Employee recognition event	11,200	2016
	CEO annual automobile allowance	7,200	2017
	Employee recognition event	23,400	2017
	CEO annual automobile allowance	7,200	2018
	Employee recognition event	47,000	2018
	Total	**$129,300**	
San Joaquin	Employee celebration	$12,800	2015
	Employee coffee	22,400	2015
	Employee coffee	28,200	2016
	Employee coffee	27,300	2017
	Employee end of year party	10,000	2017
	Employee coffee	25,400	2018
	Total	**$126,100**	
Santa Clara	Employee picnic	$5,000	2016
	Employee picnic	10,500	2017
	Employee picnic	7,000	2018
	Total	**$22,500**	
	Total of All Three Health Plans	**$277,900**	

Source: Analysis of a selection of the three health plans' administrative expenses from 2015 through 2018.

We question how DHCS would consider these expenses reasonable. Further, these expenses are not strictly necessary for the health plans to operate. DHCS explained that it oversees health plans' administrative expenses at the aggregate level—meaning that it performs a calculation to ensure that each health plan's administrative expenses do not exceed 15 percent of its net revenue. DHCS stated that it does not perform audits of health plans' financial information and that it monitors the health plans' aggregate expenditures at the category level, such as the total amount they spend on marketing. However, we believe this limited review is insufficient because as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that the health plans comply with contractual and legal requirements that administrative expenses be reasonable and necessary.

State law and regulations are, in some instances, inconsistent. For example, one section of state regulations generally authorizes charitable or other contributions as allowable administrative expenses, while another section specifically prohibits donations as allowable administrative expenses. Further, state regulations generally define allowable administrative expenses in broad categories, such as the cost of soliciting and enrolling subscribers and enrollees; salaries, bonuses, and benefits; costs associated with the establishment and maintenance of provider agreements; and the costs of marketing. Conversely, federal regulations specifically disallow spending federal funds for entertainment costs. DHCS asserted, however, that these specific federal regulations are not applicable to the health plans because they receive premiums to provide managed care instead of a fee-for-service reimbursement.

Without specific guidance and direct oversight from DHCS, the health plans indicated that they rely on existing requirements and their own professional judgment to determine what administrative expenses are reasonable and necessary, which likely contributed to them making the questionable expenditures we show in Table 1. Thus, DHCS risks that health plans are making administrative expenses that are not reasonable and necessary. Therefore, we believe that DHCS would benefit from providing specific direction to the health plans regarding the types of administrative expenses that are reasonable and necessary.

The Health Plans' Bonus Programs Vary, and DHCS Lacks Guidance on What Constitutes Reasonable Bonuses

State and federal regulations both allow health plans to use Medi-Cal funding to pay employees reasonable bonuses. However, we found that the three health plans we reviewed take different approaches when determining executive and staff bonuses, resulting in amounts that vary widely from one plan to another. Likely contributing to these inconsistencies is that DHCS does not oversee health plans' employee bonuses. Specifically, DHCS does not provide guidance to health plans on the types of bonus programs that are reasonable. As state law designates DHCS as the oversight entity to ensure full compliance with both its Medi-Cal contracts and applicable provisions of state and federal law, DHCS is responsible for ensuring that the health plans it contracts with and oversees have reasonable and necessary administrative expenses, including bonuses.

San Joaquin and Santa Clara both spent Medi-Cal funds on employee bonuses, whereas Kern did not pay bonuses to employees. Table 2 shows a comparison of the total bonus

amounts San Joaquin and Santa Clara paid to their executives and other employees from fiscal years 2015–16 through 2017–18. San Joaquin stated that it believes the bonuses it paid its executives and certain other employees are reasonable because its governing board approved them and because it competes against commercial health plans, so its compensation must therefore be competitive to attract and retain talented employees. In contrast, Kern explained that it maintains and administers a compensation program based on employee performance that does not currently include bonuses for any of its employees.

Table 2
San Joaquin Paid Higher Bonuses Than Santa Clara From Fiscal Years 2015–16 Through 2017–18

	SAN JOAQUIN			SANTA CLARA		
	AMOUNT	EMPLOYEES THAT RECEIVED BONUSES	AVERAGE BONUS PER EMPLOYEE	AMOUNT	EMPLOYEES THAT RECEIVED BONUSES	AVERAGE BONUS PER EMPLOYEE
Fiscal Year 2015–16						
Executives	$144,200	7	$20,600	$46,200	5	$9,200
Other Employees	358,100	44	8,100	286,100	145	2,000
Totals	**$502,300**	**51**	–	**$332,300**	**150**	–
Fiscal Year 2016–17						
Executives	$337,100*	7	$48,200	$59,700	5	$11,900
Other Employees	437,900	48	9,100	280,200	188	1,500
Totals	**$775,000**	**55**	–	**$339,900**	**193**	–
Fiscal Year 2017–18						
Executives	$220,000*	5	$44,000	$30,300†	1	$30,300
Other Employees	434,200	54	8,000	0	0	0
Totals	**$654,200**	**59**	–	**$30,300**	**1**	–

Source: San Joaquin's and Santa Clara's reported bonus payments to executives and other employees.

Note: San Joaquin stated that it did not award bonuses to two executives for fiscal year 2017–18.

* The amounts for San Joaquin's executives in fiscal years 2016–17 and 2017–18 include deferred compensation, which the health plan stated consists of funds it places into an account that is an asset of the health plan until the employees withdraw it.

† Santa Clara stated that it did not meet the goals of its bonus program and decided not to pay bonuses to any of its employees in fiscal year 2017–18, with the exception of its CEO.

We found that San Joaquin and Santa Clara followed their policies when awarding bonuses. San Joaquin and Santa Clara both have high-level policies stating that they will generally base the amounts of employee bonuses on position, salary, and performance in achieving bonus program objectives. For example, based on employee position and their annual base salary, in fiscal year 2017–18 San Joaquin allowed for up to an 18 percent bonus for the CEO and up to 15 percent for other executives. Ultimately, San Joaquin paid its executives bonuses of roughly

10 percent of their base salaries in fiscal year 2017–18. In addition, the health plan paid its CEO a bonus of 12 percent of her base salary for fiscal year 2017–18, and a bonus of 14 percent of her base salary in fiscal year 2016–17. San Joaquin stated that it uses compensation studies to inform the amounts it pays under its bonus program, along with its need to attract and retain highly qualified employees. Santa Clara's policy allows for a maximum of 5 percent of employees' base salaries as bonuses, with the exception of the CEO, who may receive a larger bonus. For example, in fiscal year 2016–17 the health plan paid bonuses of 2 percent of employees' annual salaries, and it did not pay bonuses to employees in fiscal year 2017–18 because the plan did not meet its bonus program objectives. On the other hand, Santa Clara's CEO received a bonus of 7 percent in fiscal year 2017–18 because the health plan's governing board determines the CEO bonus each year based on her employee contract, her individual performance, and other factors. Santa Clara stated that it based its rationale for determining whether these percentages were reasonable upon a comparison to other health plans, and the CEO's previous experience in working at other health plans. Finally, we found that both health plans considered whether they met their bonus program objectives when determining the bonus amounts they paid during the period we reviewed.

DHCS does not believe its role is to provide guidance regarding what constitutes a reasonable bonus program. However, we found that the health plans' bonus programs we reviewed varied and in some cases were questionable. For instance, San Joaquin paid its employees bonuses during years when it was performing poorly and was on a quality CAP. Further, we found that despite comparable executive salaries, San Joaquin paid its executives higher bonuses than those paid by Santa Clara. Without providing guidance, DHCS risks that health plans will pay bonuses when they are performing poorly, or will pay bonuses that are excessive.

Recommendations

DHCS should develop and issue an All-Plan letter or other binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses. Further, it should provide guidance to health plans on what is a reasonable bonus program. In doing so, DHCS should perform the necessary oversight to ensure health plans comply with this direction.

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DHCS Properly Recouped Excess Funds From Health Plans

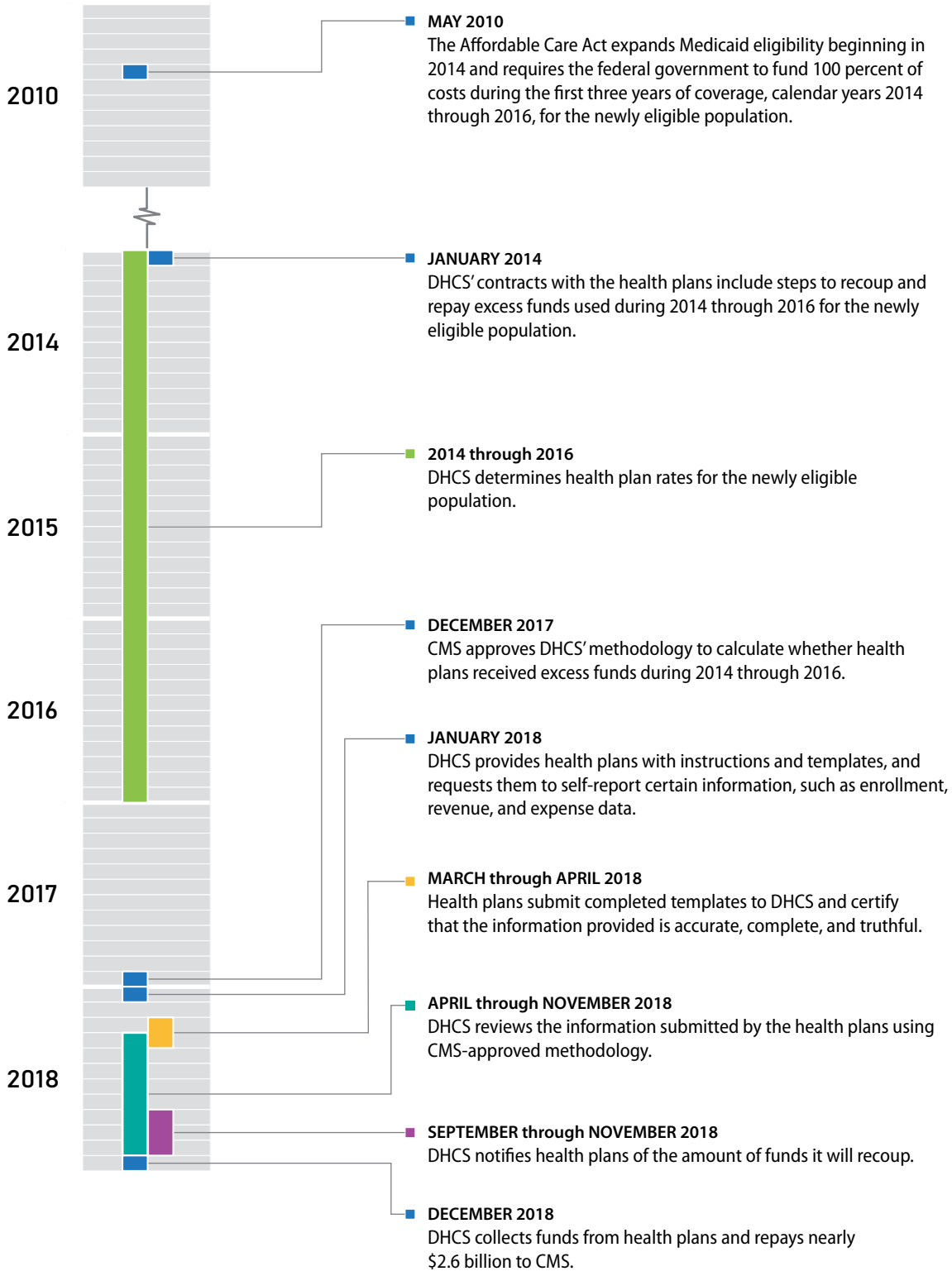
Key Point

- DHCS recovered nearly $2.6 billion in excess payments to health plans resulting from implementation of the federal Patient Protection and Affordable Care Act (Affordable Care Act).

DHCS complied with federal requirements in recouping excess funds it paid to health plans during the first three years of expanded coverage resulting from the Affordable Care Act. The Affordable Care Act expanded Medicaid eligibility requirements for certain adults in participating states and required the federal government to fund 100 percent of the health care costs for this population during the first three years of expanded coverage—2014 through 2016. In 2013 state law was amended to expand Medicaid eligibility in California. Subsequently, DHCS included provisions in its Medicaid contracts with the health plans requiring DHCS to calculate and repay the federal government any excess funds they received from covering this newly eligible population. Specifically, DHCS amended the contracts to require the health plans to spend at least 85 percent of the premiums, less certain designated amounts, they received on allowed medical expenses for newly eligible beneficiaries. Health plans that spent less than 85 percent are required to repay the difference. Alternately, health plans that spent more than 95 percent on allowed medical expenses are reimbursed by DHCS, while health plans that spent between 85 and 95 percent on allowed medical expenses do not pay or receive any funds. Figure 6 on the following page shows the timeline DHCS followed to recoup the excess funds health plans received from covering the expanded adult Medi-Cal population and to repay the federal government.

In December 2017, CMS—the federal agency that oversees the Medicaid program—approved DHCS' proposed methodology to calculate whether health plans received excess funds and to recoup these funds if necessary. This methodology included steps to review each health plan's self-reported data and compare them to data the health plans previously reported to better assess accuracy, completeness, and reasonableness, and make any adjustments it deemed necessary. DHCS completed the recoupment process in December 2018 and repaid CMS nearly $2.6 billion in excess funds, as Table 3 shows on page 33. Although DHCS acknowledged that it did not audit the health plans' self-reported data before approving the recoupment amounts, the CMS-approved methodology includes provisions for DHCS, CMS, and other state or federal oversight entities to reserve the right to audit health plans' data in the future. In addition, CMS notified DHCS that it engaged a contractor to conduct audits that will be initiated in 2019 and include a review of the health plans' self-reported data to ensure that the total recouped amount is accurate.

Figure 6
DHCS Recouped and Repaid CMS Nearly $2.6 Billion to Cover Excess Funds Paid to Health Plans



Source: The Affordable Care Act, DHCS' methodology—approved by CMS—used to calculate the amount of excess funds health plans had to remit to DHCS, and DHCS' timeline to complete the recoupment process.

Our examination of DHCS' process to review the health plans' self-reported data found that it consistently adhered to procedures that are described in CMS' approved calculation methodology that required DHCS to compare a health plan's reported enrollment, revenue, and expense data to corresponding data in DHCS' systems. To ensure that it complied with the approved methodology, DHCS developed roughly 70 procedural steps to review the health plans' self-reported data. DHCS' procedures include steps such as analyzing health plans' reported expenses and completing a qualitative review of a selection of incentive payments, which are made by health plans to providers to promote or reward improved quality of care. We reviewed selected elements of DHCS' review of Kern's reported data and found that DHCS sufficiently followed and documented the proper steps.

Table 3
DHCS Recouped Excess Funds From the Health Plans Ranging From $3 Million to $316 Million to Repay CMS

HEALTH PLAN	TOTAL EXCESS FUNDS RECOUPED (IN MILLIONS)
Alameda Alliance for Health	$179.3
Anthem Blue Cross Partnership Plan	184.2
California Health & Wellness	99.7
CalOptima	101.8
CalViva Health*	0
Care 1st Partner Plan, LLC	88.9
CenCal Health	83.9
Central California Alliance for Health	286.1
Community Health Group Partnership Plan	121.5
Contra Costa Health Plan*	0
Gold Coast Health Plan	160.5
Health Net Community Solutions, Inc.	272.1
Health Plan of San Joaquin	143.4
Health Plan of San Mateo	109.3
Inland Empire Health Plan	33.0
Kaiser Permanente	33.4
Kern Health Systems	21.8
Los Angeles Care Health Plan	226.2
Molina Healthcare of California Partner Plan, Inc.	92.1
Partnership Health Plan of California	316.4
San Francisco Health Plan	6.7
Santa Clara Family Health Plan	3.0
Total	**$2,563.3**

Source: DHCS notification letters to health plans regarding the amount of excess funds that it would recoup.

Note: The Aetna Better Health of California, Rady Children's Hospital, and the United Healthcare Community Plan are excluded from this table because these plans did not begin contracting with DHCS until after the Affordable Care Act expansion.

* CalViva Health and the Contra Costa Health Plan did not owe DHCS funds because these plans spent more than 85 percent of their premiums, less certain designated amounts, on allowable expenses for newly eligible beneficiaries.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
California State Auditor

Date: April 4, 2019

APPENDIX

Scope and Methodology

The Audit Committee directed the California State Auditor to examine DHCS' oversight of San Joaquin and similar health plans. Specifically, it directed us to identify the actions DHCS has taken to ensure that health plans provide quality of care that meets key state and federal standards. It also directed us to determine whether DHCS provides sufficient oversight of health plans' administrative expenses and employee bonuses. The table below lists the objectives that the Audit Committee approved and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant laws and regulations related to DHCS' oversight responsibilities for health plans.
2	Determine whether DHCS has conducted all required audits and rate adjustments of health plans, and evaluate its effectiveness in adjusting rates.	• Determined that DHCS' required annual medical audits do not affect health plan rate adjustments. Therefore, we interviewed DHCS staff and reviewed relevant federal laws and documents to determine what type of payment adjustments DHCS is responsible for making. • Evaluated DHCS' effectiveness and timeliness in recouping excess funds it provided to the health plans resulting from implementation of the Affordable Care Act and repaying them to CMS. • Reviewed DHCS' calculations for one health plan's total recoupment amount to ensure that it adhered to CMS' approved calculation methodology.
3	Identify and evaluate the results of actions taken by DHCS in the most recent two or three years to improve the quality of health care services delivered by San Joaquin and similar health plans, including any changes to Medi-Cal payments.	• Identified health plans DHCS considered to be similar to San Joaquin. Selected three similar health plans—Anthem, Health Net, and Molina—in addition to San Joaquin that were on quality CAPs between 2014 and 2017. We identified actions taken by DHCS to improve the quality of health care services delivered by these health plans. • Interviewed DHCS staff to determine whether it lowers Medi-Cal payments to health plans to improve health care quality. DHCS stated that it could not lower health plan payments due to poor performance because the rates it pays health plans are already as low as the law allows. • Using relevant data on health plans' performance in meeting or exceeding the MPLs for DHCS' established quality indicators, evaluated the performance trends of the health plans between 2013 and 2017 overall and specifically in the areas of diabetes, postpartum care, and monitoring persistent medications to assess the results of DHCS' actions to improve quality.
4	Identify steps DHCS has taken to ensure that the quality of care by San Joaquin and similar health plans meets key state and federal standards, including, but not limited to, standards in the area of postpartum care and diabetes treatments.	• Evaluated the actions DHCS took between 2013 and 2017 to ensure that the four health plans that were on quality CAPs met key state and federal quality of care requirements. • For example, for these four health plans, we assessed DHCS' adherence to its policies and procedures for its two primary oversight methods—quality CAPs and audit CAPs—to help ensure that health plans' quality of care meets key state and federal requirements.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
5	Determine whether DHCS provides sufficient management and oversight of San Joaquin and similar health plans, including, but not limited to, oversight of administrative costs and bonuses paid to employees.	Interviewed DHCS staff to determine whether it evaluates health plans' administrative expenses and employee bonuses to ensure that they are reasonable and necessary. Also, we determined whether DHCS provides guidance to health plans regarding what administrative expenses are reasonable and necessary.
6	Evaluate whether DHCS' oversight ensures that San Joaquin and similar health plans have sufficient controls in place to detect and prevent waste, abuse, mismanagement, and conflicts of interest.	• Reviewed DHCS' contracts with health plans to assess whether they require health plans to implement processes to detect and prevent waste, abuse, mismanagement, and conflicts of interest. • Interviewed DHCS staff and reviewed its annual medical audit policies and procedures to assess whether DHCS oversees health plans' processes to prevent and detect waste, abuse, mismanagement, and conflicts of interest. Reviewed the annual medical audits DHCS completed of Kern, San Joaquin, and Santa Clara between 2016 and 2018 to determine whether DHCS sufficiently evaluated whether the health plans had processes in place to prevent fraud, waste, and abuse.
7	To the extent possible, determine whether DHCS' administrative costs, including its employee bonuses, are appropriate and allowable under Medi-Cal funding conditions.	• For San Joaquin and two similar health plans we reviewed that were not on quality CAPs—Kern and Santa Clara—we used their financial information to determine whether their total administrative expenses were within 15 percent of the total Medi-Cal funds they received as state regulations generally require. Further, we reviewed a selection of administrative expenses the health plans made from 2015 through 2018 to identify whether they were reasonable and necessary. We also reviewed their bonus programs to determine whether they were reasonable and whether the health plans paid bonuses in compliance with their policies. • For a judgmental selection of 20 contracts, we reviewed documentation to determine whether San Joaquin followed its contracting policies. We did not identify any reportable issues.
8	Review and assess any other issues that are significant to the audit.	We did not identify any other significant issues.

Source: Analysis of the Audit Committee's audit request number 2018-115, as well as information and documentation identified in the column titled Method.

DHCS
JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides responses to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary.* The CSA conducted this audit and issued five findings and four recommendations.

DHCS agrees with three recommendations and partially agrees with one recommendation, and has prepared corrective action plans to implement them. DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Coordination Manager, at (916) 713-8812.

Sincerely,

Jennifer Kent
Director

Enclosure

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* California State Auditor's comments begin on page 47.

Ms. Elaine M. Howle
Page 2

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The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

Finding 1:	Although DHCS appropriately monitors health plans' implementation of their improvement projects for quality Corrective Action Plans (CAP), it is missing an opportunity to ensure that health plans formally adopt successful projects and to identify best practices that can be shared with other plans. Specifically, once an improvement project reaches its completion, the health plan can choose to adopt or abandon the project. If a health plan chooses to adopt the improvement project, it may do so at only the location where it was completed or it may expand the project to other locations. In instances in which the improvement projects are successful and the health plan indicates it will adopt, DHCS acknowledged that it does not formally follow up on whether the health plans do so.
Finding Agreement:	Fully Agrees with Finding
Recommendation 1:	To help identify best practices from successful improvement projects, by September 2019, DHCS should require health plans to annually report the results of those projects they plan to continue or expand to other locations. Using this information, by December 2019, DHCS should compile a list of successful improvement projects to share with other health plans on a periodic basis, but at least annually.
Recommendation Agreement:	Fully Agrees with Recommendation
Response:	DHCS currently compiles information from Medi-Cal managed care health plan (MCP) Plan Do Study Act (PDSA) cycles, Performance Improvement Projects, and CAP submissions to track the types of interventions that MCPs are exploring. DHCS shares promising practices as well as lessons learned based on this information with MCPs through individual MCP technical assistance calls, Quality Collaborative Teleconferences attended by all MCPs, Quality Improvement Highlights that are sent to all MCPs, and a variety of in person meetings, including the quarterly Medical Directors Meetings. DHCS also has developed a Quality Improvement Toolkit that allows MCPs to access many applicable resources in one location through an external SharePoint site.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

DHCS will engage further with MCPs to share promising practices and issue a document summarizing those promising practices, including results of successful PDSA cycles that the MCPs plan to expand. DHCS will work with MCPs to identify appropriate promising or best practices to be implemented in their respective geographic areas.

In addition, DHCS will require MCPs to annually report the results of successful improvement projects they plan to continue or expand to other locations, including whether or not prior year efforts were adopted.

Implementation Status:

☐ Fully Implemented:
Implementation Date:
☒ Not Fully Implemented:
Estimated Implementation Date: December 1, 2019
☐ Will Not Implement

Substantiation:

☐ Attached (Fully Implemented)
☒ Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 2: DHCS should improve its efforts to ensure health plans have adequate processes in place to prevent or detect fraud. Federal regulations mandate that DHCS' contracts with managed care plans require the plans to implement and maintain procedures that are designed to detect and prevent fraud, waste, and abuse.

Although DHCS' annual medical audits include steps for evaluating whether health plans have a fraud and abuse program that includes processes to detect and prevent fraud, they did not identify shortcomings in this area for three of the nine audit reports reviewed.

Finding Agreement: Fully Agrees with Finding

Recommendation 2: To ensure DHCS consistently identifies health plans that do not have required processes to detect and prevent fraud, it should immediately reevaluate its audit program for medical

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

audits and revise it as necessary to ensure that staff follow the audit procedures concerning fraud and abuse programs.

Recommendation Agreement: Fully Agrees with Recommendation

Response: DHCS accepts this finding with respect to Kern. DHCS plans to perform an internal review of audit work papers to identify the extent of this issue. DHCS also plans to follow up with staff to identify gaps in internal controls surrounding our audit procedures.

Additionally, DHCS is reevaluating our medical audit review process and looking for ways to implement controls to ensure that staff follow annual medical audit procedures.

Implementation Status:
☐ Fully Implemented:
Implementation Date:
☒ Not Fully Implemented:
Estimated Implementation Date: July 1, 2019
☐ Will Not Implement

Substantiation:
☐ Attached (Fully Implemented)
☒ Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 3: DHCS does not verify the steps health plans take to identify and prevent conflicts of interest. DHCS' contracts with the health plans we reviewed require them to adhere to specified state conflict of interest regulations and requirements, which include prohibiting health plans from contracting with certain individuals who have a substantial financial interest in the health plan. However, we found that DHCS does not determine through its annual medical audits whether health plans adhere to the state's conflict of interest requirements. When DHCS fails to determine whether health plans are taking steps to identify and prevent conflicts of interest, it risks that health plans are not compliant with applicable requirements and lessens assurance in a plan's ability to confirm that its staff is aware of the need to avoid contracting with providers who may have a financial interest in the plan.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

Finding Agreement:	Fully Agrees with Finding
Recommendation 3:	By September 2019 and periodically thereafter, DHCS should conduct another risk assessment and ensure that it includes a comprehensive evaluation of which contract areas—including conflicts of interest—it should focus on in its annual medical audits. Going forward, it should conduct this type of comprehensive risk assessment and ensure that it reviews health plans' conflicts of interest controls at least once every three years.
Recommendation Agreement:	Fully Agrees with Recommendation
Response:	The scope of DHCS' annual medical audits is risk based and, to date, conflict of interest controls and procedures have not been considered a high risk area. In light of the recommendation, DHCS plans to develop additional audit steps to review each plan's conflict of interest process. Specifically DHCS will draft audit procedures to verify the steps taken by the plans to prevent conflict of interest and determine whether they adhere to the state's requirements. DHCS will also look at the plan's processes and controls. DHCS' annual audit scoping for each year's medical audits includes a reassessment of each respective plan's associated risks. The scope of the audit is then augmented, or modified, to include audit test work in the areas that warrant the most attention. DHCS will revisit our processes to evaluate risks during both the annual audit planning/scoping and the assessment of global risk categories to ensure our evaluation of risks are comprehensive.
Implementation Status:	☐ Fully Implemented: Implementation Date: ☒ Not Fully Implemented: Estimated Implementation Date: September 1, 2019 ☐ Will Not Implement
Substantiation:	☐ Attached (Fully Implemented)

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

☐ Not Applicable (Not Fully Implemented or Will Not Implement)

Finding 4:	Federal and state regulations generally require that health plans' administrative expenses be below 15 percent of their revenue, and be reasonable. State regulations also require administrative expenses to be necessary. DHCS is the oversight entity to ensure compliance with applicable provisions of state and federal Medi-Cal laws. However, DHCS does not do enough to ensure, as its contracts and regulations require, that health plans' administrative expenses are reasonable and necessary. DHCS issues guidance to health plans regarding contract and legal requirements in All-Plan Letters; however, it has not issues such guidance as it relates to reasonable and necessary administrative expenses. Further, it has not specifically defined what constitutes reasonable and necessary administrative expenses under state regulations.
Finding Agreement:	Partially Agrees with Finding
Finding 5:	State and federal regulations both allow health plans to use Medi-Cal funding to pay employees reasonable bonuses. However, we found that the three health plans we reviewed take different approaches when determining executive and staff bonuses, resulting in amounts that vary widely from one plan to another. Likely contributing to these inconsistencies is that DHCS does not oversee health plans' employee bonuses. Specifically DHCS does not provide guidance to health plans on the types of bonus programs that are reasonable. As state law designates DHCS as the oversight entity to ensure full compliance with both its Medi-Cal contracts and applicable provisions of state and federal law, DHCS is responsible for ensuring the health plans it contracts with and oversees have reasonable and necessary administrative costs, including bonuses.
Finding Agreement:	Disagrees with Finding
Recommendation 4:	DHCS should develop and issue an All-Plan letter or other binding guidance by March 2020 to the health plans that specifically defines what constitutes reasonable and

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

necessary administrative expenses. Further, it should provide guidance to health plans on what is a reasonable bonus program. In doing so, DHCS should perform the necessary oversight to ensure health plans comply with this direction.

Recommendation Agreement: Partially Agrees with Recommendation

Response: DHCS supports the prudent use of federal and state Medicaid resources. DHCS is prohibited by federal law from directing a plan's administrative expenditures, absent express approval which is not available in this context. Therefore, DHCS fundamentally disagrees with the
① underlying assumptions of the findings and recommendation, and views them to be based on a flawed interpretation of applicable federal law and a misunderstanding of DHCS's
② rate setting practices related to administration. DHCS sees potential value in issuing clarifying guidance to plans, as DHCS deems appropriate, on the types of administrative costs that may be reported for purposes of rate development.

Regarding reasonable and necessary costs, DHCS maintains that its oversight of plans is based in, and limited by, its contracts with plans and its role as the Medicaid
① Agency, which does not confer sweeping regulator-like authority to direct or limit how a plan spends capitation payments received from DHCS for administration. It is important to note that DHCS does not reimburse plans for their actual incurred administrative costs, and does not formulaically base a plan's premiums on that plan's reported
② administrative costs. Instead, when developing the administrative portion of a plan's premiums, DHCS's actuaries annually evaluate plan reported administrative costs to determine reasonable and appropriate levels of funding to include in the final premiums. This rate-setting control incentivizes administrative efficiency as plans' administrative costs are not reimbursed on a one-to-one basis. In addition, federal actuaries annually review and approve the developed premiums, and this mechanism has been demonstrated to be successful as all plans are
③ operating beneath the "reasonable and necessary" 15 percent administrative cost threshold outlined in DHCS-plan contracts and applicable federal and State Medicaid law.

The Department of Health Care Services' (DHCS) Response to the California State Auditor Draft Report Titled: *Department of Health Care Services: It Oversees Medi-Cal Managed Care Health Plans' Quality of Care Sufficiently, but Does Not Ensure Plans' Administrative Costs Are Reasonable And Necessary*
Report Number: 2018-115 (18-15)

DHCS disagrees with the recommendation to issue guidance specific to plan bonus programs. Due to the diversity of possible compensation arrangements, it would be ineffective to issue guidance on bonus programs without also issuing guidance on other methods of compensation (such as salaries). DHCS believes a single, one-size-fits-all policy regarding reasonable and necessary compensation and bonuses is inherently difficult, if not impossible, to fashion based on the significant differences in local markets faced by plans and structural differences across Medi-Cal plans, which include County Organized Health Systems, Local Initiative plans, and publicly traded commercial plans. Further, pursuant to federal law, DHCS would not have the authority to enforce this guidance. Transparency of CEO compensation and bonuses for locally-governed Medi-Cal plans is publicly available and allows for each board to make determinations for appropriate compensation in a way that balances stewardship of public dollars with ability to attract qualified executives. (4)

Implementation Status:

☐ Fully Implemented:
Implementation Date:
☒ Not Fully Implemented:
Estimated Implementation Date: March 2020
☐ Will Not Implement

Substantiation:

☐ Attached (Fully Implemented)
☒ Not Applicable (Not Fully Implemented or Will Not Implement)

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COMMENTS

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on DHCS' response to the audit. The numbers below correspond to the numbers we have placed in the margin of DHCS' response.

We disagree that our finding and recommendation is based on a flawed interpretation of federal law and that federal law prohibits DHCS from directing a plan's administrative expenditures. As we describe on page 25, federal regulations, as well as state law and DHCS' contracts with the health plans, require administrative expenses to be reasonable. State regulations also require that they be necessary. Moreover, as we state on page 26, as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that the health plans comply with contractual and legal requirements for administrative expenses to be reasonable and necessary. Thus, we stand by our recommendation that DHCS develop and issue an All-Plan letter or binding guidance to the health plans that specifically defines what constitutes reasonable and necessary administrative expenses, and perform the necessary oversight to ensure they comply with this direction. (1)

DHCS misunderstands the basis of our finding. Specifically, our finding is not based on DHCS' rate setting practices, including how it develops health plans' premiums. Regardless of its rate setting practices, DHCS still has an obligation to ensure health plans' administrative expenses are reasonable and necessary. As we state on page 26, as the oversight entity that contracts with health plans, DHCS is responsible for ensuring that health plans comply with contractual and legal requirements that administrative expenses be reasonable and necessary. Thus, until it develops and issues guidance to the health plans on what constitutes reasonable and necessary administrative expenses, as we recommend on page 29, DHCS risks that health plans will make questionable administrative expenditures. (2)

We disagree that federal regulations, state law, or DHCS' contracts with the health plans define "reasonable and necessary" administrative expenses as a 15 percent threshold, as DHCS indicates in its response. As we state on page 25, health plans' administrative expenses cannot exceed 15 percent of their revenue and must be reasonable and necessary. Moreover, there is nothing precluding DHCS from requiring stricter standards, such as lowering the threshold, with CMS approval. In fact, our recommendation on page 29 intends (3)

to ensure that DHCS provides health plans with direction on what administrative expenses constitute reasonable and necessary, rather than relying on only the 15 percent threshold.

④ DHCS misunderstands our recommendation that it issue guidance to health plans regarding what constitutes a reasonable bonus program. We do not recommend that DHCS provide a one-size-fits-all policy. As we describe on page 27, state and federal regulations require that bonus programs be reasonable, and DHCS performs no oversight of health plans' bonus programs. This lack of oversight, as we state on pages 27 to 29, likely contributed to two of the health plans taking different approaches when determining executive and staff bonuses, and the third health plan not having a bonus program, resulting in amounts that vary widely from one plan to another. Notably, one of the three health plans we reviewed awarded bonuses to its employees and executives when it was performing poorly and while on a quality CAP. In fact, this health plan decided in January 2019 to provide its chief executive officer with a bonus of more than $50,000 even though DHCS had imposed a monetary sanction of $135,000 on it in October 2018 for not meeting the quality CAP requirements. In this instance, the absence of DHCS guidance allowed a health plan to award its CEO a bonus even though the health plan, under her leadership, was failing to meet the quality of care standards for its beneficiaries. Therefore, we stand by our recommendation.

Santa Clara Family Health Plan™

March 1, 2019

Ms. Elaine Howle, CPA
California State Auditor
621 Capital Mall, Suite 1200
Sacramento, CA 95814

Dear Ms.Howle:

We thank the California State Auditor for this opportunity to clarify certain comments regarding Santa Clara Family Health Plan (the Plan).

Funding Usage
The Plan receives funding from a variety of sources, including federal, state and county government funds plus investment and rental income. The Plan uses funding from all sources to pay its medical and administrative expenses. The health plan uses its professional judgment and experience prior to incurring administrative expenses, all of which were considered reasonable, necessary and in compliance with current regulatory requirements. ①

Annual Company Picnics
On an annual basis, the Plan sponsors an employee picnic. These are very modest events with an average cost of under $30 per person. Attendance of all employees is encouraged, no alcohol is allowed, and non-employees do not attend. The purpose of these picnics is to enhance employee morale, build teamwork and increase employee retention - all of which are necessary to retain talented employees in the Silicon Valley area. We are unaware of any state or federal regulations precluding holding employee picnics. ①

Team Incentive Program
The Plan maintains a program for all employees (other than the Plan's CEO) to earn a Team Incentive of up to 5% of base salary. To qualify for any payment, the Plan must achieve a net operating surplus and achieve certain annually-determined team incentive goals. The team incentive goals are a subset of the Plan's annual goals. The Governing Board reviews plan performance at fiscal year-end and approves any team incentive payout.

CEO Incentive Bonus
As per the CEO's employment agreement, the CEO is eligible for an annual incentive bonus. The amount of the bonus is determined by the Plan's Governing Board based on the CEO's job performance which is largely contingent on attaining the Plan's annual goals.

Sincerely,

Christine M. Tomcala

Christine M. Tomcala
Chief Executive Officer

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* California State Auditor's comment appears on page 51.

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COMMENT

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM SANTA CLARA FAMILY HEALTH PLAN

To provide clarity and perspective, we are commenting on Santa Clara Family Health Plan's (Santa Clara) response to the audit. The number below corresponds to the number we have placed in the margin of Santa Clara's response.

We disagree with Santa Clara that its administrative expenses were reasonable, necessary, and in compliance with regulatory requirements. As we state on page 25, federal and state regulations generally require health plans' administrative expenses to be reasonable, and state regulations also require administrative expenses to be necessary. Table 1 on page 26 shows that we identified more than $22,000 in questionable administrative expenses that Santa Clara spent on employee picnics. As we state on page 27, federal regulations specifically disallow spending federal funds for entertainment costs. Further, although Santa Clara correctly states that it has multiple funding sources, as we describe on page 25, more than 90 percent of this funding is Medi-Cal, with substantially all of the remainder consisting of other federal funds. Therefore, we stand by our conclusions. (1)